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Medicaid Division
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2027-2032

Oregon 1115 Medicaid Waiver Renewal

Application for Extension of Waiver Authorities

Project Number 11-W-00415/10 and 21-W-00073/10

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Section 1: Introduction

The Oregon Health Authority (OHA) is pleased to submit its extension application to the Centers for Medicare & Medicaid Services (CMS) for the Oregon Health Plan (OHP) 1115(a) Demonstration Waiver for the October 1, 2027 through September 30, 2032 demonstration period. This extension application builds on the successes of the current waiver and reflects OHA's commitment to advancing the health care and well-being of OHP members.

Effective in 1994 and most recently renewed in 2022, Oregon's 1115(a) demonstration has been a successful tool for innovating Oregon's health care system, improving care, and lowering costs. Oregon is excited to continue its health care transformation through specific modifications to the Medicaid and CHIP programs under its current waiver. Building on the lessons and successes of the current waiver, this waiver application focuses on sustained progress toward Oregon's health policy goals and prioritizing Tribal partner requests to improve health outcomes in communities across Oregon.

OHA honors the government-to-government relationship with the Nine Federally Recognized Tribes in Oregon and follows federal and state laws, agency policies and processes to ensure tribal sovereignty, self-determination and self-governance is respected. OHA understands the state's role of upholding the federal trust responsibility to provide health care to Indian people, as the state Medicaid authority. This also includes partnering with the Urban Indian Health Program.

In this request, Oregon proposes to renew certain authorities without modification, modify others based on implementation experience, and discontinue authorities no longer aligning with federal guidance. Informed by lessons learned and partner input, this request represents Oregon's commitment toward advancing Oregon's health care system and caring for the Oregonians supported by OHP.

Section 2: 2022 - 2027 Waiver and Key Accomplishments

2.1 Summary of 2022 - 2027 Waiver Objectives

Oregon's Section 1115(a) Demonstration aimed to strengthen its successful Coordinated Care Organization (CCO) model, evidence-based coverage design, and Tribal partnerships. Specifically, Oregon sought to advance the following goals:

- Providing a basic benefit package;

- Ensuring broad participation by health care providers;
- Implementing a clinical effectiveness and cost-effectiveness process for making decisions about provision of health care for Oregonians;
- Demonstrating the effectiveness, through extensive measurement and monitoring, of approaches to improving the delivery system for Medicaid beneficiaries in Oregon in:
    - Improving the individual experience of care;
    - Improving the health of populations; and
    - Reducing the per capita costs of care for populations through such improvements.
- Expanding the scope of services available through Indian Health Care Providers including Indian Health Service, Tribal 638 Programs, and the Urban Indian Health Program (I/T/U), stabilizing Tribal health systems, and improving health outcomes for Medicaid and low-income populations utilizing these facilities.

2.2 Key 2022 - 2027 Waiver Accomplishments

Building upon the OHP waiver's historical successes and guided by core waiver objectives, Oregon's 2022-2027 demonstration yielded substantial, measurable progress across health care access, quality, and cost containment.

Specifically, Oregon advanced its health care transformation via the following CMS-approved authorities during the 2022-2027 period:

Health-Related Social Needs (HRSN)

CMS approved Medicaid coverage of evidence-based HRSN services addressing OHP members' housing and nutrition needs. Between 2024 and 2026, OHA began providing these supports to eligible individuals to successfully address nutrition needs, keep members healthy in their homes during extreme weather events, promote members' housing stability, prevent eviction, and provide flexibility to address underlying health needs through connection to community-based services.

Nutrition Supports

OHA has launched four nutrition services over the course of the waiver, including:

- Medically Tailored Meals (MTMs), including MTM Assessments (launched in January 2025)
- Nutrition Education (launched in January 2025)

- Fruit and Vegetables (launched in July 2026)
- Pantry Stocking (launched in July 2026)

From January 2025 to June 2026, over 80,000 MTMs and 230 Nutrition Education sessions have been provided. Oregon continues to monitor progress of the recently implemented Pantry Stocking and Fruit and Vegetable benefits and build understanding of best practices for identifying and connecting eligible members to services as the program matures.

Housing Supports

OHA has been able to deliver meaningful housing-related support across Oregon. As of June 2026:

- More than 15,000 unique members have received rent and utility financial assistance. These services help members who are experiencing complex health conditions stay housed during short-term disruptions in their ability to pay their rent and utilities.
- More than 7,400 unique members have received HRSN Home Changes for Health services. These services help prevent members who have health conditions sensitive to extreme weather events, such as wildfire smoke and excessive heat from experiencing exacerbation of health conditions and requiring acute care by providing them with devices to help them stay healthy in their homes.
- More than 100 unique members have received HRSN Home Changes for Safety services. These services help improve the safety and accessibility of a member's residence by providing home modifications and remediations, such as wheelchair ramps and pest control services.
- CMS-approved infrastructure funding also fostered collaboration between Medicaid and housing providers, enabling 71 new-to-Medicaid housing providers to deliver services and resulting in the expansion of the HRSN provider network to 125 HRSN Housing providers.

Outreach and Engagement Supports

OHA has implemented HRSN Outreach & Engagement (O&E) benefits to help OHP members apply for and receive HRSN benefits as well as other social and healthcare services. As of June 2026:

- More than 28,000 unique members have received HRSN O&E services, making it the most utilized of all the HRSN benefits. By comparison, the number of unique members who have received O&E services is nearly twice the number of members who have received HRSN rent and utilities financial assistance.

Young Adults with Special Health Care Needs (YSHCN)

CMS approved expanded coverage for YSHCN ages 19 up to 26, providing eligible members with continued service access and support as they transition from pediatric to adult coverage and care. OHA initially launched the YSHCN program for eligible 19- and 20-year-olds in January 2025 and expanded coverage to 21-year-olds in January 2026. As of September 2026, over 49,000 young adults with special health care needs have enrolled in the YSHCN program. Early interviews conducted with YSHCN OHP members and key entities reported being able to access more services, or being able to access existing services more quickly compared to their previous coverage.

Continuous Eligibility (CE)

CMS approved continuous eligibility from birth through age five and 24-months of continuous eligibility for individuals ages six and older. As of July 2026, over 700,000 children aged 0-18 maintained OHP coverage due to continuous eligibility.

Delivery System

OHA strengthened the CCO model, building on its integrated, community-based approach to deliver high-quality care and address members' broader health needs. Oregon's CCO model achieved consistent overall improvement in quality of care and provision of child well-care visits for OHP members age 3-6.[1] The 2025 Mental Health Parity evaluation found that mental health and substance use disorder treatment was in parity with medical/surgical care in Oregon.[1] Additionally, for the statewide 2022-2024 Mental Health Access Performance Improvement project evaluating the percentage of members with a mental health service need who received mental health services, nearly all CCOs showed statistically significant improvement compared to baseline.[1]

Traditional Health Care Practices

Oregon made substantial progress in achieving its goal of securing Medicaid reimbursement for Traditional Health Care Practices received through Indian Health Care Providers to support improving health outcomes for Medicaid and low-income populations utilizing these facilities.

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[1] https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/OR2025_EQR_Technical_Report_F1.pdf

As of October 2026, six of the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program, Native American Rehabilitation Association of the Northwest (NARA-NW), are successfully delivering and billing Medicaid for Traditional Health Care Practices.

Overall Summary

Through close collaboration with CCOs, providers, Tribes, and community partners, and with rigorous monitoring and continuous quality improvement, Oregon successfully translated its goals into tangible benefits that measurably improved OHP member health outcomes. Oregon will build on the progress made in the 2022-2027 demonstration, through this waiver extension.

Section 3: Waiver Extension

3.1 Goals and Objectives of the Extension

3.1.1 Goals and Objectives

The extension of the Oregon Health Plan (OHP) 1115 Demonstration is an opportunity to consolidate the gains Oregon has made under the current demonstration and to concentrate the next five years on the coverage, services, and delivery system features that have proven to be most effective. Building on the goals outlined in the 2022-2027 waiver, Oregon proposes the following goals to guide the extension of the demonstration:

- Sustain a high-quality benefit package that supports the health and well-being of OHP members;
- Operate a coordinated care delivery model that is accountable for value, quality, and outcomes through ongoing measurement and monitoring;
- Maintain access to critical preventive services and treatments, in particular for young adults with special health care needs;
- Invest in targeted, high-value HRSN and reentry supports to members for whom they are most likely to benefit, including those navigating transitions in care or coverage that builds off what has been learned to date around HRSN implementation;
- Sustain access to services available through Indian Health Care Providers and strengthen the Tribal health system; and

- Implement benefits in a manner that emphasizes program integrity, fiscal responsibility, and operational sustainability in an effort to be excellent stewards of federal and state resources.

In this request, Oregon proposes to renew certain authorities without modification, modify others based on implementation experience, and discontinue authorities no longer aligning with federal guidance.

3.1.2 Alignment with Tribal Priorities

OHA is committed to working with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) to identify mechanisms that help achieve Tribal health care objectives while honoring the government-to-government relationship between the Tribes and the State.

Building on the success of the current 1115 waiver and needs of American Indian / Alaska Native (AI/AN) members, Tribal representatives, in partnership with OHA, have identified a number of Tribal priorities for inclusion in this application described in Sections 3.2.2 (Traditional Health Care Practices), 3.3.5 (Traditional Health Care Practices Implementation Funds), 3.3.6 (Primary Care Services for Tribes), 3.3.7 (Special Diabetes Program for Indians), and Sections 3.2.1, 3.3.1, and 3.3.2 (Health-Related Social Needs services). All requests related to Tribal priorities in this application are subject to further refinement based on the Tribal Consultation process. As required, Tribal Consultation will be held to review the entire application.

OHA also requests to carry forward as an appendix the Model Tribal Engagement and Collaboration Protocol from the current STCs into the renewal STCs with possible minor revisions. Indian health care providers (IHCPs) and OHA use this protocol as a summary of the federal Medicaid and managed care protections for IHCPs and AI/AN individuals.

3.2 Initiatives Continuing without Amendments

3.2.1 HRSN Services: Nutrition

The State requests to continue waiver and expenditure authority for HRSN Nutrition services.

Tribal Requests

The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to further refine the request for HRSN nutrition services that best

aligns with the Tribal health system and supports improving outcomes for the populations and communities they serve.

Progress to Date

In the short time the HRSN nutrition benefits have been implemented, the levels of benefit utilization and community interest suggests a need for the services among eligible members. While awareness of the HRSN nutrition benefits continues to increase and utilization increases, additional time is needed to develop a more complete understanding of the program's outcomes and longer-term impacts, specifically for the recently-implemented Pantry Stocking and Fruit and Vegetable benefits.

HRSN nutrition benefit implementation to date has focused on improved coordination across state, local, and community-based partners with the goal of building a robust qualified provider network that supports underserved members and members living in rural areas. Through this work, Oregon has invested in information technology infrastructure and strong regional and statewide networks to enable service delivery and program accountability.

Objectives

Access to nutritious food and a healthy diet is a primary driver of health.[2] The HRSN nutrition benefits aim to support the goals of this demonstration to invest in targeted, high-value HRSN support for OHP members navigating transitions. Nutrition benefits support members to adopt healthy behaviors, gain access to food that is healthy, fresh, and nutrient dense, and support connections to sustainable resources that address food insecurity.

Oregon’s HRSN nutrition benefit authority includes MTMs, Pantry Stocking, Fruit and Vegetables, and Nutrition Education.

- Medically Tailored Meals (MTMs) are designed to support members with nutrition sensitive conditions and medical needs,
- Pantry Stocking and Fruit and Vegetables help prevent, manage, and treat diet-related chronic diseases while supporting overall health and well-being, and
- Nutrition Education engages members to learn and grow healthy behaviors to help prevent adverse health outcomes.

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[2] https://www.cdc.gov/nutrition/php/healthy-food-environments/index.html

Oregon launched the most recent HRSN nutrition benefits in July 2026; continued implementation will provide the time needed to develop a more complete understanding of the benefits' impacts and extent to which it is meeting its intended objectives. Through the extension of HRSN nutrition authority and expenditures, Oregon seeks to demonstrate reduced health care system costs, improved food security, and improved health outcomes for OHP members in need.

Eligibility

Oregon requests to continue current approved HRSN nutrition eligibility criteria, which includes individuals who:

- Are in at least one of the following HRSN Covered Populations:
  - YSHCN (see Section 3.3.3);
  - Adults and youth discharged from an Institution for Mental Disease (IMD) within the last 12 months;
  - Adults and youth released from incarceration within the last 12 months;
  - Youth involved with child welfare;
  - Individuals transitioning to Dual Status: members enrolled in Medicaid that are transitioning to dual Medicaid and Medicare status for up to 90 days preceding the date Medicare coverage is to take effect, and 9 months after it takes effect;
  - Individuals who are homeless or at risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5;

and

- Meet a nutrition services clinical risk factor and the USDA definition of low food security.[3]
- For Pantry Stocking, in addition to being a member of one of the HRSN Covered Populations above, the OHP member must meet at least one of the following eligibility criteria:
  - Be a YSHCN (see Section 3.3.3)

[3] https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security

- Be pregnant, or
- Be a child under 21

Or,

- Meet eligibility criteria developed in Consultation with the Nine Federally Recognized Tribes of Oregon and Urban Indian Health Program (UIHP).

Covered Services

Oregon requests to continue current approved scope of HRSN nutrition services. HRSN nutrition services are designed to connect people with the framework and tools for healthy eating, and may include:

- Medically Tailored Meal Assessment
- Medically Tailored Meals (including delivery)
- Nutrition Education
- Fruit and Vegetables
- Pantry Stocking and Meals
- Connection to community-based food resources (e.g., connection to Supplemental Nutrition Assistance Program (SNAP)/Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and assistance accessing school-based food programs) through Case Management.

Food and nutrition support are intended to be provided alongside HRSN O&E services (see Section 3.3.2).

3.2.2 Traditional Health Care Practices

The State requests to extend waiver and expenditure authority for Traditional Health Care Practices.

Oregon has successfully implemented the delivery of Traditional Health Care Practices as a Medicaid covered benefit. OHA and Tribal representatives seek to continue this innovative model that demonstrates the effectiveness of Tribal Based Practices and improves the health of patients receiving care at an IHS, Tribal, or Urban Health Program.

3.2.3 Chemical Dependency

The State requests to extend waiver and expenditure authority for Chemical Dependency. Expenditures to include costs of chemical dependency treatment services for eligible individuals, which do not meet the requirements of section

1905(a)(13) of the Social Security Act, because of the absence of a recommendation of a physician or other licensed practitioner.

3.2.4 Expanded Adult Program for Individuals Exempt from Managed Care

The State requests to extend waiver and expenditure authority for individuals who are age 19 through 64, with household income from up to 133 and including 200 percent of the Federal Poverty Level (FPL), who meet the criteria to be exempt from mandatory managed care enrollment in section 1932(a)(2)(C) of the Social Security Act, including those who may be eligible for coverage under the state's Basic Health Program, and who are not otherwise eligible for Medicare or any other minimum essential coverage (as that term is defined in the Affordable Care Act (ACA)).

3.2.5 Coordinated Care Organization (CCO) Delivery System

The State requests to extend waiver and expenditure authority supporting the CCO delivery system without amendment.

Background

CCOs are community-based comprehensive managed care organizations that operate under risk contracts with the State. Oregon uses a global budget and capitation rate methodology designed to hold CCOs accountable for improving health outcomes, supporting population health, and managing growth in health care expenditures. The model incorporates quality incentive payments and value-based payment requirements intended to shift financial incentives toward prevention, coordinated care, and improved outcomes. Oregon also provides CCOs flexibility to use certain expenditures for Flexible Services that address members' health-related social needs, consistent with the terms of the demonstration.

CCOs are available statewide; however, there is not a single CCO that covers the entire state. Oregon's CCOs have regional service areas, and each county has at least one CCO. In service areas with multiple CCOs, members are given the opportunity to select or change their CCO.

During the current demonstration period, Oregon continued to strengthen the CCO model and its integrated, community-based approach to delivering care. Additional information on CCO performance, quality, and State oversight is provided in Section 7, the EQRO Technical Report in Attachment C, and Oregon's 2026 Medicaid Quality Strategy in Attachment D.

Objectives

During the extension period, Oregon will continue to use the CCO model to support integrated and coordinated care, improve health outcomes and population health, promote access and quality, advance value-based care, and manage growth in health care expenditures.

Most OHP populations will continue to be enrolled in CCOs. As of October 2026, 93% of OHP members are enrolled in a CCO.[4] American Indian or Alaska Native (AI/AN) members may elect to enroll in a CCO but are not required to do so; AI/AN members who do not enroll in a CCO receive services through the Fee-For-Service (FFS) delivery system. Dually eligible individuals are passively enrolled in CCOs with the option to opt out and return to FFS at any time. Other individuals who are not required to enroll in a CCO or who may disenroll from a CCO receive services through FFS, as applicable.

Covered Services

CCOs provide integrated physical health, behavioral health, and dental services to enrolled members. Certain services remain outside the CCO delivery system and are provided through FFS or other applicable delivery arrangements. Long-term services and supports (LTSS) are carved out of CCO coverage and delivered through FFS through the Oregon Department of Human Services (ODHS). Other service carve-outs continue to be governed by the Medicaid State Plan, CCO contracts, and applicable demonstration terms.

Managed Care Payments

Over multiple waiver cycles, Oregon has created and advanced a coordinated care model that moves from focusing on delivering health care services to a model where community-governed organizations focus on improving health outcomes and managing population health. Under Oregon's capitation rate setting methodology, a primary goal remains to see the health system shift spending to focus on prevention that reduces avoidable acute care; for example, investments in community behavioral health that could avoid hospital visits. In service of that goal, Oregon plans to implement certain CCO financial accountability requirements related to medical loss ratio (MLR) calculation, reporting, and use of rebate amounts.

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[4] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/medicaid-enrollment.aspx

Alternative Benefit Plans (ABP)

The State requests to extend the Secretary-approved coverage through the state's approved Alternative Benefit Plan (ABP) for ACA adults. Premium assistance for employer sponsored coverage will not be available through the demonstration. Oregon will continue to provide the applicable ACA adult population with comprehensive benefit coverage through the State's approved ABP during the extension period.

Individuals enrolled in the ABP receive the benefit package authorized under Oregon's approved Medicaid State Plan ABP. Beginning October 1, 2028, section 71120 of Public Law 119-21 requires cost sharing for certain adults in the Medicaid expansion population with income above 100 percent of the FPL, subject to applicable federal exemptions.

Breast and Cervical Cancer Treatment Program (BCCTP)

The State requests to extend waiver and expenditure authority for the Breast Cancer and Cervical Treatment Program (BCCTP).

BCCTP serves qualifying uninsured individuals with incomes up to 250 percent of the federal poverty level (FPL) who require treatment for breast or cervical cancer or precancerous conditions. Providers may determine individuals presumptively eligible, after which individuals submit a full OHP application and are evaluated for other Medicaid eligibility groups. Individuals who are not eligible under another Medicaid eligibility group may qualify for BCCTP for a one-year certification period if they continue to meet program eligibility requirements.

Following CMS guidance, Oregon revised its BCCTP renewal process to permit passive renewals using claims and other electronic data available to the State.

3.3 Initiatives Continuing with Amendments

3.3.1 HRSN Housing: Rent, Utilities, Tenancy Support

The State requests to continue but create a more targeted HRSN housing waiver and expenditure authority for rent, utilities, and tenancy services with amendments to the following eligibility criteria:

- Narrow eligibility to individuals who are at risk of homelessness and are experiencing high-risk pregnancy or who experienced a high-risk pregnancy and are less than 12 months postpartum.

Tribal Requests

The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to further refine the request for HRSN housing services that best aligns with the Tribal health system and supports improving outcomes for the populations and communities they serve.

Progress to Date

Launched in November 2024, the HRSN rent, utility, and tenancy services have made a significant impact in Oregon.

- As of June 2026:
  - Over 15,000 unique OHP members have received rent and utility financial assistance through the HRSN Housing program.
  - Oregon has developed a Medicaid provider network of 125 housing providers delivering HRSN Housing services to members.
- Preliminary rent and utility financial assistance data suggests:
  - 72% of members who received the benefit stayed in the same location as they received their rent payments.
  - Rural counties in Oregon have the highest rate of members receiving benefit compared to the overall Medicaid population.
  - Over half of rent recipients have one or more disabilities.
  - Avoidable emergency department visits decreased among some groups in the period immediately after receiving the benefit.

Additional time is needed to develop a more comprehensive understanding of the program's impact on health outcomes and impact on health service utilization, such as use of potentially avoidable acute care.

Objectives

Housing is a key social determinant of health, and being housed is associated with lower inpatient hospitalizations, fewer ED visits, and lower incarceration

rates.[5,6] In a study in Oregon, Medicaid costs declined by 12% on average after people moved into affordable housing.[7,8]

Oregon proposes to focus HRSN housing service eligibility on high-risk pregnant and post-partum individuals who are at risk of homelessness. This modification to HRSN Housing service eligibility is aligned with the waiver extension goals to invest in targeted high-value HRSN supports and designed around the premise that children and families are better positioned to achieve positive health and developmental outcomes when they can consistently meet basic needs through continued access to safe, stable housing. Since the start of the benefit through the first quarter of 2026, more than 1,400 pregnant or postpartum members received the HRSN rent and utilities financial assistance, demonstrating a need for these services during this critical period. This aligns with Oregon's state priorities related to maternal and child health, including the state's 2026-2030 Title V Maternal and Child Health priorities, which include postpartum care and mental health, housing instability, food sufficiency, and parent and caregiver support.[9]

Oregon seeks to demonstrate access to HRSN housing services for this population will reduce high-cost acute care utilization, increase participation in well-child visits and immunizations, support earlier identification of developmental concerns, and facilitate stronger connections to intervention services during a critical period of development when they can have the greatest impact.

Eligibility

Oregon requests to narrow HRSN housing eligibility to include individuals who:

- Have active OHP coverage; and

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[5] https://www.academicpedsjnl.net/article/S1876-2859(14)00233-2/pdf

[6] https://www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf

[7] https://oregon.providence.org/~/media/Files/Providence OR PDF/core_health_in_housing_full_report_feb_2016.pdf

[8] http://oregonhousingconference.org/wp-content/uploads/2018/10/Oregon-Housing-Conference-10-15.pdf

[9]https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Pages/PriorityAreas.aspx

- Are experiencing high-risk pregnancy or experienced a high-risk pregnancy and are less than 12 months postpartum; and
- Are at risk of becoming homeless.

Or,

- Meet eligibility criteria developed in Consultation with the Nine Federally Recognized Tribes of Oregon and Urban Indian Health Program (UIHP).

Covered Services

Oregon requests to continue current approved scope of HRSN Housing rent, utility, and tenancy services. Supports may include one or more of the following components:

- Rental assistance including rental payments and past due rent, for up to six (6) months.
- Utility costs limited to households receiving rent assistance for up to six (6) months.
- Tenancy support services for up to six (6) months including eviction prevention and other housing-related services to assist individuals in maintaining housing stability.

HRSN Housing services are intended to be provided alongside HRSN Outreach and Engagement services (see Section 3.3.2).

3.3.2 HRSN Services: Outreach & Engagement

The State requests to continue HRSN Outreach and Engagement (O&E) waiver and expenditure authority with amendments to the following eligibility requirements:

- Aligning service eligibility with the remaining HRSN Nutrition and HRSN Housing services and eligible populations.

Tribal Requests

The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to further refine the request for HRSN O&E services that best aligns with the Tribal health system and supports improving outcomes for the populations and communities they serve.

Progress to Date

HRSN O&E services are intended to complement HRSN Nutrition and HRSN Housing services to support eligible individuals in navigating eligibility requirements, completing and obtaining necessary documentation, and maintaining access to benefits for which they qualify.

As of June 2026, more than 28,000 unique members have received HRSN O&E services. HRSN O&E services are designed to be culturally-specific and responsive and support the identification of OHP members who may qualify for HRSN benefits and help them connect to HRSN benefits and other supports like medical, peer, social, educational, and legal services.

Objectives

Oregon has learned that program eligibility alone does not guarantee member HRSN benefit utilization. Case management through HRSN O&E provides the infrastructure necessary to translate member eligibility into benefit access.

Maintaining authority for the HRSN O&E services and aligning eligibility with the requested HRSN Nutrition and HRSN Housing services will ensure members continue to receive resources that improve their access to healthcare and social services, support the sustainability of HRSN service providers, and further advance system-wide cost reduction efforts.

Eligibility

Oregon requests to align eligibility with remaining HRSN Nutrition and HRSN Housing services and eligible populations. Eligibility criteria to receive HRSN O&E:

- Presumed eligible for HRSN Nutrition and HRSN Housing services as requested in Sections 3.2.1 and 3.3.1 of this application respectively.

Or,

- Meet eligibility criteria developed in Consultation with the Nine Federally Recognized Tribes of Oregon and Urban Indian Health Program (UIHP).

Covered Services

Oregon requests to maintain the existing scope of HRSN O&E services:

- Reaching out to OHP members who may qualify for HRSN benefits.
- Verifying OHP enrollment.
- Helping members maintain OHP coverage.

- Verifying presumed eligibility for HRSN benefits.
- Sending HRSN requests to members' health plans.
- Helping members gather paperwork or identification and meet other requirements.
- Helping members get and keep entitlements and benefits like TANF (temporary assistance for needy families), WIC (women, infants, children), SNAP (supplemental nutrition assistance program) and other federal and state programs.
- Helping members get access to showers, laundry, shelter and food.
- Connecting members to other services that support their needs.

3.3.3 Young Adults with Special Health Care Needs (YSHCN)

The State requests to continue YSHCN waiver and expenditure authority with amendments to the following eligibility requirements:

- Reduce financial eligibility criteria to up to 138% FPL[10]

Progress to date

As of January 1, 2026, eligible young adults through age 21 can access YSHCN benefits. YSHCN has enabled OHA to identify and prioritize high needs young adults in transition from pediatric care to adult care and drive better use of care, especially behavioral health.

As noted in *Oregon's 1115(a) Medicaid Demonstration Waiver Interim Evaluation* report, there is a body of literature suggesting that effective transition to adult care for the YSHCN population results in increased care adherence, clinic attendance, patient satisfaction, quality of life, and self-care skills while also reducing lapses or delays in care, perceived barriers to care, morbidity and mortality, hospital admission rates, and lengths of stay.[11,12] Further, research

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[10] Current authority allows Oregon to expand coverage for individuals up to 305% FPL and up to age 26, who qualify based on certain clinical criteria. As of April 2026, Oregon has implemented up to 205% FPL and enrolls ages up to 21.

[11] Okumura MJ, Kuo DZ, Ware AN, Cyr MH, White PH. Improving health care transitions for children and youth with special health care needs. Acad Pediatr. 2022 Mar;22(2):S7–13.doi:10.1016/j.acap.2021.03.014

[12] White PH, Cooley WC. Supporting the health care transition from adolescence to adulthood in the Medical Home. Pediatrics. 2018 Nov 1;142(5). doi:10.1542/peds.2018-2587

also indicates that addressing HRSN can support improvements in health outcomes for YSHCN by increasing connections to services, improving appointment attendance and treatment adherence, and reducing the risk of comorbidities and complications due to nutrition challenges.[13,14,15]

Objectives

Supporting young adults through the transition to adulthood continues to be a priority for Oregon to sustain a high-quality benefit package that supports the health and well-being of OHP members and maintain high rates of health care coverage.

In Oregon, one in five children under age 18 have a special health care need.[16] Special health care needs can include physical, intellectual and developmental disabilities; long-standing medical conditions like asthma, diabetes, or spina bifida; or mental health conditions like depression or substance use. In addition to navigating these health care needs the transition from pediatric care to adult care requires young adults to:

- Apply for health coverage separately from their parents or guardians to avoid a lapse in coverage;
- Navigate the transition from pediatric service providers and establish care with adult service providers;
- Navigate healthcare coverage changes from a package of benefits designed for children and adolescents to benefits designed for adults.

The YSHCN benefit addresses these challenges by allowing eligible young adults to keep their comprehensive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, enhanced vision and dental coverage, and

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[13] Dimitropoulos G, Morgan-Maver E, Allemang B, Schraeder K, Scott SD, Pinzon J, et al. Health care stakeholder perspectives regarding the role of a patient navigator during transition to adult care. BMC Health Serv Res. 2019 Dec 17;19(1):390.doi:10.1186/s12913-019-4227-6

[14] Ptomey LT, Wittenbrook W. Position of the Academy of Nutrition and Dietetics: nutrition services for individuals with intellectual and developmental disabilities and special healthcare needs. J Acad Nutr Diet. 2015 Apr;115(4):593–608. doi:10.1016/j.jand.2015.02.002

[15] Van Cleave J, Taft K, Ware A, Stille C. Assessing and addressing social determinants of health among children and youth with special health care needs. Acad Pediatr. 2022Mar;22(2):S28–33. doi:10.1016/j.acap.2021.07.006

[16] Cordova Nicolas, K., & Martin, A.J. (2025). Introduction to Oregon's 2025 statewide needs assessment for children and youth with special health care needs. Chapter 1. Oregon Center for Children and Youth with Special Health Needs.

access to HRSN services if eligible. This healthcare access during a critical period increases the likelihood of successful transition into adulthood with the care and access necessary for good health and quality of life.

Oregon proposes to maintain the age and clinical eligibility criteria and reduce the financial eligibility criteria to up to 138% FPL to support smooth transitions from pediatric to adult health care and promote effective use of state and federal resources. For individuals who meet all other eligibility except for income criteria, Oregon will explore care transition to other affordable coverage options.

Eligibility

Oregon requests the following eligibility criteria for the YSHCN authority. To qualify for YSHCN coverage, an individual must meet the following criteria:

- Be at least 19 years of age; and
- Have active OHP eligibility at the time they turn 19 years of age; and
- Countable income not to exceed 138% FPL; and
- Have one of the following:
    - Service or Medicaid eligibility through Aged and Peoples with Disabilities (APD); or
    - Service or Medicaid eligibility through Oregon Developmental Disability Services (ODDS); or
    - An intellectual or developmental disability; or
    - A complex chronic condition or impairment that may be physical, developmental, behavioral, or emotional in nature.

Covered Services

Oregon requests to maintain the YSHCN scope of services for young adults who meet the age, clinical, and financial eligibility criteria. YSHCN services include:

- Enhanced vision and dental benefits that are available to pregnant OHP adults through the OHP Supplemental benefit package and to members under 21 through the OHP Plus benefit package.
- Access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage until the member turns 26.
- Potential access to Health-Related Social Needs (HRSN) benefits provided they meet all HRSN-specific eligibility criteria.

3.3.4 Reentry Demonstration

The State requests to continue Reentry Demonstration waiver and expenditure authority with amendments to the following benefit parameters:

- Reduce benefit duration from up to 90-days pre-release to up to 60-days pre-release from an eligible carceral setting, consistent with recent federal approvals.

Progress to Date

Oregon received approval on 1115 Reentry Demonstration Waiver terms in 2024 and made efforts to implement this initiative. These efforts included conducting a Readiness Assessment completed by all carceral facilities in the state, designing an Implementation Plan, developing relationships with community and carceral facility partners, exploring system upgrades needed, and laying the groundwork for operational planning. Through implementation work, system limitations and competing priorities resulted in Oregon no longer being able to implement in the current demonstration. Due to the continued progress made through legislative changes, system updates, partner collaboration, operational planning, and implementation of the FCAA 2023 Sec. 5121, Oregon requests to extend the authority to fully implement the Reentry Demonstration.

Objectives

Oregon seeks to promote the objectives of the Medicaid statute by increasing access to high-quality clinically appropriate services and improving care transitions for individuals transitioning from carceral settings back to the community. Oregon intends to fully implement the Reentry Demonstration building on progress made to date and continue to promote the goals of this demonstration to maintain high rates of healthcare coverage for eligible Oregonians and invest in high-value interventions for populations navigating transitions.

Justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses,[17,18] and communities of color are

[17] https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf.

[18] https://www.oregon.gov/doc/Documents/quick-facts-issue-brief-2025.pdf

over-represented among those incarcerated in Oregon.[19,20] By increasing uninterrupted access to health care coverage, providing pre-release access to services, and increasing coordination between carceral facilities and community partners Oregon hopes to demonstrate improved health outcomes, reduced health care costs, decreased utilization of high-cost emergency services, and reduced recidivism.

Eligibility

Oregon requests to modify eligibility criteria to include individuals who are Medicaid or CHIP eligible but for their incarceration status and within 60 days prior to release from the following eligible carceral facility types; state prisons, local adult jails, youth correctional facilities, youth detention centers, and Tribal correctional facilities.

This modification to duration of pre-release period is in alignment with CMS guidance for Reentry Demonstrations released September 2026.[21]

Covered Services

Oregon requests to continue current approved scope of pre-release services:

- Case management to assess and address physical and behavioral health needs, and health related social needs;
- Medication-assisted treatment (MAT) services for all types of substance use disorder (SUD) as clinically appropriate, with accompanying counseling;
- A 30-day supply of all prescription medications that have been prescribed for the individual at the time of release, provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid and CHIP state plan coverage authority and policy;
- Limited clinical consultation services, as clinically appropriate, provided through telehealth or in-person, as needed;
- Diagnostic services, including laboratory and radiology services, and treatment services in addition to coverage for MAT described above;

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[19] https://www.oregon.gov/oya/Publications/QuickFacts.pdf.

[20] https://www.prisonersofthecensus.org/factsheets/or/Oregon-Black-impact.pdf.

[21] https://www.medicaid.gov/federal-policy-guidance/downloads/reentry-faqs-090920264015.pdf

- Prescribed drugs, in addition to MAT and the 30-day supply of prescription medication described above, and medication administration;
- Family planning services and supplies;
- Services provided by community health workers; and
- Peer support services.

Oregon will ensure that provision of services will not impede any individual from being released. As part of program design, OHP application assistance will be offered to all justice-involved individuals. Oregon's Office of Community Health and Engagement (OCHE) has developed a network of justice-involved OHP-certified assisters who are essential in helping justice-involved individuals apply for OHP prior to release and navigate benefit restoration upon release.

Oregon plans to build on progress made to date and continue to collaborate with community partners, people with lived-experience, providers, managed care entities, and carceral facilities to successfully implement the Reentry Demonstration in the 2027-2032 demonstration.

3.3.5 Traditional Health Care Practices Implementation Funds

Tribal Requests

The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to further refine a request for ongoing Traditional Health Care Practices Implementation Funds that supports further implementation of Traditional Health Care Practices. When implementing Traditional Health Care Practices, it is important to have a safe, respectful, designated area in the community to gather, to connect with the land and a place to have the materials available for service delivery of the practices being utilized. The request for Traditional Health Care Practices Implementation Funds will address this need and may include discussion with CMS on expanding the flexibilities of how to use these funds to ensure culturally appropriate service delivery is achieved.

Progress to Date

Funding to support implementation costs have been distributed to Tribes to successfully implement Traditional Health Care Practices. This has allowed Tribes to make targeted investments within the existing allowable spending categories:

- Technology
- Development of business or operational practices
- Workforce Development
- Outreach, education, and community engagement

3.3.6 Primary Care Services for Tribes

Tribal Requests

The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to identify any additional needs from the current 1115 waiver authority for Primary Care Services for Indian Health Care Providers (IHCPs) including the Urban Indian Health Program (formerly called the "Tribal Uncompensated Care Program"), which may include discussing with CMS expanding the covered services to best meet Tribal partner's needs.

Background

Primary Care Services for IHS and Tribal Programs (formerly called the "Tribal Uncompensated Care Program") was established to protect these Programs from absorbing the cost of care when OHP restricted or eliminated adult vision and dental coverage in 2010. Without it, they would have continued furnishing these services to OHP members without reimbursement. CMS has granted expenditure authority only for those two services, so IHS and Tribal Programs are not protected if other OHP benefits are reduced in the future.

Oregon's current 1115 waiver includes language providing Tribes with Medicaid reimbursement for adult dental and vision services via the UCCP. Tribal representatives have requested that UCCP be expanded to cover all OHP benefits currently available as of January 1, 2026, and to include all IHCPs (including the UIHP).

3.3.7 Special Diabetes Program for Indians (SDPI)

The State requests to continue conversations with CMS regarding waiver and expenditure authority to establish the Special Diabetes Program for Indians (SDPI) services as a Medicaid benefit.

Tribal Requests

The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to further refine the request for SDPI.

Background

SDPI was established by Congress in 1997 and is administered by the Indian Health Service (IHS), with guidance from the Tribal Leaders Diabetes Committee. AI/AN people have the highest prevalence of diabetes of any group, at approximately two times the national average. The SDPI program is a successful model for addressing the Type II Diabetes epidemic among AI/AN adults. Between 1997 to 2024, mean A1C among AI/AN people with diabetes decreased 12%.[22] However, funding levels for the program have not increased since 2004, leaving significant unmet need among AI/AN individuals, including Medicaid enrollees.[23] This history underscores the importance of considering Medicaid coverage for SDPI-type services as a complementary financing mechanism, rather than relying solely on periodic congressional appropriations.

Oregon requested this authority under the 2022-2027 1115 OHP Waiver, and CMS deferred the request for further discussion. The IHS' SDPI program has been successful in reducing rates of diabetes in Tribal communities, and it uses a Tribal- developed curriculum that keeps services culturally responsive.

Objective

Medicaid coverage of SDPI would substantially expand access to preventive care for members. Oregon hopes to demonstrate a Medicaid reimbursable SDPI benefit will further decrease diabetes prevalence and costs to Medicaid through preventive care and treatment and reduce costly hospitalization and specialized care downstream.

OHA is committed to working with CMS, IHS, and Tribal communities to ensure non-duplication of payment and services for SDPI and developing a reimbursement protocol across delivery systems.

These services would be furnished by qualified providers such as registered dietitians, nurses, pharmacists, podiatrists, Community Health Workers/Traditional Health Workers, and lifestyle coaches. Oregon would

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[22] https://www.ihs.gov/sites/sdpi/themes/responsive2017/display_objects/documents/infographic/SDPI2025Infographic.pdf

[23] https://health.gov/sites/default/files/2022-01/NCCC Report to Congress.pdf

reimburse SDPI services at the IHS or Prospective Payment System (PPS) encounter rate, up to five encounters per day for all IHCPs, including the UIHP.

3.4 Initiatives Discontinuing

The State proposes to discontinue the following initiatives where federal demonstration authority is no longer needed or aligned with current CMS policy direction. Oregon plans to wind down implemented initiatives in accordance with all federal and state requirements including notifying and transitioning impacted members to other services, when available, to meet their needs.

3.4.1 HRSN Infrastructure Funds

The State requests to discontinue this expenditure authority upon extension (September 30, 2027).

HRSN Infrastructure Funds permitted Oregon to claim federal financial participation on expenditures for allowable administrative costs and infrastructure, to the extent such activities are authorized as part of the approved HRSN infrastructure activities as described in STC 9 of the Approved 2022-2027 1115 Waiver STCs.

According to the March 4, 2025 CMS guidance on HRSN[24], CMS stated that previous HRSN-related guidance was rescinded and that CMS would consider states' applications to cover these services and supports on a case-by-case basis. Additionally, according to the April 2025 CMS guidance on Designated State Health Programs (DSHP) and Designated State Investment Programs (DSIP),[25] CMS does not anticipate extending existing Section 1115(a) expenditure authority for DSHP Funded initiatives. As a result of this federal guidance, the State is discontinuing the request for HRSN Infrastructure Funding. Oregon continues to work within CMS guidance to prepare and notify impacted partners.

[24] https://www.hhs.gov/guidance/sites/default/files/hhs-guidance documents/AID/cib03042025.pdf

[25] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

3.4.2 HRSN Services: Home Changes for Health

The State requests to discontinue the "HRSN Home Changes for Health during Extreme Weather" waiver and expenditure authority upon extension (September 30, 2027).

The HRSN Home Changes for Health benefit includes services and devices that support eligible OHP members' ability to stay safe in their homes during periods of extreme weather. Since its implementation in March of 2024 to June 2026, Oregon's over 13,349 services have been provided to over 7,400 unique members.

Oregon is currently collecting data and will continue to evaluate the impact of providing these services to OHP members who have specific medical conditions that place them at higher risk of adverse health outcomes during extreme weather events.

Oregon intends to demonstrate that member access to these services result in improved health outcomes, and reductions in preventable acute care and emergency service requests during periods of heightened utilization due to extreme weather.

Oregon will continue to distribute benefits through September of 2027.

3.4.3 HRSN Services: Home Changes for Safety

The State requests to discontinue this waiver and expenditure authority for storage fees, hotel/motel stays, home modifications, and remediations upon extension (September 30, 2027).

The HRSN Home Changes for Safety benefit includes services that support eligible OHP members' ability to stay safe and improve accessibility in their homes. Since its implementation in November 2024 to June 2026, Oregon's Home Changes for Safety has not yielded high utilization among members and represents less than 1% of both the total HRSN services delivered and unique members accessing them.

Oregon is currently collecting data and will continue to evaluate the impact of providing these services to OHP members who have specific medical conditions that place them at higher risk of adverse health outcomes without necessary home modifications.

Oregon hopes to demonstrate that member access to these services improves health outcomes and results in reductions in preventable acute care and

emergency service requests due to health conditions exacerbated by unsafe or inaccessible home environments.

Oregon will continue to distribute benefits through September of 2027.

3.4.4 Continuous Eligibility up to Age 6

The State requests to discontinue this waiver and expenditure authority upon extension (September 30, 2027).

Oregon previously received approval through the 2022-2027 1115 OHP Waiver to provide continuous enrollment for children up to age six regardless of changes in circumstances that would otherwise cause a loss of eligibility. Oregon also refers to this policy as Continuous Eligibility (CE).

CE rules have allowed over 292,000 children under six in Oregon who are OHP recipients to remain eligible despite changes in circumstance like income. While CE rules previously existed for all children for up to one year, the new expanded CE rules took effect after the Public Health Emergency Unwinding during renewal, or for new applications after July 2023. While Oregon would prefer to continue to provide CE for all populations, we understand this will not be approved.

According to the July 2025 CMS guidance, Section 1115(a) Demonstration Authority for Continuous Eligibility Initiatives,[26] specifying that CMS does not anticipate extending existing Section 1115(a) demonstration authority for expanded continuous eligibility initiatives, the State is discontinuing continuous eligibility for children up to age six. Oregon continues to work within CMS guidance to wind down the program and ensure seamless transition for impacted individuals.

3.4.5 2-year Continuous Eligibility ages six and up

The State requests to discontinue this waiver and expenditure authority upon extension (September 30, 2027).

Oregon previously received approval through the 22-27 1115 OHP Waiver to provide continuous enrollment for two years for adults and children over age 6, regardless of changes in circumstances that would otherwise cause a loss of eligibility.

[26] https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

CE rules have allowed over 448,000 children over the age of six and under 18 in Oregon who are OHP recipients to remain eligible despite changes in circumstance like income. While CE rules previously existed for all children for up to one year, the new expanded CE rules took effect after the Public Health Emergency Unwinding during renewal, or for new applications after July 2023.

As a result of July 2025 CMS guidance, Section 1115(a) Demonstration Authority for Continuous Eligibility Initiatives,[27] specifying that CMS does not anticipate extending existing Section 1115(a) demonstration authority for expanded continuous eligibility initiatives, the state is discontinuing continuous eligibility for two years for adults and children over age six. Oregon continues to work within CMS guidance to wind down the program and ensure seamless transition for impacted individuals.

3.4.6 Designated State Health Programs (DSHP)

The state requests to discontinue this expenditure authority upon extension (September 30, 2027).

The authority permits Oregon to claim federal financial participation on designated program expenditures described in the 2022-2027 1115 Waiver Approved STCs, which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in the Approved 2022-2027 1115 Waiver STCs. STC 8.3 defines DSHP-Funded Initiatives and the permissible uses of the revenue. These expenditures are specifically contingent on compliance with STC 13, as well as all other applicable STCs.

As a result of the April 2025 CMS guidance,[28] Designated State Health Programs and Designated State Investment Programs, specifying that CMS does not anticipate extending existing Section 1115(a) expenditure authority for DSHP Funded initiatives, the State is discontinuing the request for HRSN Infrastructure Funding. Oregon continues to work within CMS guidance to prepare and notify impacted partners.

[27] https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

[28] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

3.4.7 Reentry Demonstration Infrastructure Funding

The state requests to discontinue this expenditure authority upon extension (September 30, 2027).

In alignment with CMS' guidance issued April 2025,[29] Oregon requests to discontinue the DSHP Reentry Implementation expenditure authority. Because Oregon did not implement the Reentry Demonstration in the 22-27 Waiver period, a condition of accessing the funding, there were no expenditures from what was awarded.

Oregon will continue to work with CMS to request alternate sources of funding to support carceral facility and community partner infrastructure and implementation expenditure needs to fully implement the Reentry Demonstration.

3.5 Summary of Requested Demonstration Eligibility, Benefits, Cost Sharing Requirements, and Delivery System

The following table summarizes the waiver initiatives Oregon requests to continue, modify, and discontinue under this extension as well as the changes to eligibility, benefits, or cost sharing for the modified initiatives.

Table 1: Impact on Eligibility Requirements, Benefits, Cost Sharing, or Delivery System

Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System
Initiatives Continuing without Amendments	
Health-Related Social Needs (HRSN) Nutrition	No Change *Tribal Requests:* The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program (UIHP) through Tribal Consultation to further refine the request for HRSN nutrition services that best aligns with the Tribal health system and supports improving outcomes for the populations and communities they serve.

[29] https://www.medicaid.gov/resources-for-states/downloads/dshp-dsip.pdf

Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System
Traditional Health Care Practices	No Change
Chemical Dependency	No Change
Expanded Adult Program for Individuals Exempt from Managed Care	No Change
Care Coordination Organization (CCO) Delivery System	No Change
Initiatives Continuing with Amendments	
HRSN Housing: Rent, Utilities, Tenancy Support	*Changes to eligibility:* Narrow eligibility to individuals who are at-risk of homelessness and are experiencing high-risk pregnancy or who experienced a high-risk pregnancy and are less than 12 months postpartum. *Tribal Requests:* The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the UIHP through Tribal Consultation to further refine the request for HRSN housing services that best aligns with the Tribal health system and supports improving outcomes for the populations and communities they serve.
HRSN Services: Outreach & Engagement	*Changes to eligibility:* Modify eligibility to align with eligible populations for the HRSN Nutrition and HRSN Housing renewal requests. *Tribal Requests:* The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the UIHP through Tribal Consultation to further refine the request for HRSN O&E services that best aligns with the Tribal health system and supports improving outcomes for the populations and communities they serve.

Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System
Young Adults with Special Health Care Needs (YSHCN)	*Changes to eligibility:* Reduce financial eligibility criteria to up to 138% FPL.
Reentry Demonstration	*Changes to benefits:* Reduce benefit duration from up to 90-days pre-release to up to 60-days pre-release from an eligible carceral setting. *Note: this initiative was not implemented during the 2022-2027 Waiver period.*
Traditional Health Care Practices Implementation Expenditures	*Tribal Requests:* The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the UIHP through Tribal Consultation to further refine a request for ongoing Traditional Health Care Practices Implementation Funds that supports further implementation of Traditional Health Care Practices. The request for Traditional Health Care Practices Implementation Funds may include discussion with CMS on expanding the flexibilities of how to use these funds to ensure culturally appropriate service delivery is achieved.
Primary Care Services for Tribes, formerly called the Tribal Uncompensated Care Program (UCCP)	*Tribal Requests:* The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the UIHP through Tribal Consultation to identify any additional needs from the current 1115 waiver authority for Primary Care Services for Indian Health Care Providers (IHCPs) including the Urban Indian Health Program (formerly called the "Tribal Uncompensated Care Program"), which may include discussing with CMS expanding the covered services to best meet Tribal partner's needs.
Special Diabetes Program for Indians (SDPI)	*Tribal Requests:* Establish the Special Diabetes Program for Indians (SDPI) services as a Medicaid benefit.
Initiatives Discontinuing	
HRSN Infrastructure Funds	Discontinuing in accordance with CMS guidance.

Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System
HRSN Services: Home Changes for Health	Discontinuing waiver and expenditure authority upon extension.
HRSN Services: Home Changes for Safety	Discontinuing waiver and expenditure authority upon extension.
HRSN Services: One-time transition and move-in costs	Discontinuing waiver and expenditure authority upon extension. *Note: this initiative was not implemented during the 2022-2027 Waiver period.*
Continuous Eligibility up to age six	Discontinuing in accordance with CMS guidance.
2-year Continuous Eligibility for ages six and up	Discontinuing in accordance with CMS guidance.
Designated State Health Program Funds	Discontinuing in accordance with CMS guidance.
Reentry Demonstration Infrastructure Funding	Discontinuing in accordance with CMS guidance.

Section 4: Summary of Requested Waiver and Expenditure Authorities

The following table identifies the waiver and expenditure authorities Oregon requests to continue, modify, and discontinue under this extension.

Table 2: Summary of Authorities Requested and Status Under Extension

#	Title	Summarized Description	Status under Extension
Title XIX and XXI Waiver Authority/Not Applicable			

#	Title	Summarized Description	Status under Extension
1a	**Statewideness/ Uniformity** Section 1902(a)(1) 42 CFR 431.50	To enable the state to provide benefits through contracts with managed care plans that operate only in certain geographical areas of the state. (Applies to all Medicaid state plan and CHIP populations that are included in the mandatory and optional Medicaid eligibility groups).	Continue
1b	**Statewideness/ Uniformity** Section 1902(a)(1) 42 CFR 431.50	To enable the state to cover Health-Related Social Needs (HRSN) services on a geographically limited, county-by-county basis during the phase in process through December 31, 2024.	Discontinue
2	**Amount, Duration, and Scope of Services** Section 1902(a)(10)(A) 1902(a)(10)(B) 1902(a)(17) 42 CFR 440.230-250	To enable the state to offer different benefits for individuals whose eligibility is determined based on modified adjusted gross income (MAGI) (other than children under age 21, Youth with Special Health Care Needs, pregnant individuals, and individuals enrolled in the Alternative Benefits Plan) which are consistent with a Prioritized List of Health Services, as defined in STC 4.2.d, subject to certain exceptions for protected benefits. This authority will expire January 1, 2027.	Discontinue
3	**Amount, Duration, and Scope of Services and Comparability** Section 1902(a)(10)(B) 1902(a)(17)	To the extent necessary to allow the state to offer the HRSN services as described in this application. To the extent necessary enable the state to provide HRSN services based on service delivery systems that are not otherwise available to all beneficiaries in the same eligibility group during the phase in process. To the extent necessary to allow the state to offer different benefits for individuals who are eligible under the Expanded Adult Program for Individuals Exempt from Managed Care expenditure authority.	Continue
4	**Freedom of Choice** Section 1902(a)(23)(A) 42 CFR 431.51	To enable the state to restrict freedom-of-choice of provider by offering benefits only through managed care plans (and other insurers) in a manner not authorized by section 1932 of the Act because beneficiaries may not have a choice of managed care plans. This does not authorize restricting freedom of choice of family planning providers. (Applies to all Medicaid state plan and CHIP populations included in the mandatory and optional Medicaid eligibility groups).	Continue

#	Title	Summarized Description	Status under Extension
5	**Managed Care Plan Enrollment** Section 1902(a)(4) as implemented in 42 CFR 438.56(c) and 438.52	To enable managed care entities to permit enrollees eligible through Medicaid or the CHIP state plan, a period of only 30 days after enrollment to disenroll without cause, instead of 90 days, except beneficiaries newly entering a managed delivery system. All beneficiaries newly entering a managed delivery system receive 90 days to disenroll. Medicaid and CHIP beneficiaries newly entering a managed delivery system are individuals who have never had Coordinated Care Organization-enrollable Oregon Health Plan eligibility. (Applies to all Medicaid state plan and CHIP populations included in the mandatory and optional Medicaid eligibility groups).	Continue
6	**Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** Section 1902(a)(84)(D)	To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.	Continue
7	**Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release** Section 2102(d)(2)	To enable the state not to provide coverage of the screening, diagnostic, referral, and case management services identified in section 2102(d)(2) of the Act for a targeted low-income child as a state plan benefit in the 30 days prior to the release of such targeted low-income child from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.	Continue

#	Title	Summarized Description	Status under Extension
8	**Amount, Duration, and Scope of Services and Comparability** Section 1902(a)(10)(B))	To enable the state to provide coverage for all IHS SDPI covered services as Medicaid-reimbursable services for AI/AN members.	Continue
Expenditure Authority			
1	**Managed Care Enrollment Restrictions**	Expenditures for payments to obtain coverage for eligible individuals pursuant to contracts with managed care plans that do not comply with section 1903(m)(2)(a)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(c)(2)(i) relating to restricting enrollees' right to disenroll in the initial 90 days of enrollment in a Coordinated Care Organization (CCO).	Continue
2	**Continuous Eligibility**	Expenditures for costs of medical assistance to eligible individuals who have been guaranteed 6 to 12 months of benefits when enrolled, and who cease to be eligible for Medicaid during the 6-12-month period after enrollment.	Discontinue
3	**Chemical Dependency**	Expenditures for costs of chemical dependency treatment services for eligible individuals which do not meet the requirements of section 1905(a)(13) of the Act, because of the absence of a recommendation of a physician or other licensed practitioner.	Continue
4	**Indian Health Services operating under ISDEAA**	Expenditures for primary care services furnished to eligible individuals by Indian Health Service (IHS) and tribal health facilities operating under the Indian Self Determination and Education Assistance Act (ISDEAA) 638 authority that were restricted or eliminated from coverage effective January 1, 2010 for non-pregnant adults enrolled in OHP.	Continue
5	**Designated State Health Programs (DSHP)**	Permits Oregon to claim federal financial participation on designated program expenditures described in the 2022-2027 1115 Waiver Approved STCs, which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified	Discontinue

#	Title	Summarized Description	Status under Extension
		amounts as set forth in the Approved 2022-2027 1115 Waiver STCs.	
6	**Health-Related Social Needs (HRSN) Services**	Expenditures for approved evidence-based health-related social needs services not otherwise eligible for Medicaid payment furnished to individuals who meet the qualifying eligibility criteria as described in Sections 3.2.1, 3.3.1, and 3.3.2 of this application.	Continue with modifications to services and eligibility
7	**Health-Related Social Needs Infrastructure**	Permits Oregon to claim federal financial participation on expenditures for allowable administrative costs and infrastructure, to the extent such activities are authorized as part of the approved HRSN infrastructure activities as described in the Approved 2022-2027 1115 Waiver STC 9.	Discontinue
8	**Continuous Eligibility**	Expenditures for continued benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in the Approved 2022-2027 1115 Waiver STC 4.5.c.	Discontinue
9	**Youth with Special Health Care Needs (YSHCN)**	Expenditures for services for individuals ages 19 through 26, with income up to 138 percent FPL, and meet all other eligibility criteria as defined in Section 3.3.3 of this application.	Continue with modifications to eligibility
10	**Expanded Adult Program for Individuals Exempt from Managed Care**	Expenditures for individuals who are age 19 through 64, with household income from 133 up to and including 200 percent of the FPL, who meet the criteria to be exempt from mandatory managed care enrollment in section 1932(a)(2)(C) of the Act, including those who may be eligible for coverage under the state's Basic Health Program, and who are not otherwise eligible for Medicare or any other minimum essential coverage (as that term is defined in the Affordable Care Act (ACA)).	Continue
11	**Expenditures for Pre-Release Services**	Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 60 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.	Continue with modifications to benefit duration

#	Title	Summarized Description	Status under Extension
12	**Expenditures for Pre-Release Administrative Costs**	Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in Approved 2022-2027 1115 Waiver STC 10.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.	Discontinue
13	**Traditional Health Care Practices**	Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.	Continue
14	**Traditional Health Care Practices Implementation Expenditures**	Expenditures for allowable administrative and implementation costs not otherwise determined eligible for Medicaid payment, to the extent such activities are authorized as described in Section 3.3.5 of this application.	Continue
15	**Special Diabetes Program for Indians (SDPI)**	Expenditures for all IHS SDPI covered services as Medicaid-reimbursable services received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.	Continue
Title XXI Expenditure Authority			
16	**Continuous Eligibility**	Expenditures for continued benefits for individuals who have been determined eligible under groups specified in Table 1 of STC 4 for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility redetermination, except as noted in Approved 2022-2027 1115 Waiver STC 4.5.c.	Discontinue

#	Title	Summarized Description	Status under Extension
17	**Expenditures for Pre-Release Services**	Expenditures for pre-release services, as described in these STCs, provided to qualifying Children's Health Insurance Program (CHIP) individuals who are or would be eligible for CHIP if not for their incarceration status, for up to 60 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative.	Continue with modifications to benefit duration
18	**Traditional Health Care Practices**	Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Children's Health Insurance Program beneficiaries who are able to receive services delivered by or through these facilities.	Continue
Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services and Traditional Health Care Practices			
1	**Statewideness** Section 1902(a)(1)	To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.	Continue
2	**Amount, Duration, and Scope of Services and Comparability** Section 1902(a)(10)(B)	To enable the state to provide only a limited set of pre-release services, as specified in Section 3.3.4 of this application, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.	Continue
3	**Freedom of Choice** Section 1902(a)(23)(A)	To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.	Continue
4	**Comparability; Freedom of Choice** Section 1902(a)(23) Section 1902(a)(10)(B)	To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 18 only if the covered traditional health care practices are received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations	Continue

#	Title	Summarized Description	Status under Extension
		under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.	

Section 5: Demonstration Financing and Budget Neutrality

Oregon's Demonstration is required to be budget-neutral, meaning federal spending under the demonstration cannot exceed what it would be in the absence of the waivers and expenditure authorities. Information regarding Oregon's 1115 Waiver budget neutrality assessments for the projected renewal period can be found in Attachment A. Pending completion of Tribal Consultation, Attachment A may be updated with additional Tribal requests.

Section 6: Evaluation

6.1 Summary of Evaluation Results of Current Demonstration to Date

Draft interim evaluation results for the current demonstration are included as Attachment E Draft 2022-2027 Interim Waiver Evaluation Report, pending CMS approval.

6.2 Demonstration Extension Proposed Evaluation Plan

The goals and objectives of this demonstration extension as listed in Section 3.1 of this application are intended to support continuity of care; invest in targeted HRSN and Reentry services; align with Tribal priorities; and implement benefits in a manner that emphasizes program integrity, fiscal responsibility, and operational sustainability. The state has developed proposed evaluation metrics for each requested initiative listed in Table 3 below.

Table 3: Proposed Evaluation of the Proposed Demonstration Renewal by Authority

Objectives	Proposed Hypothesis	Potential Approaches
HRSN Nutrition		
This HRSN-related focus area is designed to increase beneficiary food stability through services including nutrition education, assessments for and provision of medically tailored meals, pantry stocking, and fruit and vegetables. Studies have shown that food insecurity is associated with poor physical health and an increased number of chronic conditions,[30] and is a risk factor for depression, stress, and anxiety.[31] Food instability can also contribute to poor medication adherence and postponed medical care.[32,33,34] Related initiatives addressing food insecurity, such as the Supplemental Nutrition Assistance Program (SNAP) and food prescription services, have been	**HRSN Research Hypothesis 1.** The demonstration will meet HRSN for nutrition and/or reduce the severity of HRSN for nutrition among beneficiaries overall and among subpopulations who experience inequities in HRSN. **HRSN Research Hypothesis 2.** By meeting or reducing the severity of HRSN for nutrition, the demonstration will increase beneficiaries' use of preventive and routine care and reduce their use of potentially avoidable hospital care, leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience inequities in hospital care. **HRSN Research Hypothesis 3.** By meeting or reducing HRSN for nutrition, the demonstration will	Data Sources: • Oregon Medicaid claims • CCO financial reporting • CCO contract reporting • HRSN nutrition beneficiary survey • Interviews with people who received HRSN nutrition services • All Payers All Claims (APAC) data for Medicare claims (for dual-eligible Medicaid members) • REALD and SOGI Data Repository

[30] Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Manag Care. 2018;24(9):399.

[31] Pourmotabbed A, Moradi S, Babaei A, Ghavami A, Mohammadi H, Jalili C, et al. Food insecurity and mental health: a systematic review and meta-analysis. Public Health Nutr. 2020;23(10):1778–90.

[32] Wilder ME, Kulie P, Jensen C, Levett P, Blanchard J, Dominguez LW, et al. The impact of social determinants of health on medication adherence: a systematic review and meta-analysis. J Gen Intern Med. 2021;36:1359–70.

[33] Ma CT, Gee L, Kushel MB. Associations between housing instability and food insecurity with health care access in low-income children. Ambulatory Pediatrics. 2008;8(1):50–7.

[34] Thomas M, Miller DP, Morrissey TW. Food insecurity and child health. Pediatrics. 2019;144(4).

Objectives	Proposed Hypothesis	Potential Approaches
shown to reduce food insecurity and affect health outcomes.[35,36,37,38] Pending completion of Tribal Consultation to determine best approach for ensuring the Tribes' members' HRSNs are supported.	improve physical and behavioral health outcomes among beneficiaries overall and among subpopulations who experience inequities in physical and mental health outcomes.	
Traditional Healthcare Practices		
Since 2003 representatives from the Tribes in Oregon and dedicated researchers have worked together to develop a Tribal Based Practice review template and through the Tribal Based Practice Review Panel have approved 22 Tribal Based Practices (TBP). The State of Oregon then recognized that TBP should be seen as equivalent to Evidence Based Practices. In 2007 Oregon Mental Health and Addictions Division approved the use of state contracted funding to be used for implementing Tribal Based Practices. Through the development of these practices there was a goal to have some of the TBP become Medicaid Billable. This demonstration waiver is allowing the	**Research Hypothesis 1.** The development of technical systems and operational practices across I/T/U facilities will support delivery of and increase access to THCP services. **Research Hypothesis 2.** The operationalization and delivery of THCP services will improve member and community health outcomes.	• MMIS Claims Data • Site Visits to I/T/Us • Descriptive Trend Analysis • Qualitative analysis (i.e., content analysis, thematic analysis across I/T/Us) • Quantitative analysis (i.e., means & percentages; t-test and statistical analysis as appropriate for survey data)

[35] Ettinger de Cuba S, Chilton M, Bovell-Ammon A, Knowles M, Coleman SM, Black MM, et al. Loss of SNAP is associated with food insecurity and poor health in working families with young children. Health Aff. 2019;38(5):765–73.

[36] Gundersen C, Waxman E, Crumbaugh AS. An examination of the adequacy of Supplemental Nutrition Assistance Program (SNAP) benefit levels: impacts on food insecurity. Agric Resour Econ Rev. 2019;48(3):433–47.

[37] Nguyen PY, Astell-Burt T, Rahimi-Ardabili H, Feng X. Effect of nature prescriptions on cardiometabolic and mental health, and physical activity: a systematic review. Lancet Planet Health. 2023;7(4):e313–28.

[38] Bhat S, Coyle DH, Trieu K, Neal B, Mozaffarian D, Marklund M, et al. Healthy food prescription programs and their impact on dietary behavior and cardiometabolic risk factors: a systematic review and meta-analysis. Advances in Nutrition. 2021;12(5):1944–56.

Objectives	Proposed Hypothesis	Potential Approaches
state to implement that longstanding goal.		
Primary Care Services for Tribes (formerly Uncompensated Care Program)		
Pending completion of Tribal Consultation.	**Research Hypothesis 1.** Member access to appropriate care will be maintained or improved. **Research Hypothesis 2.** Quality of care will be maintained or improved. **Research Hypothesis 3.** Member satisfaction with their healthcare will be maintained or improved.	• Member and Provider Data • Claims/encounter data • National/regional benchmarks • Beneficiary Survey
Special Diabetes Program for Indians (SDPI)		
Medicaid coverage of SDPI is expected to substantially expand access to preventive care for members. Oregon expects a Medicaid reimbursable SDPI benefit will further decrease diabetes prevalence and costs to Medicaid through preventive care and treatment and reduce costly hospitalization and specialized care downstream.	**Research Hypothesis 1.** Member access to appropriate care will be maintained or improved. **Research Hypothesis 2.** Quality of care will be maintained or improved. **Research Hypothesis 3.** Member satisfaction with their healthcare will be maintained or improved.	• Member and Provider Data • Claims/encounter data • National/regional benchmarks • Beneficiary Survey
HRSN Housing: Rent, Utilities, and Tenancy Services		
To help beneficiaries who meet specific eligibility criteria maintain stable housing, the state will provide rental assistance, utility costs, and tenancy services. The ultimate goal of providing housing support is to improve health outcomes and reduce inequities among eligible population members. This includes people who are at-risk of homelessness and are experiencing high-risk pregnancy, or who experienced a high-risk pregnancy	**HRSN research hypothesis 1.** The demonstration will meet HRSN for case management-like services and/or reduce the severity of HRSN for case management-like services among beneficiaries overall and among subpopulations who experience inequities in HRSN. **HRSN research hypothesis 2.** By providing case management like services for HRSN, the demonstration will increase beneficiaries' use of preventive and routine care and reduce their use of potentially	• Eligibility and enrollment data • Oregon Medicaid claims • CCO financial reporting • CCO contract reporting • YSHCN beneficiary survey • Interviews with people who received

Objectives	Proposed Hypothesis	Potential Approaches
and are less than 12 months postpartum. Pending completion of Tribal Consultation to determine best approach for ensuring the Tribes' members' HRSNs are supported.	avoidable hospital care, leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience inequities in hospital care. **HRSN research hypothesis 3.** By meeting or reducing HRSN for case management-like services, the demonstration will improve physical and behavioral health outcomes among beneficiaries overall and among subpopulations who experience inequities in physical and mental health outcomes	YSHCN benefits and services • All Payers All Claims (APAC) data for Medicare claims (for dual-eligible Medicaid members) • READ and SOGI Data Repository
HRSN Outreach and Engagement (O&E)		
In addition, the HRSN portion of the demonstration will include HRSN Case management like services. The waiver's outreach and engagement services will connect OHP members to the HRSN benefits described above and provide additional supports. Services will involve contacting and engaging individuals in the covered populations who may be eligible for HRSN services through a variety of strategies (i.e., mail, text, phone, email, community and street-level outreach, etc.). In addition, HRSN Case management services will involve assessing members' HRSN service needs and transmitting information for eligibility determination and service authorization. The benefit will also involve connection to and coordination of related services, including helping members to enroll or maintain enrollment in Medicaid and to secure other benefits (such as Temporary Assistance for Needy	**HRSN Research Hypothesis 1.** The demonstration will meet HRSN for case management-like services and/or reduce the severity of HRSN for case management-like services among beneficiaries overall and among subpopulations who experience inequities in HRSN. **HRSN Research Hypothesis 2**. By providing case management like services for HRSN, the demonstration will increase beneficiaries' use of preventive and routine care and reduce their use of potentially avoidable hospital care, leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience inequities in hospital care. **HRSN Research Hypothesis 3.** By meeting or reducing HRSN for case management-like services, the demonstration will improve physical and behavioral health outcomes among beneficiaries overall and among subpopulations who	• Eligibility and enrollment data • Oregon Medicaid claims • CCO financial reporting • CCO contract reporting • YSHCN beneficiary survey • Interviews with people who received YSHCN benefits and services • All Payers All Claims (APAC) data for Medicare claims (for dual-eligible Medicaid members) READ and SOGI Data Repository

Objectives	Proposed Hypothesis	Potential Approaches
Families (TANF); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Supplemental Nutrition Assistance Program (SNAP); etc.), as well as other types of navigation assistance. Social needs navigation programs have been shown to decrease health care utilization, especially in low-income populations and increase access to preventive care such as well-child visits.[39,40] Navigation programs can also decrease family social needs and improve health outcomes.[41] For example, community health workers (CHWs) provide navigation and education support that helps reduce barriers to health care coverage and improve connections to health care and social services;[42,43] studies have shown that being connected with a CHW can improve patient experiences	experience inequities in physical and mental health outcomes.	

[39] Schickedanz A, Sharp A, Hu YR, Shah NR, Adams JL, Francis D, et al. Impact of social needs navigation on utilization among high utilizers in a large integrated health system: a quasi-experimental study. J Gen Intern Med. 2019;34:2382–9.

[40] Hill S, Topel K, Li X, Solomon BS. Engagement in a social needs navigation program and health care utilization in pediatric primary care. Acad Pediatr. 2022;22(7):1221–7.

[41] Gottlieb LM, Hessler D, Long D, Laves E, Burns AR, Amaya A, et al. Effects of social needs screening and in-person service navigation on child health: a randomized clinical trial. JAMA Pediatr. 2016;170(11):e162521–e162521.

[42] Menendez T, Barragan NC, Kuo T, Morrison JL. Using health navigators to connect at-risk clients to community resources. Journal of Public Health Management and Practice. 2022;28(2):E397–403.

[43] Albritton E. How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities [Internet]. Families USA 2019. 2016. Available from: https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf.

Objectives	Proposed Hypothesis	Potential Approaches
and self-reported health, as well as chronic disease outcomes.[44,45] Pending completion of Tribal Consultation to determine best approach for ensuring the Tribes' members' HRSNs are supported.		
Young Adults with Special Healthcare Needs (YSHCN)		
This component of the demonstration aims to smooth the transition from pediatric to adult health care by allowing YSHCN to retain child eligibility levels and benefits through age 25. Evidence suggests that continuity of coverage supports improved access to and utilization of care. This consistency is particularly important for young adults with complex medical and behavioral health needs. The demonstration's eligibility and benefit policies design for young adults with special health care needs (YSHCN) support two of Oregon's policy goals: 1) maximizing continuous and equitable access to coverage; and 2) improving health outcomes by streamlining life and coverage transitions.	**YSHCN Research Hypothesis 1.** The YSHCN policy will improve continuity of Medicaid coverage for YSHCN. **YSHCN Research Hypothesis 2.** The YSHCN policy will improve continuity of care for Medicaid-enrolled YSHCN. **YSHCN Research Hypothesis 3.** The YSHCN policy will improve health care access and utilization for Medicaid-enrolled YSHCN.	• Eligibility and enrollment data • Oregon Medicaid claims • CCO financial reporting • CCO contract reporting • YSHCN beneficiary survey • Interviews with people who received YSHCN benefits and services • All Payers All Claims (APAC) data for Medicare claims (for dual-eligible Medicaid members) • REALD and SOGI Data Repository

[44] Kangovi S, Mitra N, Grande D, Huo H, Smith RA, Long JA. Community health worker support for disadvantaged patients with multiple chronic diseases: a randomized clinical trial. Am J Public Health. 2017;107(10):1660–7.

[45] Kangovi S, Mitra N, Norton L, Harte R, Zhao X, Carter T, et al. Effect of community health worker support on clinical outcomes of low-income patients across primary care facilities: a randomized clinical trial. JAMA Intern Med. 2018;178(12):1635–43.

Objectives	Proposed Hypothesis	Potential Approaches
Reentry Services		
The demonstration's policies for individuals transitioning out of participating carceral facilities are designed to address state priorities around improving continuity and quality of care when reentering the community. Oregon plans to implement a pre-release benefit package that includes, at minimum, the following services to OHP-eligible incarcerated individuals within 60 days prior to release: 1) case management to assess any physical, behavioral health, and health related social needs; 2) medication-assisted treatment (MAT) as clinically appropriate; and 3) a 30-day supply of all prescription medications provided at the time of reentry into the community.	**Reentry Research Hypothesis 1.** The Reentry policy will expand Medicaid enrollment and improve continuity of coverage into the community post-release. **Reentry Research Hypothesis 2.** The Reentry policy will improve continuity of care into the community post-release. **Reentry Research Hypothesis 3.** The Reentry policy will improve health care access, utilization, and quality post-release. **Reentry Research Hypothesis 4.** The Reentry policy will decrease mortality in the near-term post-release.	• Eligibility and enrollment data • Oregon Medicaid claims • REALD/SOGI Data Repository • Oregon Death Data/Vital Statistics Program

The proposed evaluation questions, hypotheses, measures and data sources are subject to change. The State and its independent evaluator will refine these elements based on feedback during the approval process.

Section 7: Quality Improvement

7.1 External Quality Review Organization (EQRO) Reports

Oregon contracted with the Health Services Advisory Group (HSAG) to meet the federal requirement to conduct an annual assessment of CCO performance as outlined in 42 CFR 438.364. HSAG publishes an annual Technical Quality Report

evaluating CCO performance and offering recommendations regarding the quality, timeliness, and accessibility of health care services provided by the CCOs. The latest report covering calendar year (CY) 2025 is included in this application as Attachment C and posted on Oregon's website here:

https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/OR2025_EQR_Technical_Report_F1.pdf

7.1.1 Summary of EQRO Technical Quality Report Findings

Overall, the results of the 2025 HSAG Technical Quality report show positive movement across all domains (quality, timeliness, and access to care) from CY 2024 to CY 2025, with the number of strengths compared to weaknesses showing varying levels of improvement. HSAG identified the following notable accomplishments related to CCO performance on quality, timeliness, and access to care:

- The number of strengths in the **quality domain** increased from 49% in CY 2024 to 70% in CY 2025.
- The incentive measure of *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* showed **consistent overall improvement** in CCOs' aggregate performance across three years: 63% (MY 2022), 65% (MY 2023), and 69% (MY 2024).
- The administration of Mental Health/SUD and Medical/Surgical benefits was largely found to be **in parity** for the CCOs based on findings from the 2025 Mental Health Parity Evaluation, and collaboration with community partner groups.
- Throughout CY 2025, OHA **provided ongoing technical assistance** to the CCOs across multiple program and contract deliverable areas, including fraud, waste, and abuse (FWA) and program integrity; notice of adverse benefit determination (NOABD) requirements; member handbook requirements; and network adequacy reporting. OHA also developed new and enhanced existing guidelines for CCO Contract deliverables to better support CCOs in meeting their reporting obligations.
- The CY 2025 Compliance Monitoring Review activity identified **numerous best practices** among the CCOs related to provider engagement activities focused on respecting member rights, proactive safeguards aimed at protecting member privacy, and the use of care coordinators and trained customer service representatives to resolve member concerns, while providing a clear and compliant pathway for disenrollment requests.

The full 2025 HSAG Technical Quality report is included as Attachment C of this application.

7.1.2 Performance Improvement Project Findings

Under Oregon's 1115 2022-2027 demonstration waiver, CCOs conducted CCO-specific and statewide Performance Improvement Projects (PIPs) addressing priority areas for quality improvement. Statewide PIPs included the Mental Health (MH) Service Access Monitoring PIP and the Substance Use Disorder Initiation and Engagement in Treatment PIP. The Mental Health Service Access Monitoring PIP concluded in 2024, and beginning in 2025, the statewide integration PIP shifted to oral health access.

Mental Health Service Access Monitoring PIP

This PIP focused on increasing access to MH services for OHP members ages 2 years and above with an identified MH service need. The MH Access statewide PIP responds to member needs identified as priorities for the state in response to the COVID-19 pandemic.

- **Performance Indicator(s):** Percentage of members with a MH service need who received MH services.
- **Findings From 2025 HSAG Technical Quality Report:** Nearly all CCOs received a *High Confidence* rating for achieving significant improvement, reporting remeasurement year (RY) 3 performance indicator results that demonstrated statistically significant improvement compared to baseline results.

Substance Use Disorder PIP

The Substance Use Disorder PIP focuses on increasing initiation of and engagement in SUD treatment for OHP members ages 13 years and older who have a newly identified SUD episode. The PIP allows the CCOs to further focus efforts on improving treatment for members with SUD as part of the broader efforts encompassed by the 1115 SUD demonstration waiver.

- **Performance Indicator(s):** (a) The percentage of new SUD episodes that were followed by treatment initiation within 14 days, and (b) the percentage of new SUD episodes that were followed by treatment engagement within 34 days of treatment initiation.
- **Findings From 2025 HSAG Technical Quality Report:** With a few exceptions, most CCOs did not demonstrate statistically significant improvement in their remeasurement year (RY) 2 results for both

performance indicators leading to ratings below *High Confidence*.

7.2 CCO and State Quality Assurance Monitoring

Oregon uses various mechanisms to ensure the managed care delivery model is accountable for value, quality, and outcomes through ongoing measurement and monitoring. By maintaining a robust performance monitoring system, Oregon is able to track progress, identify areas for improvement, and support accountability across all CCOs. This framework reinforces the state's commitment to improving access, addressing health disparities, and driving system wide quality improvement. As Oregon continues to utilize the CCO model, the Quality Strategy will remain central to evaluating performance and advancing meaningful, measurable, outcomes for Medicaid members.

Oregon employs the following mechanisms to monitor CCO performance and enforce compliance:

- **Appointment and Availability Studies:** Used to review CCO provider availability and accessibility and to determine compliance with contractually defined performance standards. Secret and Revealed shopper telephone surveys are used to capture information on new and existing patient appointment availability and wait times at the sampled location.
- **Network Adequacy Monitoring:** CCOs must submit an annual Delivery System Network (DSN) provider narrative report and quarterly DSN provider capacity reports, that crosswalk to the network standards in the CCOs contracts with the State.
- **Operational Reviews:** Conducted periodically in response to gaps in performance, CCO request, or EQRO request. Reviews include validating CCO data submissions and the CCO's quality assurance activities.
- **Quality Management Committee Reviews:** The OHA Quality Management Committee meets quarterly to review contract compliance issues across all delivery systems and performance metrics.
- **Consumer Assessment Surveys:** Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. The survey results inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

- **Quality Management Plans:** CCOs are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to ensure quality performance.
- **Ongoing Focused Reviews:** Focused reviews are conducted in response to suspected deficiencies that are identified through routine monitoring and evaluation of CCO deliverables and processes. Operational reviews supplement the state monitoring program of CCOs, by providing CCOs with direct and focused areas of improvement.
- **Reporting and Auditing for Suspected Fraud, Waste, and Abuse:** CCOs are required to report suspected fraud waste or abuse within 7 days for investigation. The OHA Office of Program Integrity conducts ongoing audits of providers, subcontractors and other downstream entities receiving Medicaid funds through CCOs.
- **Compliance Enforcement:** Oregon determines the appropriate action to resolve noncompliance including increased monitoring frequency, notice to cure, improvement plans, and corrective action plans. Additional regulatory compliance mechanisms Oregon may apply include restricting enrollment, financial penalties, and, ultimately, non-renewal of contracts.

Additional information on Oregon's managed care quality and oversight framework is provided in the 2026 Medicaid Quality Strategy in Attachment D.

7.3 Quality Incentive Payments

Oregon's CCO Quality Incentive Program links CCO financial incentives to performance on State-selected quality measures and improvement targets. The program is intended to align CCO financial incentives with improvements in quality, health outcomes, and the priorities of Oregon's CCO delivery model.

7.3.1 Incentivizing Equitable Care

SB 966, passed by the Oregon Legislature in 2023, divided the Quality Incentive Program into two complementary components: upstream measures focused on improving the social determinants of health and downstream measures, which focus on traditional medical care and are derived from the CMS Medicaid Core Set.

7.3.2 Incentive Metrics Governance

The Metrics & Scoring Committee, comprised of measurement experts, CCO representatives, and members at large, is the public body charged with incentive metrics governance. The committee selects incentive measures and sets benchmarks and improvement targets. Public comment is heard at each committee meeting, and plain-language materials are being developed to further engage OHP members and other stakeholders in committee decision-making.

Section 8: Public Notice, Public Comment, and Tribal Consultation Process

8.1 Public Notice and Public Comment Process

[Section to be completed post-public comment period]

8.1.1 Public Notice

8.1.2 Public Comment Process

8.1.3 Public Hearings

8.2 Summary of Public Comments and Responses

[Section to be completed post-public comment period]

8.3 Tribal Consultation

[Section to be completed post-Tribal Consultation period]

Section 9: Attachments

A. Budget Neutrality

B. Public Comment Logs

Pending completion of 30-day public comment and 60-day Tribal Consultation.

C. External Quality Review Technical Report (2025)

HSAG External Quality Review Technical Report (2025)

https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/OR2025_EQR_Technical_Report_F1.pdf

D. Oregon's Medicaid Quality Strategy (2026)

Oregon's Medicaid Quality Strategy (2026)

https://www.oregon.gov/oha/HSD/OHP/SiteAssets/Pages/Quality-Strategy/2026%20OHA%20Medicaid%20Quality%20Strategy_Final.pdf

E. Draft 2022-2027 Interim Waiver Evaluation Report

Draft 2022-2027 Interim Waiver Evaluation Report

Medicaid Division
500 Summer Street NE
Salem, OR 97301
https://www.oregon.gov/oha/Pages/index.aspx

Attachment A: Budget Neutrality Worksheets and Projections

Oregon Section 1115 Budget Neutrality Calculation
Overview$ in millions

	Current Waiver					Proposed Waiver				
Demonstration Years (DY)	21	22	23	24	25	26	27	28	29	30
Federal Fiscal Years	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 28	FFY 29	FFY 30	FFY 31	FFY 32
Without Waiver (WOW)	**$ 6,190**	**$ 6,470**	**$ 6,353**	**$ 6,485**	**$ 6,796**	**$ 6,638**	**$ 6,952**	**$ 7,334**	**$ 7,738**	**$ 8,163**
With Waiver (WW)										
Total PMPM payments	$ 4,718	$ 4,796	$ 5,135	$ 5,156	$ 5,898	$ 6,346	$ 6,646	$ 7,011	$ 7,397	$ 7,804
Other Payments										
Primary Care Services for Tribes	$ 0.8	$ 0.9	$ 1.0	$ 1.1	$ 1.7	$ 1.8	$ 2.2	$ 2.6	$ 3.2	$ 3.8
Designated State Health Programs	$ -	$ 148	$ 226	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Traditional Health Care Practices (Implementation)	$ -	$ -	$ -	$ -	$ 4.4	$ 2.3	$ 2.3	$ -	$ -	$ -
With Waiver Total	**$ 4,719**	**$ 4,945**	**$ 5,363**	**$ 5,157**	**$ 5,904**	**$ 6,350**	**$ 6,650**	**$ 7,014**	**$ 7,400**	**$ 7,808**
Base Variance WOW Less WW	$ 1,471	$ 1,525	$ 990	$ 1,328	$ 891	$ 288	$ 301	$ 320	$ 337	$ 355
Net Cumulative Variance Current	$ 1,471	$ 2,996	$ 3,986	$ 5,314	$ 6,206					
Net Cumulative Variance Current & Proposed Waiver						$ 6,494	$ 6,795	$ 7,115	$ 7,453	$ 7,808

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Oregon Section 1115 Budget

Neutrality Summary

	Current Waiver					Proposed Waiver				
	21	22	23	24	25	26	27	28	29	30
	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 28	FFY 29	FFY 30	FFY 31	FFY 32
Without Waiver (WOW)										
Medicaid Per Capita										
PCR	$ 900,224,121	$ 924,474,106	$ 996,973,410	$ 984,032,468	$ 1,044,266,584	$ 1,103,798,692	$ 1,159,560,689	$ 1,223,340,842	$ 1,290,626,453	$ 1,361,609,310
PWO	$ 457,233,581	$ 488,674,298	$ 508,830,509	$ 544,943,875	$ 551,851,666	$ 459,845,382	$ 484,527,185	$ 511,176,098	$ 539,290,497	$ 568,952,252
CMO	$ 1,689,789,625	$ 1,767,665,471	$ 1,816,296,060	$ 1,867,823,919	$ 1,955,097,810	$ 1,896,376,194	$ 1,970,119,647	$ 2,078,486,397	$ 2,192,802,693	$ 2,313,402,440
BCCP	$ 4,681,316	$ 3,581,857	$ 2,015,926	$ 2,079,546	$ 2,305,174	$ 2,249,014	$ 2,368,569	$ 2,498,838	$ 2,636,278	$ 2,781,275
Old Age Assistance	$ 667,579,950	$ 732,313,676	$ 604,871,577	$ 603,705,313	$ 620,360,292	$ 733,015,607	$ 778,865,341	$ 821,704,892	$ 866,900,581	$ 914,580,376
Aid to Blind/Disabled	$ 2,294,901,082	$ 2,374,622,845	$ 2,239,727,104	$ 2,292,199,001	$ 2,421,262,555	$ 2,188,520,875	$ 2,287,955,059	$ 2,413,789,571	$ 2,546,546,761	$ 2,686,602,432
Foster Children	$ 175,269,738	$ 178,696,906	$ 184,017,404	$ 190,013,241	$ 200,513,409	$ 254,615,402	$ 268,376,820	$ 283,137,022	$ 298,709,055	$ 315,137,481
Without Waiver (WOW) Total Neutrality Ceiling	**$ 6,189,679,413**	**$ 6,470,029,160**	**$ 6,352,731,992**	**$ 6,484,797,363**	**$ 6,795,657,489**	**$ 6,638,421,166**	**$ 6,951,773,310**	**$ 7,334,133,660**	**$ 7,737,512,317**	**$ 8,163,065,566**
With Waiver (WW)										
Medicaid Per Capita										
PCR	$ 854,359,057	$ 856,018,325	$ 941,218,322	$ 973,670,970	$ 1,068,896,958	$ 1,094,157,641	$ 1,149,427,892	$ 1,212,643,336	$ 1,279,342,928	$ 1,349,707,801
PWO	$ 298,717,360	$ 313,338,801	$ 353,842,141	$ 347,593,184	$ 368,764,487	$ 412,745,388	$ 434,899,212	$ 458,817,738	$ 484,052,334	$ 510,674,640
CMO	$ 1,341,356,469	$ 1,407,242,036	$ 1,552,668,456	$ 1,551,093,275	$ 1,739,043,475	$ 1,825,815,796	$ 1,896,812,728	$ 2,001,142,285	$ 2,111,208,905	$ 2,227,316,137
BCCP	$ 3,414,659	$ 2,476,104	$ 1,476,631	$ 1,493,455	$ 2,024,720	$ 2,159,294	$ 2,274,086	$ 2,399,164	$ 2,531,119	$ 2,670,330
Old Age Assistance	$ 617,224,320	$ 655,536,882	$ 645,033,881	$ 576,073,743	$ 648,264,556	$ 729,547,621	$ 775,184,347	$ 817,820,652	$ 862,798,041	$ 910,252,008
Aid to Blind/Disabled	$ 1,415,448,686	$ 1,379,894,858	$ 1,436,640,591	$ 1,487,131,168	$ 1,836,884,460	$ 2,030,237,592	$ 2,122,483,269	$ 2,239,219,404	$ 2,362,373,850	$ 2,492,302,632
Foster Children	$ 187,444,410	$ 181,119,800	$ 204,275,758	$ 218,578,034	$ 234,371,494	$ 251,231,338	$ 264,809,804	$ 279,374,314	$ 294,739,029	$ 310,950,451
	$ 4,717,964,962	$ 4,795,626,805	$ 5,135,155,780	$ 5,155,633,829	$ 5,898,250,150	$ 6,345,894,670	$ 6,645,891,337	$ 7,011,416,893	$ 7,397,046,207	$ 7,803,873,999
Medicaid Aggregate - With Waiver only										
Primary Care Services for Tribes	$ 781,745	$ 882,059	$ 1,020,987	$ 1,115,912	$ 1,728,134	$ 1,819,734	$ 2,188,502	$ 2,632,002	$ 3,165,376	$ 3,806,838
Designated State Health Programs	$ -	$ 148,388,709	$ 226,484,082	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Traditional health care practices (Implementation)	$ -	$ -	$ -	$ -	$ 4,350,000	$ 2,294,625	$ 2,294,625	$ -	$ -	$ -
	$ 781,745	$ 149,270,768	$ 227,505,069	$ 1,115,912	$ 6,078,134	$ 4,114,359	$ 4,483,127	$ 2,632,002	$ 3,165,376	$ 3,806,838
With Waiver (WW) Total Actuals	**$ 4,718,746,707**	**$ 4,944,897,573**	**$ 5,362,660,849**	**$ 5,156,749,741**	**$ 5,904,328,284**	**$ 6,350,009,029**	**$ 6,650,374,465**	**$ 7,014,048,894**	**$ 7,400,211,583**	**$ 7,807,680,837**
Base Variance WOW Less WW	$ 1,470,932,706	$ 1,525,131,587	$ 990,071,143	$ 1,328,047,622	$ 891,329,205	$ 288,412,136	$ 301,398,846	$ 320,084,766	$ 337,300,734	$ 355,384,728
Net Cumulative Variance Current	$ 1,470,932,706	$ 2,996,064,293	$ 3,986,135,435	$ 5,314,183,058	$ 6,205,512,263					
Net Cumulative Variance Current & Proposed Waiver Periods						$ 6,493,924,400	$ 6,795,323,245	$ 7,115,408,011	$ 7,452,708,745	$ 7,808,093,473

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Oregon Section 1115 Budget

Hypothetical Summaries (Medicaid Authorizable Populations)

	Current Waiver					Proposed Waiver				
	21	22	23	24	25	26	27	28	29	30
	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 28	FFY 29	FFY 30	FFY 31	FFY 32
Hypothetical 1 - ACA Adults Per Capita										
Without Waiver	$ 5,509,792,575	$ 5,394,335,005	$ 5,885,705,269	$ 6,162,275,845	$ 6,237,790,225	$ 5,329,032,404	$ 5,015,580,284	$ 5,291,432,959	$ 5,582,450,049	$ 5,889,479,564
With Waiver	$ 5,035,369,853	$ 4,889,847,198	$ 5,329,316,211	$ 5,705,935,185	$ 5,734,316,627	$ 5,167,436,437	$ 4,863,487,190	$ 5,130,959,531	$ 5,413,147,340	$ 5,710,848,745
Variance	$ 474,422,722	$ 504,487,807	$ 556,389,058	$ 456,340,660	$ 503,473,598	$ 161,595,967	$ 152,093,094	$ 160,473,428	$ 169,302,709	$ 178,630,819
Hypothetical 2 - YSHCN Per Capita										
Without Waiver	$ -	$ -	$ 3,842,693	$ 21,190,461	$ 41,647,052	$ -	$ -	$ -	$ -	$ -
With Waiver	$ -	$ -	$ 3,565,495	$ 18,429,505	$ 29,099,838	$ -	$ -	$ -	$ -	$ -
Variance	$ -	$ -	$ 277,198	$ 2,760,956	$ 12,547,214	$ -	$ -	$ -	$ -	$ -
Hypothetical 3 - CE Per Capita										
Without Waiver										
CE PCR	$ 24,030,623	$ 24,677,954	$ 26,613,253	$ 26,267,807	$ 27,875,699	$ -	$ -	$ -	$ -	$ -
CE PWO	$ 12,205,414	$ 13,044,694	$ 13,582,745	$ 14,546,756	$ 14,731,153	$ -	$ -	$ -	$ -	$ -
CE CMO	$ 1,860,815	$ 1,946,573	$ 2,000,126	$ 2,056,869	$ 2,152,976	$ -	$ -	$ -	$ -	$ -
CE BCCP	$ 124,963	$ 95,614	$ 53,813	$ 55,512	$ 61,534	$ -	$ -	$ -	$ -	$ -
CE Old Age Assistance	$ 17,820,409	$ 19,548,414	$ 16,146,469	$ 16,115,337	$ 16,559,926	$ -	$ -	$ -	$ -	$ -
CE Aid to Blind/ Disabled	$ 61,260,193	$ 63,388,289	$ 59,787,377	$ 61,188,064	$ 64,633,292	$ -	$ -	$ -	$ -	$ -
CE Foster Children	$ 193,009	$ 196,783	$ 202,642	$ 209,245	$ 220,808	$ -	$ -	$ -	$ -	$ -
	$ 117,495,427	$ 122,898,322	$ 118,386,425	$ 120,439,589	$ 126,235,388	$ -	$ -	$ -	$ -	$ -
With Waiver										
CE PCR	$ 22,794,282	$ 22,812,110	$ 25,062,249	$ 25,961,308	$ 28,533,184	$ -	$ -	$ -	$ -	$ -
CE PWO	$ 7,974,198	$ 8,320,768	$ 9,423,246	$ 9,270,540	$ 9,843,816	$ -	$ -	$ -	$ -	$ -
CE CMO	$ 1,483,327	$ 1,581,176	$ 1,609,981	$ 1,621,296	$ 1,915,054	$ -	$ -	$ -	$ -	$ -
CE BCCP	$ 91,100	$ 67,059	$ 39,214	$ 39,792	$ 54,048	$ -	$ -	$ -	$ -	$ -
CE Old Age Assistance	$ 16,475,531	$ 17,226,866	$ 17,174,114	$ 15,364,693	$ 17,304,803	$ -	$ -	$ -	$ -	$ -
CE Aid to Blind/ Disabled	$ 37,780,935	$ 36,871,851	$ 38,253,502	$ 39,657,855	$ 49,033,877	$ -	$ -	$ -	$ -	$ -
CE Foster Children	$ 195,518	$ 188,923	$ 200,536	$ 228,568	$ 258,093	$ -	$ -	$ -	$ -	$ -
	$ 86,794,891	$ 87,068,754	$ 91,762,842	$ 92,144,052	$ 106,942,875	$ -	$ -	$ -	$ -	$ -
Variance	$ 30,700,536	$ 35,829,568	$ 26,623,583	$ 28,295,537	$ 19,292,514	$ -	$ -	$ -	$ -	$ -
Hypothetical 4 - MAGI Expanded Adult & Expanded Adults Exempt from Managed care Per Capita										
Without Waiver										
MAGI Expanded Adult Program	$ -	$ 220,815,089	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Expanded Adults Exempt from Managed Care	$ -	$ 2,437,788	$ 12,194,956	$ 22,211,609	$ 24,642,157	$ 24,497,101	$ 28,394,845	$ 29,956,520	$ 31,604,206	$ 33,342,490
	$ -	$ 223,252,877	$ 12,194,956	$ 22,211,609	$ 24,642,157	$ 24,497,101	$ 28,394,845	$ 29,956,520	$ 31,604,206	$ 33,342,490
With Waiver										
MAGI Expanded Adult Program	$ -	$ 118,812,539	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Expanded Adults Exempt from Managed Care	$ -	$ 1,162,519	$ 6,448,083	$ 14,252,628	$ 15,671,809	$ 21,688,739	$ 25,139,612	$ 26,522,383	$ 27,981,132	$ 29,520,157
	$ -	$ 119,975,058	$ 6,448,083	$ 14,252,628	$ 15,671,809	$ 21,688,739	$ 25,139,612	$ 26,522,383	$ 27,981,132	$ 29,520,157
Variance	$ -	$ 103,277,819	$ 5,746,873	$ 7,958,981	$ 8,970,348	$ 2,808,362	$ 3,255,234	$ 3,434,137	$ 3,623,074	$ 3,822,333
Hypothetical 5 - Reentry Initiative Per Capita & Aggregate										
Without Waiver										
Reentry Initiative Services Per Capita	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,732,204	$ 12,106,391	$ 18,458,957	$ 37,345,284
Reentry Initiative Non-Services Aggregate	$ -	$ 17,325,000	$ 57,750,000	$ 40,425,000	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ 17,325,000	$ 57,750,000	$ 40,425,000	$ -	$ -	$ 2,732,204	$ 12,106,391	$ 18,458,957	$ 37,345,284
With Waiver										
Reentry Initiative Services Per Capita	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,732,204	$ 12,106,391	$ 18,458,957	$ 37,345,284
Reentry Initiative Non-Services Aggregate	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,732,204	$ 12,106,391	$ 18,458,957	$ 37,345,284
Variance	$ -	$ 17,325,000	$ 57,750,000	$ 40,425,000	$ -	$ -	$ -	$ -	$ -	$ -
Hypothetical 6 - Health Related Social Needs										
Without Waiver	$ 51,000,000	$ 276,000,000	$ 232,000,000	$ 232,000,000	$ 232,000,000	$ 78,867,607	$ 79,431,646	$ 80,106,022	$ 80,912,317	$ 81,876,339
With Waiver	$ -	$ 31,251,309	$ 70,804,942	$ 163,633,277	$ 182,174,865	$ 78,867,607	$ 79,431,646	$ 80,106,022	$ 80,912,317	$ 81,876,339
Variance	$ 51,000,000	$ 244,748,691	$ 161,195,058	$ 68,366,723	$ 49,825,135	$ -	$ -	$ -	$ -	$ -

Oregon Section 1115 Member Months

	Current Waiver					Proposed Waiver				
	21	22	23	24	25	26	27	28	29	30
	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 28	FFY 29	FFY 30	FFY 31	FFY 32
Current Services Caseload										
PCR	1,180,111	1,151,993	1,180,926	1,107,982	1,117,687	1,070,039	1,065,489	1,065,489	1,065,489	1,065,489
PWO	198,667	201,832	199,769	203,372	195,770	204,934	204,677	204,677	204,677	204,677
CMO	3,298,051	3,285,746	3,215,366	3,149,150	3,139,307	3,082,586	3,035,483	3,035,483	3,035,483	3,035,483
BCCP	1,932	1,405	752	737	777	775	774	774	774	774
Old Age Assistance	904,310	951,106	753,199	720,756	710,103	747,411	752,760	752,760	752,760	752,760
Aid to Blind/Disabled	1,103,817	1,089,851	980,861	957,865	965,454	998,003	988,954	988,954	988,954	988,954
Foster Children	205,523	199,563	195,719	192,473	193,437	193,929	193,754	193,754	193,754	193,754
	6,892,411	6,881,497	6,526,593	6,332,336	6,322,536	6,297,677	6,241,890	6,241,890	6,241,890	6,241,890
Hypothetical 1 - Per Capita										
ACA Adults Per Capita	7,259,757	6,737,108	6,967,558	6,914,660	6,634,465	5,591,556	4,988,294	4,988,294	4,988,294	4,988,294
Hypothetical 2 - Per Capita										
YSHCN	-	-	4,872	25,636	48,076	-	-	-	-	-
Hypothetical 3 Per Capita										
CE PCR	31,502	30,751	31,524	29,577	29,836	-	-	-	-	-
CE PWO	5,303	5,388	5,333	5,429	5,226	-	-	-	-	-
CE CMO	3,632	3,618	3,541	3,468	3,457	-	-	-	-	-
CE BCCP	52	38	20	20	21	-	-	-	-	-
CE Old Age Assistance	24,140	25,389	20,106	19,240	18,956	-	-	-	-	-
CE Aid to Blind/ Disabled	29,465	29,093	26,183	25,569	25,772	-	-	-	-	-
CE Foster Children	226	220	216	212	213	-	-	-	-	-
	94,320	94,496	86,922	83,514	83,480	-	-	-	-	-
Hypothetical 4 Per Capita										
MAGI Expanded Adult Program	-	275,781	-	-	-	-	-	-	-	-
Expanded Adults Exempt from Managed Care	-	2,342	11,105	19,172	20,161	26,095	28,670	28,670	28,670	28,670
Hypothetical 5 Per Capita										
Reentry Initiative Services	-	-	-	-	-	-	1,815	7,623	11,017	21,127

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Oregon Section 1115 Per Member Per Month

	Current Waiver					Proposed Waiver (5.5% Inflation Rate)				
Demonstration Years (DY)	21	22	23	24	25	26	27	28	29	30
Federal Fiscal Years	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 28	FFY 29	FFY 30	FFY 31	FFY 32
Without Waiver										
PCR	$ 762.83	$ 802.50	$ 844.23	$ 888.13	$ 934.31	$ 1,031.55	$ 1,088.29	$ 1,148.15	$ 1,211.30	$ 1,277.92
PWO	$ 2,301.51	$ 2,421.19	$ 2,547.09	$ 2,679.54	$ 2,818.88	$ 2,243.87	$ 2,367.28	$ 2,497.48	$ 2,634.84	$ 2,779.76
CMO	$ 512.36	$ 537.98	$ 564.88	$ 593.12	$ 622.78	$ 615.19	$ 649.03	$ 684.73	$ 722.39	$ 762.12
BCCP	$ 2,422.52	$ 2,548.49	$ 2,681.01	$ 2,820.42	$ 2,967.08	$ 2,902.26	$ 3,061.88	$ 3,230.28	$ 3,407.95	$ 3,595.39
Old Age Assistance	$ 738.22	$ 769.96	$ 803.07	$ 837.60	$ 873.62	$ 980.74	$ 1,034.68	$ 1,091.59	$ 1,151.63	$ 1,214.97
Aid to Blind/Disabled	$ 2,079.06	$ 2,178.85	$ 2,283.43	$ 2,393.03	$ 2,507.90	$ 2,192.90	$ 2,313.51	$ 2,440.75	$ 2,574.99	$ 2,716.61
Foster Children	$ 852.80	$ 895.44	$ 940.21	$ 987.22	$ 1,036.58	$ 1,312.93	$ 1,385.14	$ 1,461.32	$ 1,541.69	$ 1,626.48
With Waiver										
PCR	$ 723.96	$ 743.08	$ 797.02	$ 878.78	$ 956.35	$ 1,022.54	$ 1,078.78	$ 1,138.11	$ 1,200.71	$ 1,266.75
PWO	$ 1,503.61	$ 1,552.47	$ 1,771.25	$ 1,709.15	$ 1,883.66	$ 2,014.04	$ 2,124.81	$ 2,241.67	$ 2,364.96	$ 2,495.03
CMO	$ 406.71	$ 428.29	$ 482.89	$ 492.54	$ 553.96	$ 592.30	$ 624.88	$ 659.25	$ 695.51	$ 733.76
BCCP	$ 1,767.04	$ 1,761.75	$ 1,963.79	$ 2,025.52	$ 2,606.10	$ 2,786.48	$ 2,939.74	$ 3,101.43	$ 3,272.01	$ 3,451.97
Old Age Assistance	$ 682.54	$ 689.24	$ 856.39	$ 799.26	$ 912.92	$ 976.10	$ 1,029.79	$ 1,086.43	$ 1,146.18	$ 1,209.22
Aid to Blind/Disabled	$ 1,282.32	$ 1,266.13	$ 1,464.67	$ 1,552.55	$ 1,902.61	$ 2,034.30	$ 2,146.19	$ 2,264.23	$ 2,388.76	$ 2,520.14
Foster Children	$ 912.04	$ 907.58	$ 1,043.72	$ 1,135.63	$ 1,211.61	$ 1,295.48	$ 1,366.73	$ 1,441.90	$ 1,521.20	$ 1,604.87
Hypothetical 1 - ACA Adults Per Capita										
Without Waiver	$ 758.95	$ 800.69	$ 844.73	$ 891.19	$ 940.21	$ 953.05	$ 1,005.47	$ 1,060.77	$ 1,119.11	$ 1,180.66
With Waiver	$ 693.64	$ 725.85	$ 764.88	$ 825.19	$ 864.32	$ 924.15	$ 974.98	$ 1,028.60	$ 1,085.17	$ 1,144.85
Hypothetical 2 - YSHCN Per Capita										
Without Waiver	$ -	$ 752.60	$ 788.73	$ 826.59	$ 866.27	$ -	$ -	$ -	$ -	$ -
With Waiver	$ -	$ -	$ 731.83	$ 718.89	$ 579.05	$ -	$ -	$ -	$ -	$ -
Hypothetical 3 - CE Per Capita										
Without Waiver										
CE PCR	$ 762.83	$ 802.50	$ 844.23	$ 888.13	$ 934.31	$ -	$ -	$ -	$ -	$ -
CE PWO	$ 2,301.51	$ 2,421.19	$ 2,547.09	$ 2,679.54	$ 2,818.88	$ -	$ -	$ -	$ -	$ -
CE CMO	$ 512.36	$ 537.98	$ 564.88	$ 593.12	$ 622.78	$ -	$ -	$ -	$ -	$ -
CE BCCP	$ 2,422.52	$ 2,548.49	$ 2,681.01	$ 2,820.42	$ 2,967.08	$ -	$ -	$ -	$ -	$ -
CE Old Age Assistance	$ 738.22	$ 769.96	$ 803.07	$ 837.60	$ 873.62	$ -	$ -	$ -	$ -	$ -
CE Aid to Blind/ Disabled	$ 2,079.06	$ 2,178.85	$ 2,283.43	$ 2,393.03	$ 2,507.90	$ -	$ -	$ -	$ -	$ -
CE Foster Children	$ 852.80	$ 895.44	$ 940.21	$ 987.22	$ 1,036.58	$ -	$ -	$ -	$ -	$ -
With Waiver										
CE PCR	$ 723.58	$ 741.82	$ 795.03	$ 877.77	$ 956.35	$ -	$ -	$ -	$ -	$ -
CE PWO	$ 1,503.65	$ 1,544.40	$ 1,767.08	$ 1,707.65	$ 1,883.66	$ -	$ -	$ -	$ -	$ -
CE CMO	$ 408.42	$ 436.99	$ 454.69	$ 467.52	$ 553.96	$ -	$ -	$ -	$ -	$ -
CE BCCP	$ 1,766.06	$ 1,787.38	$ 1,953.67	$ 2,021.75	$ 2,606.10	$ -	$ -	$ -	$ -	$ -
CE Old Age Assistance	$ 682.51	$ 678.52	$ 854.18	$ 798.59	$ 912.92	$ -	$ -	$ -	$ -	$ -
CE Aid to Blind/ Disabled	$ 1,282.22	$ 1,267.40	$ 1,461.00	$ 1,551.00	$ 1,902.61	$ -	$ -	$ -	$ -	$ -
CE Foster Children	$ 863.89	$ 859.67	$ 930.44	$ 1,078.39	$ 1,211.61	$ -	$ -	$ -	$ -	$ -
Hypothetical 4 - MAGI Expanded Adult & Expanded Adults Exempt from Managed care Per Capita										
Without Waiver										
MAGI Expanded Adult Program	$ 758.95	$ 800.69	$ 844.73	$ 891.19	$ 940.21	$ -	$ -	$ -	$ -	$ -
Expanded Adults Exempt from Managed Care	$ -	$ 1,040.90	$ 1,098.15	$ 1,158.55	$ 1,222.27	$ 938.76	$ 990.39	$ 1,044.86	$ 1,102.33	$ 1,162.96
With Waiver										
MAGI Expanded Adult Program	$ -	$ 430.82	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Expanded Adults Exempt from Managed Care	$ -	$ 496.38	$ 580.65	$ 743.41	$ 777.33	$ 831.14	$ 876.85	$ 925.08	$ 975.96	$ 1,029.64
Hypothetical 5 - Reentry Initiative Per Capita										
Without Waiver	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,505.35	$ 1,588.14	$ 1,675.49	$ 1,767.64
With Waiver	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,505.35	$ 1,588.14	$ 1,675.49	$ 1,767.64

Oregon CHIP Allotment Historical Spending & Allotment Projections

	CHIP Allotment Per CMS 21-B Report				Actuals/ Projections		Projections (inflated 5.5%) annually				
	FFY 22	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 28	FFY 29	FFY 30	FFY 31	FFY 32
Federal Share	$ 461,841,489	$ 529,752,655	$ 545,799,037	$ 662,316,661	$ 693,204,991	$ 747,229,183	$ 788,326,788	$ 831,684,761	$ 877,427,423	$ 925,685,932	$ 976,598,658
State Share	$ 340,388,175	$ 360,547,098	$ 395,472,767	$ 327,785,362	$ 291,041,766	$ 288,614,120	$ 304,487,897	$ 321,234,731	$ 338,902,642	$ 357,542,287	$ 377,207,113
Total Funds	$ 802,229,664	$ 890,299,753	$ 941,271,804	$ 990,102,023	$ 984,246,757	$ 1,056,452,966	$ 1,114,557,879	$ 1,175,858,562	$ 1,240,530,783	$ 1,308,759,977	$ 1,380,741,775

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5 YEARS OF HISTORIC DATA

Population 1 - Parent, Caretaker, Relative

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 854,359,057	$ 856,018,325	$ 941,218,322	$ 973,670,970	$ 1,068,896,958	$ 4,694,163,633
Eligible Member Months	1,180,111	1,151,993	1,180,926	1,107,982	1,117,687	
PMPM Costs	$ 723.96	$ 743.08	$ 797.02	$ 878.78	$ 956.35	
Avg. Monthly Eligibles	98,343	95,999	98,411	92,332	93,141	

	Annual Change				5-Year Average
Total Expenditures	0.19%	9.95%	3.45%	9.78%	5.84%
Eligible Member Months	-2.38%	2.51%	-6.18%	0.88%	-1.29%
PMPM Costs	2.64%	7.26%	10.26%	8.83%	7.25%

Population 2 - Pregnant Woman

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 298,717,360	$ 313,338,801	$ 353,842,141	$ 347,593,184	$ 368,764,487	$ 1,682,255,972
Eligible Member Months	198,667	201,832	199,769	203,372	195,770	
PMPM Costs	$ 1,503.61	$ 1,552.47	$ 1,771.25	$ 1,709.15	$ 1,883.66	
Avg. Monthly Eligibles	16,556	16,819	16,647	16,948	16,314	

	Annual Change				5-Year Average
Total Expenditures	4.89%	12.93%	-1.77%	6.09%	5.54%
Eligible Member Months	1.59%	-1.02%	1.80%	-3.74%	-0.34%
PMPM Costs	3.25%	14.09%	-3.51%	10.21%	6.01%

Population 3 - Children's Medicaid

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 1,341,356,469	$ 1,407,242,036	$ 1,552,668,456	$ 1,551,093,275	$ 1,739,043,475	$ 7,591,403,712
Eligible Member Months	3,298,051	3,285,746	3,215,366	3,149,150	3,139,307	
PMPM Costs	$ 406.71	$ 428.29	$ 482.89	$ 492.54	$ 553.96	

Avg. Monthly Eligibles	274,838	273,812	267,947	262,429	261,609
			Annual Change		**5-Year Average**
Total Expenditures		4.91%	10.33%	-0.10%	12.12%	6.82%
Eligible Member Months		-0.37%	-2.14%	-2.06%	-0.31%	-1.22%
PMPM Costs		5.30%	12.75%	2.00%	12.47%	8.13%

Population 4 - BCCP

	FFY 23	**FFY 24**	**FFY 25**	**FFY 26**	**FFY 27**	**FFY 2023- 27**
Total Expenditures	$ 3,414,659	$ 2,476,104	$ 1,476,631	$ 1,493,455	$ 2,024,720	$ 10,885,568
Eligible Member Months	1,932	1,405	752	737	777	
PMPM Costs	$ 1,767.04	$ 1,761.75	$ 1,963.79	$ 2,025.52	$ 2,606.10	
Avg. Monthly Eligibles	161	117	63	61	65	
			Annual Change			**5-Year Average**
Total Expenditures		-27.49%	-40.36%	1.14%	35.57%	-7.78%
Eligible Member Months		-27.27%	-46.50%	-1.94%	5.37%	-17.59%
PMPM Costs		-0.30%	11.47%	3.14%	28.66%	10.74%

Population 5 - Old Age Assistance

	FFY 23	**FFY 24**	**FFY 25**	**FFY 26**	**FFY 27**	**FFY 2023- 27**
Total Expenditures	$ 617,224,320	$ 655,536,882	$ 645,033,881	$ 576,073,743	$ 648,264,556	$ 3,142,133,383
Eligible Member Months	904,310	951,106	753,199	720,756	710,103	
PMPM Costs	$ 682.54	$ 689.24	$ 856.39	$ 799.26	$ 912.92	
Avg. Monthly Eligibles	75,359	79,259	62,767	60,063	59,175	
			Annual Change			**5-Year Average**
Total Expenditures		6.21%	-1.60%	-10.69%	12.53%	1.61%
Eligible Member Months		5.17%	-20.81%	-4.31%	-1.48%	-5.35%
PMPM Costs		0.98%	24.25%	-6.67%	14.22%	8.20%

Population 6 - Aid to Blind/Disabled

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 1,415,448,686	$ 1,379,894,858	$ 1,436,640,591	$ 1,487,131,168	$ 1,836,884,460	$ 7,555,999,763
Eligible Member Months	1,103,817	1,089,851	980,861	957,865	965,454	
PMPM Costs	$ 1,282.32	$ 1,266.13	$ 1,464.67	$ 1,552.55	$ 1,902.61	
Avg. Monthly Eligibles	91,985	90,821	81,738	79,822	80,455	
			Annual Change			**5-Year Average**
Total Expenditures		-2.51%	4.11%	3.51%	23.52%	7.16%
Eligible Member Months		-1.27%	-10.00%	-2.34%	0.79%	-3.20%
PMPM Costs		-1.26%	15.68%	6.00%	22.55%	10.74%

Population 7 - Foster Children

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 187,444,410	$ 181,119,800	$ 204,275,758	$ 218,578,034	$ 234,371,494	$ 1,025,789,496
Eligible Member Months	205,523	199,563	195,719	192,473	193,437	
PMPM Costs	$ 912.04	$ 907.58	$ 1,043.72	$ 1,135.63	$ 1,211.61	
Avg. Monthly Eligibles	17,127	16,630	16,310	16,039	16,120	
			Annual Change			**5-Year Average**
Total Expenditures		-3.37%	12.78%	7.00%	7.23%	5.91%
Eligible Member Months		-2.90%	-1.93%	-1.66%	0.50%	-1.50%
PMPM Costs		-0.49%	15.00%	8.81%	6.69%	7.50%

Hypothetical 1 - ACA Adults

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 5,035,369,853	$ 4,889,847,198	$ 5,329,316,211	$ 5,705,935,185	$ 5,734,316,627	$ 26,694,785,074
Eligible Member Months	7,259,757	6,737,108	6,967,558	6,914,660	6,634,465	
PMPM Costs	$ 693.60	$ 725.81	$ 764.88	$ 825.19	$ 864.32	
Avg. Monthly Eligibles	604,980	561,426	580,630	576,222	552,872	
			Annual Change			**5-Year Average**

Total Expenditures		-2.89%	8.99%	7.07%	0.50%	3.42%
Eligible Member Months		-7.20%	3.42%	-0.76%	-4.05%	-2.15%
PMPM Costs		4.64%	5.38%	7.89%	4.74%	5.66%

Hypothetical 2 - YSHCN

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ -	$ -	$ 3,565,495	$ 18,429,505	$ 29,099,838	$ 51,094,838
Eligible Member Months	-	-	4,872	25,636	48,076	
PMPM Costs			$ 731.83	$ 718.89	$ 605.28	
Avg. Monthly Eligibles	-	-	406	2,136	4,006	

			Annual Change		5-Year Average
Total Expenditures			416.88%	57.90%	237.39%
Eligible Member Months			426.19%	87.53%	256.86%
PMPM Costs			-1.77%	-15.80%	-8.79%

Hypothetical 3 - CE PCR

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 22,794,282	$ 22,812,110	$ 25,062,249	$ 25,961,308	$ 28,533,184	$ 125,163,133
Eligible Member Months	31,502	30,751	31,524	29,577	29,836	
PMPM Costs	$ 723.58	$ 741.82	$ 795.03	$ 877.77	$ 956.35	
Avg. Monthly Eligibles	2,625	2,563	2,627	2,465	2,486	

			Annual Change		5-Year Average
Total Expenditures	0.08%	9.86%	3.59%	9.91%	5.86%
Eligible Member Months	-2.38%	2.51%	-6.18%	0.88%	-1.29%
PMPM Costs	2.52%	7.17%	10.41%	8.95%	7.26%

Hypothetical 3 - CE PWO

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 7,974,198	$ 8,320,768	$ 9,423,246	$ 9,270,540	$ 9,843,816	$ 44,832,569
Eligible Member Months	5,303	5,388	5,333	5,429	5,226	

PMPM Costs	$ 1,503.65	$ 1,544.40	$ 1,767.08	$ 1,707.65	$ 1,883.66	
Avg. Monthly Eligibles	442	449	444	452	435	
		Annual Change				**5-Year Average**
Total Expenditures		4.35%	13.25%	-1.62%	6.18%	5.54%
Eligible Member Months		1.59%	-1.02%	1.80%	-3.74%	-0.34%
PMPM Costs		2.71%	14.42%	-3.36%	10.31%	6.02%

Hypothetical 3 - CE CMO

	FFY 23	**FFY 24**	**FFY 25**	**FFY 26**	**FFY 27**	**FFY 2023- 27**
Total Expenditures	$ 1,483,327	$ 1,581,176	$ 1,609,981	$ 1,621,296	$ 1,915,054	$ 8,210,834
Eligible Member Months	3,632	3,618	3,541	3,468	3,457	
PMPM Costs	$ 408.42	$ 436.99	$ 454.69	$ 467.52	$ 553.96	
Avg. Monthly Eligibles	303	302	295	289	288	
		Annual Change				**5-Year Average**
Total Expenditures		6.60%	1.82%	0.70%	18.12%	6.81%
Eligible Member Months		-0.37%	-2.14%	-2.06%	-0.31%	-1.22%
PMPM Costs		7.00%	4.05%	2.82%	18.49%	8.09%

Hypothetical 3 - CE BCCP

	FFY 23	**FFY 24**	**FFY 25**	**FFY 26**	**FFY 27**	**FFY 2023- 27**
Total Expenditures	$ 91,100	$ 67,059	$ 39,214	$ 39,792	$ 54,048	$ 291,213
Eligible Member Months	52	38	20	20	21	
PMPM Costs	$ 1,766.06	$ 1,787.38	$ 1,953.67	$ 2,021.75	$ 2,606.10	
Avg. Monthly Eligibles	4	3	2	2	2	
		Annual Change				**5-Year Average**
Total Expenditures		-26.39%	-41.52%	1.47%	35.83%	-7.65%
Eligible Member Months		-27.27%	-46.50%	-1.94%	5.37%	-17.59%
PMPM Costs		1.21%	9.30%	3.48%	28.90%	10.72%

Hypothetical 3 - CE Old Age Assistance

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 16,475,531	$ 17,226,866	$ 17,174,114	$ 15,364,693	$ 17,304,803	$ 83,546,007
Eligible Member Months	24,140	25,389	20,106	19,240	18,956	
PMPM Costs	$ 682.51	$ 678.52	$ 854.18	$ 798.59	$ 912.92	
Avg. Monthly Eligibles	2,012	2,116	1,675	1,603	1,580	
		Annual Change				**5-Year Average**
Total Expenditures		4.56%	-0.31%	-10.54%	12.63%	1.59%
Eligible Member Months		5.17%	-20.81%	-4.31%	-1.48%	-5.35%
PMPM Costs		-0.58%	25.89%	-6.51%	14.32%	8.28%

Hypothetical 3 - CE Aid to Blind/ Disabled

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 37,780,935	$ 36,871,851	$ 38,253,502	$ 39,657,855	$ 49,033,877	$ 201,598,020
Eligible Member Months	29,465	29,093	26,183	25,569	25,772	
PMPM Costs	$ 1,282.22	$ 1,267.40	$ 1,461.00	$ 1,551.00	$ 1,902.61	
Avg. Monthly Eligibles	2,455	2,424	2,182	2,131	2,148	
		Annual Change				**5-Year Average**
Total Expenditures		-2.41%	3.75%	3.67%	23.64%	7.16%
Eligible Member Months		-1.27%	-10.00%	-2.34%	0.79%	-3.20%
PMPM Costs		-1.16%	15.28%	6.16%	22.67%	10.74%

Hypothetical 3 - CE Foster Children

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ 195,518	$ 188,923	$ 200,536	$ 228,568	$ 258,093	$ 1,071,637
Eligible Member Months	226	220	216	212	213	
PMPM Costs	$ 863.89	$ 859.67	$ 930.44	$ 1,078.39	$ 1,211.61	
Avg. Monthly Eligibles	19	18	18	18	18	

	Annual Change				5-Year Average
Total Expenditures	-3.37%	6.15%	13.98%	12.92%	7.42%
Eligible Member Months	-2.90%	-1.93%	-1.66%	0.50%	-1.50%
PMPM Costs	-0.49%	8.23%	15.90%	12.35%	9.00%

Hypothetical 4 - MAGI Expanded Adult Program

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ -	$ 118,812,539	$ -	$ -	$ -	$ 118,812,539
Eligible Member Months	-	275,781	-	-	-	
PMPM Costs		$ 430.82				
Avg. Monthly Eligibles	-	22,982	-	-	-	

	Annual Change				5-Year Average
Total Expenditures			-100.00%		-100.00%
Eligible Member Months			-100.00%		-100.00%
PMPM Costs					

Hypothetical 4 - Expanded Adults Exempt from Managed Care

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ -	$ 1,162,519	$ 6,448,083	$ 14,252,628	$ 15,671,809	$ 37,535,039
Eligible Member Months	-	2,342	11,105	19,172	20,161	
PMPM Costs		$ 496.38	$ 580.65	$ 743.41	$ 777.33	
Avg. Monthly Eligibles	-	195	925	1,598	1,680	

	Annual Change				5-Year Average
Total Expenditures			454.66%	121.04%	9.96%	195.22%
Eligible Member Months			374.17%	72.64%	5.16%	150.66%
PMPM Costs			16.98%	28.03%	4.56%	16.52%

Hypothetical 5 -Reentry Initiative Services

	FFY 23	FFY 24	FFY 25	FFY 26	FFY 27	FFY 2023- 27
Total Expenditures	$ -	$ -	$ -	$ -	$ -	$ -

Eligible Member Months	-	-	-	-	-	
PMPM Costs						
Avg. Monthly Eligibles	-	-	-	-	-	
		Annual Change				**5-Year Average**
Total Expenditures						
Eligible Member Months						
PMPM Costs						

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Attachment E:
Oregon 1115(a) Medicaid Demonstration Waiver Interim Evaluation Report - DRAFT

Please note: The following report is a draft of Oregon's 2022-2027 1115(a) Medicaid Waiver Interim Evaluation. The report has undergone extensive review by subject matter experts and members of the Oregon Health Authority's leadership and was submitted to CMS on September 29th, 2026. It is currently under review by CMS. Some of the content in the report, including presentation of the results, interpretation of findings, recommendations, and conclusions are subject to change based on CMS feedback. The report will not be considered final until the state receives CMS approval.

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Section A. Executive Summary

General Background

The goals of Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver are to reduce preventable coverage loss, address health-related social needs, and improve access to services for young adults with special health care needs. The Centers for Medicare & Medicaid Services (CMS) approved Oregon's demonstration effective October 1, 2022, to September 30, 2027, as well as an amendment to the waiver in April 2023, and includes the following new policies:



Continuous eligibility (CE) allows for continuous Medicaid/Oregon Health Plan (OHP) eligibility and enrollment for children up to age six, and two years of continuous enrollment for OHP members ages six and older.



Temporary Medicaid expansion (TME) provides coverage to adults ages 19-64 with incomes at 138-200% of Federal Poverty Level (FPL), as long as they were already enrolled in Medicaid to maintain Medicaid/OHP coverage for this group until the launch of Oregon's Basic Health Program, known as OHP Bridge, in July 2024.



Health-related social needs (HRSN) provides benefits for certain OHP members facing critical life transitions. HRSN benefits cover Housing (including home changes for health), Nutrition, and Outreach & Engagement (O&E).



Young adults with special health care needs (YSHCN) expands OHP eligibility and pediatric benefits up to age 26 for young adults who have complex medical and behavioral health needs and incomes up to 300% of the FPL.

Evaluation Questions and Hypotheses

The overarching hypothesis is that this demonstration will increase continuity of coverage, better meet OHP members' HRSN, and increase access to and quality of care for YSHCN. We further hypothesize that the demonstration policies will improve continuity of care, improve connection to outpatient care, and decrease use of more costly acute care services. The long-term goal of these policies is to improve health of all OHP members. Each policy area has several specific research questions, further divided into implementation questions and evaluation questions, presented in Section F.

Methodology and Limitations

The evaluation uses a mixed-method design to assess the impact of the Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver on Oregon's stated goals of reducing preventable coverage loss, addressing HRSN, and improving access to health care for YSHCN. Qualitative data sources include OHP members, key entity, and OHA staff interviews as well as online discussion boards. Quantitative analyses for this interim report include descriptive data for beneficiaries of each of the policy areas. The specific methodological design varies based on the

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policy. For complete details on the methodological approach, see the CMS-approved evaluation design and Section D for the data and analyses used in this interim report.

There are several limitations inherent to our methodology such as:

- The qualitative sample may not fully represent key entities' and OHP members' experiences.
- Qualitative data collection was mostly limited to English and Spanish speakers.
- Early quantitative analyses are descriptive, limiting ability to assess causal impacts or statistically significant changes.
- Several quantitative data sources have quality, completeness, and timing limitations.

For a complete overview of methodological limitations, see Section E.

Results, Lessons Learned and Recommendations

This interim report presents results for each policy area and for demonstration costs, but results should all be considered preliminary, as data collection and analysis are still ongoing. Additionally, because this is an interim report, not all evaluation questions (and related data and analyses) listed in the evaluation design are included. See Section C for a full list of what will be included in the interim and summative reports.

Below we provide key findings, lessons learned, and recommendations for each policy area (CE & TME, HRSN, and YSHCN) and cost, based on the interim results. For more information, see Section F and Section I.

Continuous Eligibility and Temporary Medicaid Expansion

CE and TME enrollment and coverage transitions

- In 2024, the first calendar year after CE implementation, 153,501 individuals under age six and 1,562,949 individuals ages 6–64 were enrolled in the OHP at some point during the year.
- During calendar years 2023 and 2024, 67,917 individuals were enrolled in OHP through the TME policy at some point. Of these members, the majority (80.4%) transitioned to OHP Bridge or another OHP category of aid without a gap in coverage.

CE and TME policy implementation

- Most state and community implementation partners viewed CE and TME as policy successes. Strong implementation infrastructure and cross-agency coordination supported rollout, while coordination gaps, confusion about policy details, and staffing constraints created some challenges.

- CE reduced administrative burden by supporting staff efficiency and operational stability for CCO partners, though longer coverage periods made pre-redetermination outreach and contact verification more demanding for some CCOs.
- CE communication strategies for members emphasized transcreation, plain-language summaries, and cultural responsiveness. Trusted local support from sources such as clinic staff, caseworkers, or local advocates also helped members understand and navigate their coverage.

TME member experiences and coverage continuity

- The TME-to-OHP Bridge transition was low-touch and often felt seamless to members, who generally experienced TME as continued coverage rather than as a named policy. Members also described this continued coverage as providing financial protection and reducing stress for their households.
- Roughly twenty thousand people moved seamlessly from TME to OHP Bridge; all else being equal, it is likely they would have lost coverage without the TME policy in place.

OHP membership stability, disenrollment and churn

- Following the end of the federal continuous coverage requirement associated with the PHE, OHP membership remained relatively stable, disenrollment rebounded during CE implementation but stayed below pre-pandemic levels, and churn remained low after declining during the PHE.
- Average annual days enrolled increased during the PHE and declined somewhat in subsequent years after CE was implemented but remained above pre-pandemic levels.
- Sociodemographic compositions of continuously enrolled members and members experiencing churn were broadly similar.

CE and TME Lessons Learned and Recommendations

- Connecting temporary coverage policies to a defined next-step coverage pathway supports coverage continuity.
- Invest early in cross-agency coordination and shared implementation infrastructure.
- Prioritize plain-language and culturally responsive communication as part of implementation planning.
- Supplement existing communication efforts with short scripts and talking points that help staff and partners explain coverage changes during member interactions.
- Pair longer continuous eligibility periods with strategies to keep member contact information up to date.

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Health-Related Social Needs

Utilization of HRSN services

- From March 2024 to September 2025, 19,495 OHP members received HRSN services.
- After O&E, which is primarily used to help people connect to needed services, Housing (rent and utilities, tenancy support, hotel/motel stays, storage fees, and home accessibility modifications and remediation services) was the most commonly requested and received category of HRSN service in the time frame of this report.
- Receipt of Housing (home changes for health) devices and services peaked in summer 2024 but has since declined.[1]

HRSN implementation

- Implementation of Medicaid HRSN services leveraged existing infrastructure but also required new partners, roles, rules, systems, and workflows.
- HRSN Service Providers, CCOs, and OHA dedicated significant time and resources to capacity building, training, and technical assistance in support of implementation. They reported that clear communication supported collaboration.
- Designated State Health Program (DSHP) funds – delivered through CCBF grants - were critical for building HRSN infrastructure and for enabling the system to respond to developing needs.
- Detailed HRSN eligibility criteria, documentation requirements, and billing rules created a significant learning curve and workload for HRSN Service Providers and CCOs. HRSN guidance changes before and after benefit launch contributed to implementation burden.
- For some HRSN Service Providers, the financial risk of retrospective payment for services created barriers to participation.
- Strategies to address HRSN implementation barriers included changes to eligibility rules and communications, investments in system capacity, payment increases, and ongoing training and technical assistance.

HRSN service delivery

- There are multiple entry points to request HRSN services; CCOs also leveraged existing programs or data to help identify and refer participants.
- CCOs and HRSN Service Providers have adjusted their service delivery roles both proactively and in response to implementation experiences. Role flexibility, including

[1] Different HRSN benefit categories had different start dates: O&E and Housing (home changes for health) began in March 2024; the remaining Housing benefits launched in November 2024 along with expanded O&E, and some Nutrition benefits – medically tailored meals and nutrition education – started in January 2025.

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having CCOs perform some HRSN service delivery when needed, appears to be a promising practice for increasing overall capacity to provide HRSN services.

- High demand for rent support and the complexity of benefit operations strained the capacity of HRSN Service Providers and CCOs at times and caused delays in authorizations and service delivery/rent payment, especially in the Portland metro area.

Beneficiary experiences and impacts to date

- Beneficiaries generally found the *initial request* process for HRSN accessible and encountered few difficulties.
- Especially in the first several months and in more urban areas, beneficiaries seeking rent support faced long wait times. These delays contributed to increased stress about housing and finances and, in some cases, limited the ability of the benefit to reduce eviction risk.
- After receiving HRSN services, many beneficiaries reported reduced stress and improvements in mental and emotional well-being.
- People receiving rent & utility benefits generally reported increased housing and financial stability and people receiving Housing (home changes for health) benefits generally reported improved quality of living environments.
- Some HRSN beneficiaries reported health improvements (such as breathing easier with an air filter) or increased time and capacity to focus on getting needed health and self-care; others reported no health changes.

HRSN Lessons Learned and Recommendations

- Phased implementation of benefits provided some time for learning and adjustment; states could also consider starting with narrower eligibility criteria and/or referral routes.
- Infrastructure investments, especially in workforce development, are critical to successful implementation.
- Reduce administrative complexity and add flexibility for eligible beneficiaries.
- Provide clear and timely information to members about HRSN eligibility rules and application status.
- Fully leverage the experience of social service providers to design workable rules and processes within the confines of Medicaid requirements.

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Young Adults with Special Health Care Needs

YSHCN policy implementation

- The YSHCN policy established a new OHP eligibility category and benefit package but required few new processes or operational policies. CCOs made minimal changes to their workflows, which contributed to smooth implementation.
- The biggest changes occurred at the State level. OHA and partners developed eligibility rules, passive enrollment mechanisms, a YSHCN screener embedded into the ONE system, payment systems, and created new materials to support outreach and rollout.

YSHCN OHP member enrollment routes and characteristics

- 33,855 YSHCN OHP members were enrolled during calendar year 2025; of these, 422 (1.2%) were new Medicaid enrollees. Over 90% of YSHCN OHP members were already eligible for Medicaid outside of the YSHCN policy.
- The majority of YSHCN OHP members were identified and enrolled passively via qualifying behavioral health (BH) diagnoses or Pediatric Medical Complexity Algorithm (PMCA) scores.
- There were some notable demographic differences among YSHCN OHP members across the three different identification routes (passive via BH/PMCA scores, passive via ODDS or active via screener).

YSHCN policy outreach and communication

- Awareness of the YSHCN policy was limited among some members and community partners. There are opportunities to expand outreach in frontier and rural areas and at colleges and universities.
- YSHCN OHP members and eligible individuals face unique barriers to outreach. YSHCN OHP members may be less responsive to mail and phone outreach due to their age, and less responsive generally due to their qualifying conditions.
- To address outreach barriers, some CCOs report developing new outreach methods, such as text messaging, robocalling, and online patient portals.

YSHCN OHP member access to and utilization of health care

- YSHCN OHP members largely noted few to no disruptions to their care and cited a range of health services utilized while under YSHCN OHP coverage. Some YSHCN OHP members reported being able to access more services, or being able to access existing services faster compared to their previous coverage.
- Some YSHCN OHP members reported difficulties finding providers who accepted OHP and noted the additional challenge of having to orient a new provider to their complex health history. This is potentially due to low provider availability, particularly providers who are willing to take on complex cases and providers located in rural areas.

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YSHCN Lessons Learned and Recommendations

- Passive enrollment and screeners embedded in the OHP application were seamless ways to assess eligibility.
- Strong communication plans are needed for partner awareness.
- Reaching young adult members is difficult and may require additional efforts and multiple modes of outreach.
- Increasing available providers is needed alongside improving duration of covered benefits.

Cost and Sustainability

Administrative costs to implement and operate the demonstration

- Between 2022 and 2024, OHA spent $60.2 million on the demonstration; non-grant CCO spending is not yet reflected in these numbers.
- Of this, $23 million was spent on demonstration administration including: staffing, equipment, and overtime; consulting and contracting; information technology projects; outreach and operations; evaluator costs; and other administrative expenditures related to demonstration implementation and operation.
- In October 2024, OHA and Oregon CCOs awarded the remaining $37.2 million through CCBF investments to organizations supporting delivery of HRSN services.
- The largest identified investments were associated with HRSN implementation and activities classified as not specific to any one policy component, while substantially smaller expenditures were attributed to CE, TME, and YSHCN. Costs reported align with approved funding allocations to each of the components and may not reflect actual hours spent on components.
- HRSN drove the highest component-specific spending, consistent with the novelty of the benefit and the upfront investment required to build HRSN Service Provider networks, infrastructure, data systems, and internal capacity.

Lessons learned and recommendations related to cost and sustainability will be included in the summative evaluation report when more complete data are available.

Conclusions

This report provides an overview of advancements towards Oregon's demonstration goals through late 2025 or early 2026 (data availability varies by policy area). While the demonstration is still in progress, this interim report contains promising findings. Oregon has made significant progress in implementing the demonstration, including:

- Successful transition to 24-month continuous eligibility under CE
- Effective implementation of TME for eligible members for the OHP Bridge program
- Launch of O&E and Housing under HRSN; partial launch of Nutrition benefits
- Rollout of YSHCN benefits for 19-21 year-olds

A tremendous amount of work went into implementing these policies. It is still too early in the analysis to determine whether the implementation of these policies met the goals of the demonstration (that assessment will be included in the summative report). However, this report highlights promising interim results such as 80% of individuals transitioning off TME without a gap in coverage, the rapid development of infrastructure for delivering HRSN services, and the extension of OHP coverage and pediatric benefit to almost 34,000 YSHCN OHP members. See Section G for a summary of conclusions for each policy area at this point in the demonstration.

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Section B. General Background Information

Waiver Overview

Demonstration name: Oregon Health Plan (OHP), Project Number 11-W-00415/10
Approval date: September 28, 2022
Waiver time period: October 1, 2022, through September 30, 2027

Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver (the "demonstration") builds on achievements from previous efforts, with a specific focus on meaningful progress toward health equity. In this demonstration, Oregon aims to address some of the complex challenges facing many of its underserved residents, including individuals experiencing major life transitions such as children aging out of foster care, people exiting carceral settings, young adults with complex medical needs approaching adulthood, individuals experiencing homelessness or at risk of losing housing, and adults transitioning to dual Medicaid-Medicare enrollment. The demonstration goals are to:

- Reduce preventable coverage loss;
- Address health-related social needs (HRSN); and
- Improve access to services for young adults with special health care needs (YSHCN).

To address these goals, the Oregon Health Authority (OHA) submitted a renewal request for its 1115 demonstration waiver to the Centers for Medicare & Medicaid Services (CMS) and it was approved on September 28, 2022. The demonstration is effective October 1, 2022, to September 30, 2027, and includes new policies for **continuous eligibility (CE)**, **HRSN**, and **YSHCN**. In April 2023, CMS approved an amendment to the waiver to authorize a **temporary Medicaid expansion (TME).** Of note, in October 2024 CMS also approved an amendment to provide expenditure authority for coverage of traditional health care practices, but the evaluation of that area of the demonstration is outside the scope of this report.

Evidence Supporting Waiver Goals

Preventable coverage loss. Strong evidence exists showing that continuity of coverage and reduced frequency of disenrollment and re-enrollment (also known as "churn") supports access to and continuity of care (1,2). Improved access in turn leads to increased utilization of important preventive care services and decreased use of acute and other costly types of care over time (1–4). Reducing churn also benefits health systems, since churn can lead to high rates of uncompensated care (5). For children under age six, preventing coverage gaps can reduce the risk of missing important preventive care recommended for this age group. Individuals experiencing churn are disproportionately likely to be people of color (2); thus, policies

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supporting continuous eligibility – such as CE and TME – also have the potential to reduce inequities. Leading up to the demonstration, broader policy changes – including the unwinding of the COVID-19 public health emergency (PHE) – created the potential for widespread loss of coverage among Oregon's Medicaid population. During the PHE, the federal Families First Coronavirus Response Act (FFCRA) required states to maintain continuous Medicaid coverage for enrolled members. This meant that OHP members remained covered during the PHE even if their income or other qualifying circumstances changed, and Oregon saw notable coverage gains during this period (6,7). The federal continuous coverage requirement ended on March 31, 2023, and the PHE unwinding period began immediately thereafter. The unwinding process involved redeterminations for approximately 1.4 million OHP members and placed nearly 300,000 at risk of losing coverage, including those whose incomes were above standard OHP limits at the time of redetermination (6).

Supporting unmet HRSN. Addressing social determinants of health can improve population health, reduce disability, and lower overall health care costs (8). At the individual level, actions to improve adverse social conditions and remedy unmet needs can affect health care utilization and health status via several mechanisms, including connections to social services that reduce social risk; emotional support arising from positive relationships with social service navigators; better connection to health care services; and the use of information about social need and services to tailor an individual's health care services (9).

Improving housing and food security are key to addressing HRSN. A large body of literature establishes the connection between housing and health. Eviction has been associated with greater Medicaid churn (10), and housing instability can lead to poor health outcomes (11–13) and more health encounters, including increased emergency department visits (14,15). Receiving housing has been shown to have many positive impacts including increasing access to preventive care and reducing use of the emergency department (16–18). Additionally, studies have shown that food insecurity is associated with poor physical health and an increased number of chronic conditions (19), and is a risk factor for depression, stress, and anxiety (20). Food insecurity can also contribute to poor medication adherence (21) and postponed medical care (14,22). Related initiatives addressing food insecurity, such as the Supplemental Nutrition Assistance Program (SNAP) and food prescription services, have been shown to reduce food insecurity (23,24) and affect health outcomes (23,25,26).

Support for YSHCN. YSHCN often struggle to get access to needed health care and health-related services. These challenges can be exacerbated during the transition to adulthood when coverage gaps often occur and young adults may be relying less on others to meet their individual needs. Addressing eligibility for coverage is a key mechanism to support access to services. The positive impact that continuous eligibility can have is particularly important for the YSHCN population because life transitions, such as transitioning from pediatric to adult care,

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remain a key challenge (27,28) and can greatly impact their usual source of care (29). A body of literature suggests that effective transition to adult care for the YSHCN population results in increased care adherence, clinic attendance, patient satisfaction, quality of life, and self-care skills (27,30) while also reducing lapses or delays in care, perceived barriers to care, morbidity and mortality, hospital admission rates, and lengths of stay (27). Further, research also indicates that addressing HRSN can support improvements in health outcomes for YSHCN by increasing connections to services, improving appointment attendance and treatment adherence, and reducing the risk of comorbidities and complications due to nutrition challenges (31–33).

Overview of Waiver Policy Areas and Implementation up to Q2 2026

Since demonstration approval, OHA has been working on policy implementation. Below we provide a brief overview of each policy and the status of its implementation as of Q2 2026.

Continuous eligibility

Brief Policy Overview and Population: This policy under the demonstration allows for continuous OHP eligibility and enrollment for children up to age six, and two years of continuous enrollment for OHP members ages six and older. All OHP members qualify for the CE periods, with the exception of those receiving OHP-covered home- and community-based services in order to remain in community-based settings. Coverage for these members aligns with the timeframe that is standard for their coverage type and program.

Implementation: CE was implemented July 1, 2023.

Temporary Medicaid expansion

Brief Policy Overview and Population: This amendment allowed individuals aged 18 – 64 years with incomes above the traditional OHP limits (138% up to 200% FPL) who did not have access to affordable coverage elsewhere to remain enrolled between PHE unwinding in 2023 and the 2024 launch of OHP Bridge (a new program that provides health coverage for adults with incomes between 138% and 200% of the FPL). The goals were to reduce the likelihood of loss of coverage and help maintain continuity of care, particularly because OHP Bridge enrollees could stay enrolled with the same CCO as they had under the TME policy, with access to the same network of health care providers.

Implementation: TME took effect on April 1, 2023, at the start of the OHP eligibility redetermination process, and ended with the launch of OHP Bridge on July 1, 2024.

Health-related social needs

Brief Policy Overview and Population: This policy provides coverage of new HRSN benefits for members facing life transitions who meet specific clinical risk factors and social needs eligibility

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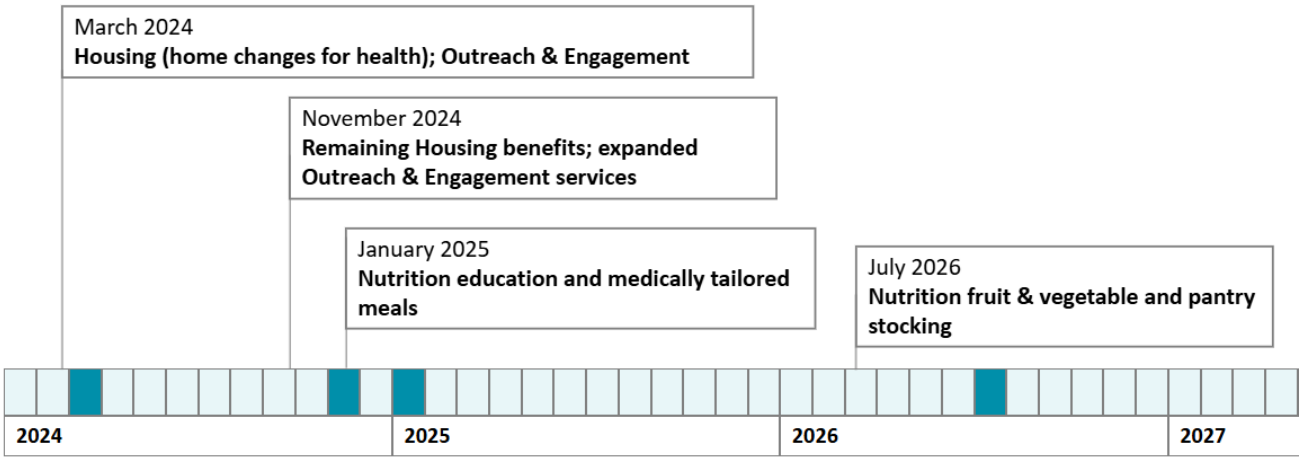
criteria. HRSN benefits cover Housing support, Nutrition support, and O&E needed to support those services.

Implementation: Following waiver approval in late 2022, the state began planning for implementation of HRSN services and related infrastructure. The planning phase included development of initial definitions for covered services and eligible populations, fee schedules, and qualifications for HRSN Service Providers (organizations such as community action agencies, social service providers, and some community-based clinics). Rules and requirements for member identification, service requests and authorizations, case management, and payment were also developed in the planning phase. HRSN implementation plans were documented in the state's New Initiatives Implementation Plan and HRSN Infrastructure and HRSN Services Protocols. Oregon submitted a draft of the HRSN Services Protocol on August 31, 2023, in accordance with the special terms and conditions (STCs), and CMS approved it on February 1, 2024. To support implementation, OHA has made two rounds of Community Capacity Building Fund (CCBF) awards, in 2024 and 2025, for technology, development of business or operational practices, workforce development, and outreach, education and stakeholder convening in support of HRSN implementation.

Rollout of HRSN benefits has occurred in phases (Figure 1):

- March 2024: Launch of Housing (home changes for health) and O&E services
- November 2024: Launch of remaining Housing benefits and expanded O&E services
- January 2025: Launch of Nutrition benefits including medically tailored meals and nutrition education
- July 2026: Launch of the remaining approved Nutrition benefits—fruit & vegetable benefit and pantry stocking

Figure 1. Implementation timeline of HRSN benefits



Young adults with special health care needs

Brief Policy Overview and Population**:** The YSHCN policy includes some key benefit changes for young adults. First, the YSHCN policy extends OHP coverage to individuals earning up to 205% FPL (increased from 138% FPL) for all young adults 19 through 25 years of age who have one or more of the following qualifying health care needs established before age 19:

- One or more complex chronic conditions as identified in the Pediatric Medical Complexity Algorithm (PMCA)
- Serious emotional disturbance or serious mental health issue indicated by qualifying behavioral health (BH) diagnosis
- Diagnosed intellectual or developmental disability (IDD)
- "Elevated service need" or functional limitations as determined by two or more affirmative responses to related screening questions developed by OHA (34)

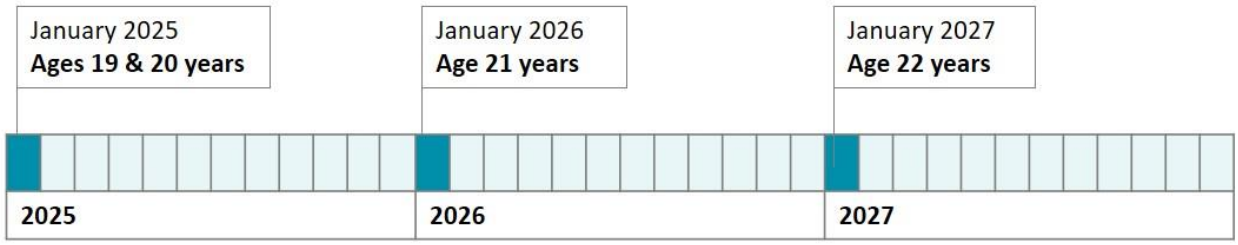
Second, all federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children and young adults up to age 21 will now be covered for YSHCN up to age 26. Third, YSHCN are a covered population for the HRSN benefit, meaning they are eligible to receive HRSN services if they meet specific clinical and social risk factors.

Implementation: Eligibility for YSHCN benefits has been rolled out by age group. The implementation schedule is as follows (Figure 2):

- Jan 2025: YSHCN ages 19 and 20 are eligible
- Jan 2026: YSHCN ages 19 through 21 are eligible
- Jan 2027: YSHCN ages 19 through 22 are eligible

Contingent on available budget, all other YSHCN age groups (23 through 25 years) will become eligible after the end of the demonstration period.

Figure 2. YSHCN age group roll out

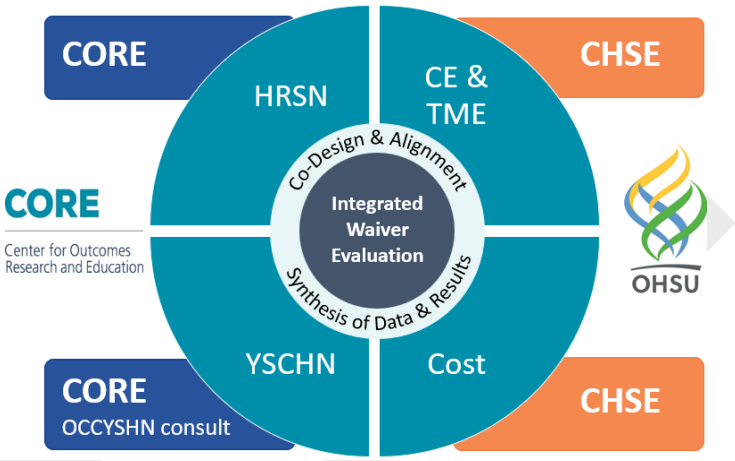


Section C. Evaluation Questions and Hypotheses

Evaluation Team

The evaluation was designed by the Center for Outcomes Research and Education (CORE). CORE was also selected as the independent evaluator in partnership with the Center for Health System Effectiveness (CHSE). CORE is leading the evaluation overall and specifically taking on evaluation of the HRSN and YSHCN policies. For YSHCN, CORE has also contracted with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) as consultants. CHSE is subcontracting with CORE and taking lead on the CE/TME and cost evaluations. CORE and CHSE are working closely together and coordinating all aspects of the evaluation from the approach to interpretation of results (Figure 3). Note that the Northwest Portland Area Indian Health Board is designing the evaluation for the Traditional Healthcare Practices component of the waiver. This report does not include information about the Traditional Healthcare Practices component of the waiver or its evaluation.

Figure 3. Evaluation team design



Overarching Hypothesis and Development of Measurable Outcomes

The overarching hypothesis is that the demonstration will lead to increased continuity of coverage, better meet OHP members' HRSNs, and increase access and quality of care for YSHCN. We further hypothesize that demonstration policies will improve continuity of care, improve connection to outpatient care, and decrease use of more costly acute care services. The long-term goal of these policies is to improve the health of all OHP members. This aligns with the objectives of Titles XIX and XXI by helping to demonstrate the effectiveness of approaches to improving the delivery system for Medicaid beneficiaries in Oregon toward the following outcomes: 1) Improving the individual experience of care; 2) Improving the health of populations; and 3) Reducing the per capita costs of care for populations through such improvements.

Each policy area has several specific CMS-approved research questions, further divided into implementation questions and evaluation questions. These questions are presented in Section F under the heading for each specific policy area.

To identify measurable outcomes for these research questions, the evaluation team worked with OHA to create logic models that included short, interim, and long-term outcomes for each policy area. The outcomes will be measured qualitatively and quantitatively through a variety of primary and secondary data sources. Outcomes include everything from themes identified from interviews to metrics on use of acute care services or chronic disease management, to changes in self-reported health and stress levels. These outcomes were reviewed with subject matter experts at OHA to ensure alignment with the policy area and activities. As needed, OHA built out new data fields and data systems to support this measurement. The complete logic models are included in Section F under the heading for each specific policy area.

What is Included in this Report

This interim report presents results for each policy area, but these results should all be considered preliminary, as data collection and analysis are still ongoing. Additionally, because this is an interim report, not all data and analyses listed in the evaluation design are included. In Table 1 we provide an overview of which analyses are presented in the interim report and which additional analyses will be included in the summative report by policy area.

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Table 1. Overview of data included in the interim and summative reports

Interim Report Due September 30, 2026 All results included in the interim report are considered preliminary.	**Summative Report Due March 30, 2029** Final results from everything included in the interim report with additional rounds of data collection, AND:
CE/TME • Key entity interviews • OHP member interviews for TME • Description of CE population • Description of TME population **HRSN** • Key entity interviews (rounds 1 and 2) and online discussion board (round 1) • HRSN beneficiary interviews • Description of HRSN beneficiary population • Description of HRSN benefits received • Environmental scan of social service investment and availability (round 1) **YSHCN** • Key entity interviews (rounds 1 and 2) • YSHCN OHP member interviews • Description of YSHCN population • Description of engagement routes **Cost** • OHA staff interviews • Findings from cost data collected from OHA	**CE/TME** • OHP member interviews for CE • Analysis of claims, TAF data (if including other state comparisons), and other secondary data **HRSN** • Survey analysis • Provider interviews • Analysis of claims, CCO Financial & Contract reporting, and other included secondary data **YSHCN** • Provider interviews • Analysis of ONE Eligibility System and other secondary data **Cost** • CCO interviews • Analysis of claims, CCO Financial reporting, uncompensated care, and other included secondary data • Analysis of cost data collected from OHA and CCOs • Document analysis

Section D. Methodology

Methodological Design

The evaluation of Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver uses a mixed-methods design to assess the impact of the demonstration on Oregon's stated goals of reducing preventable coverage loss, addressing health-related social needs, and improving access to health care for young adults with special health care needs. The specific methodological design varies based on the policy area. For complete details on the methodological approach, see the CMS-approved evaluation design.

For this interim report, we used a mixed-method, convergent approach that leveraged parallel collection of qualitative and quantitative data. We presented and interpreted quantitative and qualitative results together if they were relevant to the same research question. All quantitative analyses presented here are descriptive, with more rigorous methodological designs coming in the summative report when data are finalized, and more data are available. The qualitative data included multiple rounds of interviews as well as online discussion boards. Qualitative interviews were designed to capture varying perspectives and experiences from individuals involved in the creation and implementation of the demonstration as well as from people participating in the policies or receiving the benefits.

Focus and Comparison Populations

Quantitative populations

The descriptive quantitative analyses in this report included everyone who received the relevant benefit, up to time of last data collection before preparation for this report (Figure 4). The time periods for the data varied by policy area due to different implementation timelines and data availability. Specific population eligibility criteria for each policy area are described in Section B and Section F as appropriate.

For the interim report, we included data for a CE comparison population, namely anyone enrolled in Medicaid during the time frame of January 2019 through March 2023. The comparison to this population was descriptive; appropriate statistical testing on this and other comparison populations will be included in the summative report.

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Figure 4. Quantitative focus populations included in the Interim Report

Policy Area	Definition	Date Range
CE	Enrolled in Medicaid, excluding individuals eligible for Medicaid due to the receipt of home and community-based services	April 2023 – December 2024
TME	Enrolled in Medicaid under the TME policy	April 2023 – July 2024
HRSN	Received at least one HRSN service	March 2024 – September 2025
YSHCN	Enrolled in Medicaid under the YSHCN policy	January – December 2025

Qualitative populations

Across all policy areas, qualitative data collection included the following two categories of participants:

- Key entities: Appropriate representatives from OHA, Oregon Department of Human Services (ODHS), CCOs, or relevant partnering organizations (e.g. HRSN Service Providers, community-based organizations) connected to each policy area.
- OHP members: Individuals who were eligible and received the benefit in the related policy area.

Table 2 provides an overview of the number of people included in this report who participated in qualitative data collection (interviews or asynchronous discussion boards) by policy area. We plan to continue interviews and discussion boards with key entities and interviews with OHP members throughout the rest of the demonstration period; information from these future interviews and discussion boards will be included in the summative report.

Table 2. Qualitative focus populations included in the Interim Report

Population	Key entity	OHP member
CE interviews	35	N/A
TME interviews	35	24
HRSN interviews	34	49
HRSN discussion boards	60	N/A
YSHCN interviews	27	10
Cost interviews	2	N/A

Potential key entity interviewees were identified in partnership with OHA and based on existing lists (e.g. of contracted HRSN Service Providers) to ensure appropriate, knowledgeable, and representative individuals were recruited. Purposive sampling was used to maximize staff representation by organization/state agency, organizational role, and policy expertise.

Participants in the discussion boards were recruited via email outreach to all CCOs and all enrolled HRSN Service Providers for whom contact information was available. OHA also announced the opportunity to participate in the discussion board at their monthly HRSN Service Provider office hours.

OHP members were selected for interview recruitment using a quota sampling approach with targets set to ensure diversity across race, geography, and select other characteristics depending on the policy. More details on the interview samples, including specific quota characteristics for each policy area, are provided in the Study Populations sub-sections for each policy area in Section F.

Evaluation Period

The evaluation was launched in 2025 and ends in Q1 of 2029. An overview of the timeline of main activities for the evaluation is provided in Figure 5.

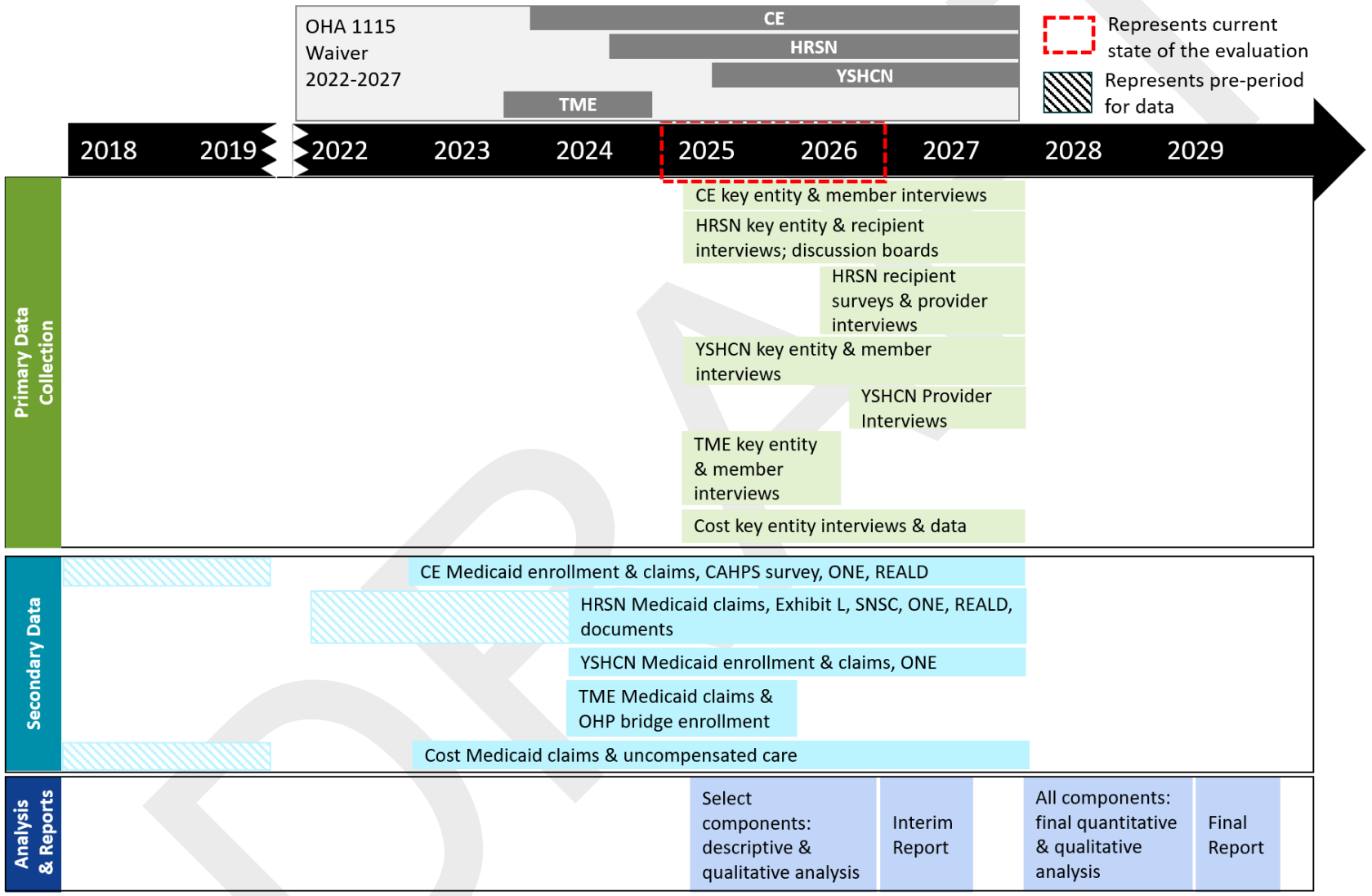
The data collection window included in this report varies by policy area, population, and data source (see details in specific policy area results sections). Briefly, primary and secondary data collection was as follows:

- Primary interview data included in this interim report was collected in 2025 and early 2026. The discussion board data was collected in Q3 of 2025. Interviews and discussion boards will continue, with healthcare provider interviews being added, through 2027.
- Secondary data is being collected on an ongoing basis and includes data from the launch of the waiver and, in some cases, pre-period data for comparison. At this point in the evaluation, quantitative data has been analyzed to provide descriptive overviews of the population and some relevant early outcomes. Date ranges for the quantitative data sources vary by policy area and are described in Section D and Section F.

The summative report is due in Q1 of 2029 and will include the remaining qualitative and quantitative data collection and analysis.

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Figure 5. Overview of evaluation period and data collection



Evaluation Measures

Evaluation measures in this report include qualitative findings and themes, population descriptive measures, and select outcome variables. Qualitative findings and themes are described in the results section for each specific policy area. Quantitative measures used in the analyses for this report are described below.

See the CMS-approved evaluation design for a complete list of potential quantitative evaluation measures for each policy area.

Population descriptive measures. All population descriptive measures were calculated in the same way from the same data sources, regardless of policy area.

- **Age** and **sex** came from the Medicaid Management Information System (MMIS).
- **Race/ethnicity, language, and disability status** data were collected via the REALD repository, with some imputation from MMIS as described below.
    - For **race/ethnicity**, individuals indicated if they belong to 43 detailed categories, which could then be collapsed to nine aggregate categories for reporting based off 2020 REALD standards, including multiracial and unknown. This aggregate variable was considered primary race. For individuals with missing race/ethnicity in the REALD repository, race was imputed from MMIS when available.
    - For **language**, we used preferred spoken language. Similar to race/ethnicity, for individuals with missing language in the REALD repository, language was imputed from MMIS where available, with one exception: language was not imputed from MMIS if it was "English" because the MMIS historically defaulted to English as the preferred language if the field was blank. If an individual had missing language in the REALD repository and English in MMIS, their language remained classified as unknown.
    - **Disability** is assessed through questions about limitations across the following categories: hearing, vision, physical/mobility, cognitive/memory, learning, communication, mental health, self-care, and independent living. For this report, we chose a composite disability variable that combined REALD responses with information on disability services (e.g. SSI, LTC). The categories for this composite variable are non-disabled (responded no to each of the questions about limitations); 1 limitation (responded yes to only one question about limitation but not limitations with self-care and independent living); 2+ limitations (responded yes to two or more questions about limitations but not limitations with self-care and independent living); and independent living/self-care disability

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(responded yes to limitations with self-care or independent living, or receiving other disability services).

- **Geography** was created using definitions from the Oregon Office of Rural Health, which categorizes zip codes as urban, rural, or frontier (35). Zip codes were considered rural if they were ten or more miles from a population center of at least 40,000 people. Frontier zip codes were those located in counties with six or fewer people per square mile. Because we relied on the most recent address on file, some individuals had addresses outside of Oregon, indicating that they had moved at some point after being included in the focus population. These zip codes were categorized as Unknown geography.

Outcome variables. The outcome variables in this report differed across policy areas. The variables below are therefore listed and described by policy area.

CE outcome measures. We calculated CE outcome measures from MMIS enrollment and claims data. All measures were calculated for 2019 through 2024.

- **Enrollment**: count and proportion of unique members enrolled in OHP in each calendar year.
- **Disenrollment**: count and proportion of unique individuals enrolled in OHP who were disenrolled for any reason during the calendar year.
- **Churn**: count and proportion of individuals with a temporary loss of Medicaid enrollment followed by reenrollment within a three-month or shorter gap during the calendar year.

TME outcome measures. We calculated TME outcome measures from MMIS enrollment data. The evaluation window varies for each measure and is indicated below.

- **Enrollment**: count of TME members identified based on the Program Eligibility Resource Code (PERC) code "AE" for "Adult Expansion Plan." This measure was calculated from April 2023 to November 2024 and includes those ever enrolled in the program.
- **Transition to other coverage:** count and proportion of TME members who transitioned to OHP Bridge based on PERC codes "BR" ("OHP Bridge Basic Health Program") and "PE" ("OHP Bridge Basic Medicaid"). This measure was calculated for July through December 2024.
- **Coverage gaps:** count and proportion of TME members whose transition to OHP Bridge or other OHP categories of aid was classified as seamless coverage (gaps in coverage of zero days), coverage gap less than three months, or no coverage within three months. This measure was calculated for July through December 2024.

HRSN outcome measures. HRSN outcome measures were calculated from Exhibit L or MMIS claims data. If Exhibit L and MMIS provided contradictory information, MMIS was prioritized

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over Exhibit L. Several of the measures include HRSN service category in their definition; HRSN categories are Housing (including specifics for home changes for health), Nutrition, and O&E. All measures are calculated for March 2024 through September 2025.

- **HRSN recipients:** count of unique individuals receiving at least one HRSN service, in total and by HRSN category.
- **HRSN recipients per month:** count of unique individuals receiving HRSN services per month, in total and by HRSN category.
- **HRSN service categories received:** count and proportion of HRSN recipients who received each HRSN service category.
- **Housing (home changes for health) service type:** count and proportion of HRSN home changes for health recipients who received each type of device; i.e. air conditioner, air filter, heater, mini-fridge, and portable power supply.
- **Remaining Housing service types:** count and proportion of HRSN Housing recipients who received each remaining type of Housing service; i.e. home accessibility modifications and remediation services, hotel/motel stays, rent/utilities, storage fees, and tenancy support.
- **Nutrition service type:** count and proportion of HRSN nutrition recipients who received each type of available nutrition service; i.e. medically tailored meals and nutrition education.

YSHCN outcome measures. We calculated YSHCN outcome measure from MMIS enrollment data. All measures were calculated for January through December 2025.

- **Enrollment:** count of unique individuals enrolled in Medicaid under the YSHCN policy.
- **Newly enrolled in Medicaid:** count and proportion of YSHCN OHP members whose first day of enrollment in Medicaid was also the first day they were eligible as YSHCN.
- **Supplemental coverage:** count and proportion of YSHCN OHP members who were already eligible for Medicaid outside of their YSHCN status. Identified via PERC (see Attachment 3 for more details).
- **Standalone coverage:** count and proportion of YSHCN OHP members who were only eligible for Medicaid due to their YSHCN status; i.e. they earned between 139% and 205% FPL. Identified via PERC (see Attachment 3 for more details).
- **Passive enrollment:** count and proportion of YSHCN OHP members who gained YSHCN coverage status due to qualifying behavioral health (BH) diagnoses or pediatric medical complexity algorithm (PMCA) scores, or who were referred via the Office of Developmental Disabilities Services (ODDS).

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- **Active enrollment:** count and proportion of YSHCN OHP members who gained YSHCN coverage by completing a screener that automatically appears for individuals in the appropriate age range when they apply for Medicaid.

Cost outcome measures. We calculated cost outcomes measures using data collected from OHA (see Attachment 4 for categories and definitions). All cost information collected from OHA covered 2022 through 2024.

- **Total spending:** total administrative spending between the start of the demonstration through calendar year 2024. Types of spending included in this measure are staff payroll and benefits and employee services and support (including indirect spending); consulting and contracting; information technology projects; outreach and operations; and grants related to demonstration implementation and operation.
- **Spending disaggregated by policy area:** total administrative spending disaggregated by each policy area of the demonstration.

Data Sources

The following primary and secondary data sources were used in this interim report. A complete set of potential secondary data sources for the evaluation can be found in Attachment 4 of the CMS-approved evaluation design.

Primary data sources

- **Interviews.** We developed semi-structured interview guides and associated recruitment materials including information sheets and reviewed them with policy area subject matter experts at OHA. For interviews with YSHCN OHP members, we additionally reviewed materials with staff at OCCYSHN to ensure that they were appropriate for this audience.

  Key entity interview participants were recruited through email and phone outreach with up to five contact attempts. OHP member recruitment was conducted using text, email, and phone calls depending on the available contact information; some members only had a phone number or email address listed, not both. A maximum of three attempts were made to recruit OHP members for interviews.

  Interviews were conducted by phone or over Microsoft Teams or Cisco WebEx virtual video platform. All participants reviewed the study information and verbally consented to participate prior to engaging in the interviews and the interviewer requested consent to record the interview before beginning. For the time period of data collection represented in this report, recruitment and interviews were conducted primarily in English and Spanish. Recruitment and interviews can be conducted in additional

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languages as needed. Key entity interviews lasted approximately 60 minutes. OHP member interviews lasted approximately 30 minutes. OHP member participants were compensated $50 for engaging in an interview.

- **Asynchronous discussion board** for HRSN key entities**.** The online discussion board was conducted in English using the Qualboard platform. Discussion board prompts were developed by the evaluation team and reviewed by HRSN subject matter experts at OHA.

  Personnel from all CCOs and all enrolled HRSN Service Providers for whom contact information was available were invited to participate; participants were recruited through email outreach with up to three contact attempts. The evaluation team also collaborated with OHA to advertise the discussion board at their monthly HRSN Service Provider office hours. OHA staff were not included in the discussion board sample, and all discussion board participants were assigned pseudonyms to encourage candid responses. Participants engaged in the discussion board over the course of three weeks, with periodic prompts and follow-ups provided by the evaluation team to structure discussions.

- **Cost data collection.** Administrative cost data was collected from OHA. Administrative costs were defined as non-service costs incurred by OHA to plan, implement, administer, and operate the demonstration, distinct from direct medical or service delivery expenditures. Cost data were provided by OHA's Budget team, drawing on existing budget and expenditure records to summarize total administrative spending incurred by OHA across the 2022–2024 period. Evaluators validated data by confirming definitions and limitations of data reported.

Secondary Data Sources

- **CCO Financial Reporting (Exhibit L)**. CCOs report annual spending related to health-related services, including HRSN. Expenditures are reported at both the individual member level for direct services and at the organization level for community benefit initiatives. Data from Exhibit L included in this report cover March 2024 through September 2025.

- **Documents related to HRSN.** A framework was developed to identify documents related to HRSN implementation or the broader context of health-related social need service availability outside the waiver. Examples of the types of documents included are publicly available reports from OHA, CCOs, or other agencies, public testimony, meeting records, and news articles. Documents collected were created in 2024 or later.

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- **Medicaid Management Information System (MMIS).** MMIS contains detailed data about Medicaid enrollees and health care services paid by Medicaid, including information on HRSN services expenditures. Data from MMIS used for this report cover the years 2018 through 2025.
- **ONE Eligibility System.** The ONE Eligibility System allows individuals to apply for or renew Medicaid and other benefits, check application status, and update information. Data from the ONE Eligibility System used for this report covers the years 2018 through 2025.
- **Race, Ethnicity, Language and Disability Data Repository (REALD).** The REALD repository provides information on OHP members' race/ethnicity, preferred language, and disability status. Data from the REALD repository used for this report cover the years 2018 through 2025.
- **Social Needs Service Coordination Report (SNSC).** CCOs submit information quarterly on HRSN recipient member identification, closed loop referral information, and care coordination. Data from the SNSC used in this report cover January through September 2025.
- More detail on each of the Secondary Data Sources can be found in Attachment 2.

Efforts to validate, clean and connect the data

All administrative data sources were linked using unique, individual-level Medicaid ID numbers. If an individual's information was contradictory across data sources, decisions about which data source to use were made following the logic described in the Evaluation Measures section.

Analytic Methods

The qualitative and quantitative analysis approaches included in this report are described below.

Qualitative analysis

Interviews and Discussion Boards. Interviews were transcribed using GoTranscript or WebEx's transcription feature. Online discussion board content was available as a transcript and downloaded for analysis. Interviews, online discussion board data, and relevant documents were coded in Atlas.ti 25 using a coding framework developed for each policy area. Approximately 10% of interviews were double coded for accuracy. Coding teams discussed and resolved coding discrepancies; after discussion, the codebooks were updated with new codes and refined code definitions as needed. Coders also updated the coded data to ensure they

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reflected these changes. Once the codebooks were finalized, transcripts were split across the team for independent coding. Coded data from all sources were summarized, mapped to evaluation questions, and examined to identify patterns that were then transformed into themes using an inductive thematic analysis approach, consistent with methods described by Braun and Clarke (36). Where possible, a comparative thematic analysis approach was used to make comparisons across larger subgroups (e.g. across OHP members who received different categories of HRSN services). We expect to include more subgroup analysis in the summative evaluation report.

Environmental scan. To loosely gauge changes in local availability of and investment in social services, information from existing documents (e.g. agency reports, news articles) was extracted and catalogued. The nature of the reported change, timeframe, scale, and any stated implications or mitigation plans were captured in an Excel spreadsheet. Extracted information was synthesized across sources to identify patterns in reported changes by service type and geography and to highlight commonly cited drivers, such as policy changes, funding cycles, economic conditions, or emergent events.

Descriptive quantitative analysis

Descriptive statistics (e.g. counts, means, proportions) were constructed for each population descriptive measure and the policy-specific outcome measures described in the Evaluation Measures section. The interim report does not include any statistical testing; appropriate statistical testing based on the policy area specific evaluation designs will be included in the summative report. For the CE and TME analyses, we highlighted relative between-group differences of 10% or greater.

For the cost analysis specifically, we calculated total administrative spending related to the demonstration by summing aggregate expenditures across all reported costs.

To protect the confidentiality of individuals in the data, we suppress small numbers in this report. Primary suppression was applied when a subgroup numerator fell between 1 and 12. Secondary suppression was applied to prevent back-calculation of other suppressed value(s); if a single cell needed to be suppressed, the subgroup with the next smallest number was also suppressed. We did not suppress the Unknown category (since “Unknown” is not itself an identifying characteristics) unless doing so would allow us to avoid performing secondary suppression on another category. Secondary suppression was not applied when more than one subgroup was already suppressed. Cells with a numerator of 0 were reported as such, since no individuals were at risk of identification.

Section E. Methodological Limitations

Methodological limitations inherent in this evaluation fall into three categories: limitations with the study design; limitations with the data sources and data collection; and limitations with the analysis.

Study Design

Qualitative design: Our qualitative study design is limited by a potential bias in our sample population, as only those individuals who agree to interviews or discussion boards contribute information to our evaluation. This bias could be driven by interest in engaging in research, access to our recruitment methods – although we were able to mitigate this somewhat by including multiple forms of outreach– and the ability to navigate any logistical constraints such as having easy access to a phone or computer with Internet connectivity to participate.

Additionally, in some places our study design intentionally limited who was included. For the HRSN policy, we interviewed only those who had received the benefit, limiting our perspective to those who had successfully completed the process. In other places, decisions about policy rollout limited who could be included. For example, the YSHCN policy is being implemented as a staged rollout, starting with 19 and 20 -year-olds in 2025. While this strategy has important benefits for ensuring that the state infrastructure can support the expansion of coverage and provision of new benefits to this group, it also means that only 19- and 20-year-olds contributed their perspectives to this interim report. With one exception, the qualitative data collection represented in this report was conducted in either English or Spanish, so our perspective is limited to individuals who could speak one of those two languages. Therefore, even with a focus on recruitment of diverse demographics and characteristics to capture varying experiences and perspectives, the interviews may not be representative of the full population.

Quantitative design: Our quantitative design is limited to a descriptive approach at this point in the analysis. This limits our ability to understand any changes or differences in outcomes that are associated with the demonstration. Patterns observed in administrative data across years or across sociodemographic groups may reflect overlapping policy and operational changes. We do not apply formal significance testing or pre-specified thresholds.

Moving forward, some analyses will continue to be descriptive because of a lack of appropriate comparison groups or existence of systematically collected data; however, we will include pre/post and cross-state comparison groups for several of the research questions in the summative report.

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Data Sources and Collection

Qualitative data collection: For qualitative interviews and asynchronous online discussion boards, data are subject to social desirability and recall biases. For example, interviews with CE and TME key entities and TME members were conducted in 2025 and asked participants to reflect on experiences with policies that were implemented between 2023 and 2024. As a result, some participants were recalling events that occurred one to three years prior to the interview. This lag may have affected recall of specific details and, in some cases, shaped perspectives through hindsight.

The YSHCN OHP member population had a 4% response rate to interview invitations, which was lower than that of other populations included in the evaluation. Despite using multiple outreach approaches (i.e., text, email, and phone calls), recruitment within this group remained challenging. In some cases, the contact information in the ONE system belonged to the member's caregiver rather than the member, which further delayed or complicated recruitment efforts. For the interim report, the recruitment of Open Card/Fee for Service (FFS) key entity representatives for the YSHCN policy did not result in any interviews; recruitment will continue to ensure their perspectives are included in the summative report.

Quantitative data sources: Several of the data sources being used, including CCO financial reporting (Exhibit L) and REALD repository data, have limitations due to the quality of that data and how it is changing over time. These data sources are undergoing continuous quality improvement efforts at OHA. For example, OHA is continuing to monitor the quality of the REALD data to support greater completeness. For these sources, we are using the latest extracts to ensure we have the most accurate information. Additionally, relying on Medicaid enrollment and claims to understand health care utilization means we are unable to observe services received outside of OHP.

OHA phased in claims submission to MMIS for HRSN services, which required us to combine data sources (e.g. MMIS and Exhibit L) for some analyses to obtain a complete picture. Further, some data sources, such as the SNSC, were implemented after the demonstration had already begun; use of this data started as soon as it was available.

Finally, specifically for the cost data collection, the reported administrative spending is considered preliminary and is focused on costs within OHA. This may not correspond to total 1115 Waiver costs reported to CMS given differences in budgeting and reporting processes. Reported spending did not include all expenditures. For example, ODHS expenditures and CCO administrative costs are not included in this interim report and will be incorporated in the summative report. Costs reported by OHA align with approved funding allocations to each of the components and may not reflect actual hours spent on components.

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Analysis and Interpretation

Qualitative analysis: Qualitative data was coded and reviewed across multiple members of the evaluation team, which is important to limit bias but can lead to discrepancies in coding. To ensure consistency and to limit coder bias, we randomly selected approximately 10% of interview transcripts for double coding and used a qualitative approach to support intercoder reliability. Coding discrepancies were reviewed during regular consensus meetings, during which analysts discussed differences in code application, clarified code definitions, and reached agreement through discussion.

Quantitative analysis: As stated, the quantitative analyses are descriptive in nature and therefore limit conclusions about differences or change that may be associated with the waiver benefits.

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Section F. Results

In this section, we present results by each specific policy area. The policy area sections begin with an overview of key findings, followed by an overview of relevant information on the policy, a complete list of the research questions, logic model, an overview of research questions included in the interim report, a description of the study population, and results by research question.

Continuous Eligibility and Temporary Medicaid Expansion

Summary of Key Findings

CE and TME enrollment and coverage transitions

- In 2024, the first calendar year after CE implementation, 153,501 individuals under age six and 1,562,949 individuals ages 6–64 were enrolled in the OHP at some point during the year.
- During calendar years 2023 and 2024, 67,917 individuals were enrolled in OHP through the TME policy at some point. Of these members, the majority (80.4%) transitioned to OHP Bridge or another OHP category of aid without a gap in coverage.

CE and TME policy implementation

- Most state and community implementation partners viewed CE and TME as policy successes. Strong implementation infrastructure and cross-agency coordination supported rollout, while coordination gaps, confusion about policy details, and staffing constraints created some challenges.
- CE reduced administrative burden by supporting staff efficiency and operational stability for CCO partners, though longer coverage periods made pre-redetermination outreach and contact verification more demanding for some CCOs.
- CE communication strategies for members emphasized transcreation, plain-language summaries, and cultural responsiveness. Trusted local support from sources such as clinic staff, caseworkers, or local advocates also helped members understand and navigate their coverage.

TME member experiences and coverage continuity

- The TME-to-OHP Bridge transition was low-touch and often felt seamless to members, who generally experienced TME as continued coverage rather than as a named policy. Members also described this continued coverage as providing financial protection and reducing stress for their households.
- Roughly twenty thousand people moved seamlessly from TME to OHP Bridge; all else being equal, it is likely they would have lost coverage without the TME policy in place.

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OHP membership stability, disenrollment and churn

- Following the end of the federal continuous coverage requirement associated with the PHE, OHP membership remained relatively stable, disenrollment rebounded during CE implementation but stayed below pre-pandemic levels, and churn remained low after declining during the PHE.
- Average annual days enrolled increased during the PHE and declined somewhat in subsequent years after CE was implemented but remained above pre-pandemic levels.
- Sociodemographic compositions of continuously enrolled members and members experiencing churn were broadly similar.

Context and background

As described in Section B, Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver was implemented following the end of the federal continuous coverage requirement and during the PHE unwinding period. Within this context, Continuous Eligibility (CE) and Temporary Medicaid Expansion (TME) were designed to preserve coverage continuity gains and reduce preventable coverage loss among OHP members (37).

CE overview and eligibility. CE applied to most OHP and Children's Health Insurance Program (CHIP) enrollees who were receiving Medicaid benefits when the policy launched on July 1, 2023 (38,39). These included members who completed a renewal following the end of the PHE, and those who newly applied and were found eligible on or after April 1, 2023. For members ages six and older, the two-year continuous enrollment period was based on the renewal or application date. CE remains in effect for new OHP enrollees and current members.

CE applies to Medicaid and CHIP enrollees in most OHP eligibility categories, with limited exceptions, including individuals eligible for Medicaid due to the receipt of home and community-based services (federal Medicaid regulation 42 CFR 435.217) (39). CE applies to all other OHP eligibility categories, so long as the member remains an Oregon resident, does not request termination of eligibility, does not die, and the agency does not determine that eligibility was erroneously granted.

TME overview and eligibility. TME took effect on April 1, 2023, as Oregon began unwinding the PHE-era continuous Medicaid coverage requirement and resumed OHP eligibility redeterminations. TME served as a temporary stopgap for individuals with incomes above traditional OHP limits (138FPL), allowing them to maintain coverage until the launch of the OHP Bridge Basic Health Program on July 1, 2024. Oregon created OHP Bridge to provide coverage for individuals with incomes between 133 and 200% FPL who do not have access to affordable coverage elsewhere (40). The lower FPL floor reflects the fact that OHP Bridge eligibility does not apply Medicaid's 5% income disregard.

Continuous enrollment efforts prior to the PHE period. CE and TME also build on earlier Oregon efforts to support continuous Medicaid enrollment. Before the PHE, children younger than 18 who were eligible for OHP or CHIP could remain continuously enrolled for 12 months, reflecting CHIP policies (41). CHIP was expanded through Health Care for All Oregon Children, also known as Healthy Kids, which provided 12 months of continuous enrollment for children enrolled in OHP (42,43). Oregon also had a narrower adult continuity policy through the Extended Medical Assistance (EXT) program, which allowed certain parents and caretaker relatives with dependent children in the home to remain enrolled for 12 months if their income exceeded the standard OHP eligibility threshold (138% FPL) at redetermination (44). Unlike EXT, TME and OHP Bridge eligibility are not contingent on having a dependent child in the household.

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CMS-Approved Research Questions and Logic Model

CE and TME Implementation Questions

1. How are the CE and TME policies being implemented?
    - *1a.* Did implementation of the CE and TME policies happen as expected, and what factors facilitated or impeded success?
    - *1b.* What impact does the CE policy have on administrative burden related to redetermination for the OHA, Oregon Department of Human Services (ODHS), Area Agency on Aging (AAA), and CCO staff?
    - *1c.* What is the understanding of the CE policy among OHP members?

CE and TME Evaluation Questions

1. The CE and TME policies will improve the experience of enrollment in Medicaid for OHP members.
    - *1.1.* What is the experience of the CE policy for OHP members, including what impact it has on administrative burden (e.g., time and stress) related to renewals?
    - *1.2*. For OHP members eligible for the TME policy, what is the experience of transitioning from OHP under the public health emergency to TME, and from TME to OHP Bridge?
2. The CE and TME policies will increase enrollment, improve continuity of Medicaid coverage, and reduce churn; and will decrease inequities in all these outcomes.
    - *2.1.* How does the CE policy impact enrollment and renewal rates?
    - *2.2*. How does the CE policy impact rates of churn?
    - *2.3*. How long are individuals enrolled in Medicaid under the CE policy?
    - *2.4.* Which members covered by the TME policy end up on OHP Bridge?
    - *2.5.* How do the CE and TME policies impact inequities in enrollment, coverage continuity, and churn?
3. The CE and TME policies will improve health care access, utilization, and quality for OHP members; and will decrease inequities in all these areas.
    - *3.1.* How do the CE and TME policies impact access to and use of preventive and primary care, including continuity of care?
    - *3.2.* How do the CE and TME policies impact use of acute and costly care, especially potentially preventable emergency department visits and hospitalizations?

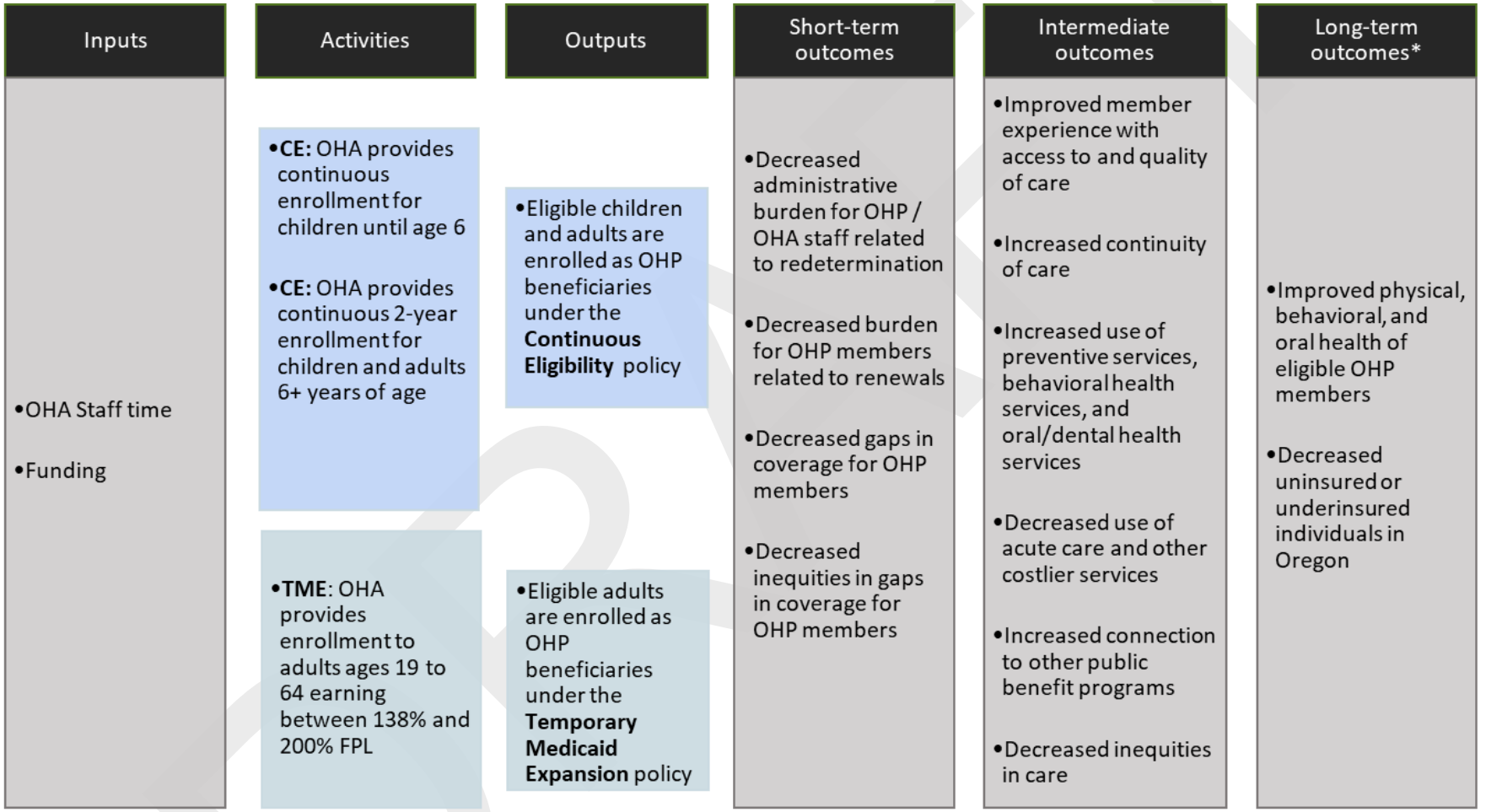
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- *3.3.* How do the CE and TME policies impact access to and use of behavioral health care?
- *3.4.* How do the CE and TME policies impact access to and use of oral health care?
- *3.5.* How do the CE and TME policies impact inequities in health care access, utilization, and quality?

4. The CE policy will improve access overall, and decrease inequities in access, to other public benefits for OHP members.
    - *4.1.* How does the CE policy impact connection to non-health care public benefit programs (such as Supplemental Nutrition Assistance Program [SNAP], Temporary Assistance for Needy Families [TANF], Employment-Related Day Care [ERDC] assistance, or Special Supplemental Nutrition Program for Women, Infants, and Children [WIC])?
    - *4.2.* How does the CE policy impact inequities in connection to non-health care public benefits?

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Figure 6. CE and TME logic model



Research questions included in this report

The evaluation questions and hypotheses outlined above define the full scope of the evaluation plan. This interim report presents analyses supported by currently available data. For implementation question 1 and hypothesis 1, the interim report draws on qualitative interviews with CE and TME implementation partners and TME OHP members. CE OHP member interviews had not yet begun at the time of drafting, and findings from these interviews will be incorporated into the summative report.

This interim report also includes descriptive quantitative analyses that complement the qualitative findings. For hypothesis 2, the interim report presents descriptive measures of enrollment, churn, length of enrollment, and coverage inequities. The summative evaluation will build on these interim findings by examining the evaluation questions and hypotheses in greater depth and by adding robust quantitative analyses for hypotheses 2-4.

Study Population

Qualitative data – Implementation partner sample. Implementation partners were staff involved in implementing the CE and TME policies. This included OHA staff supporting technical and logistical implementation and outreach and education. It also included staff from ODHS's ONE Customer Service Center, other ODHS offices, CCOs, and community partner organizations serving members affected by these policies. Recruitment for implementation partner interviews began in April 2025 and is ongoing. For this interim report, results include only interview data collected through March 2026 to allow sufficient time for analysis.

Out of 63 CE and TME implementation partners contacted, 35 individuals from four organization and entity types agreed to be interviewed, for a response rate of 56%. See Table 3 for a breakdown of the interviewees. The remaining contacts either declined to participate (N=10) or could not be reached (N=18). Interview participants included directors or similar leadership roles, policy analysts and administrators, outreach coordinators, and community health workers. Of the 35 interviewees, 12 were OHA employees, 10 were ODHS employees, nine were CCO employees, and four were employees of community partner organizations.

Most interviewees (N=27) were involved in both the CE and TME policies and discussed their experiences and level of involvement with both policies during a single interview. However, a handful of interviewees had experience in only one of the policies, so we focused interviews with these implementation partners on that one policy area.

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Table 3. CE and TME implementation partner interviews recruitment statistics

Implementation partner group	Individuals interviewed	State staff	CCO staff	Community partners
CE implementation partners	6	4	0	2
TME implementation partners	2	2	0	0
Both CE & TME implementation partners	27	16	9	2
Total	**35**	**22**	**9**	**4**

Qualitative data – TME OHP member sample. TME members received OHP coverage between May 2023 to July 2024 due to their enrollment under the TME policy. Recruitment for TME member interviews began in July 2025 and is ongoing. This interim report reflects interviews completed through March 2026.

OHA provided access to data from the MMIS and the REALD repository, including contact information and sociodemographic variables for OHP members enrolled under the TME policy. We recruited members for interviews whose characteristics reflected the geographic and racial/ethnic diversity of the OHP member universe. When members could not be reached, we recruited replacement members with similar geographic and demographic characteristics to help maintain the intended balance of the interview sample.

For the TME member interviews, of the 315 OHP members contacted, 24 agreed to be interviewed; the remaining contacts either declined to participate (N=57) or could not be reached (N=234). See Table 4 for a breakdown of interview statistics.

Table 4. Summary of TME member interviews

	N = 24
Race/ethnicity	
American Indian/Alaska Native	2
Asian	1
Black/African American	2
Latino/a/x/e	4
Middle Eastern/North African	2
Multiracial/Other	1
Native Hawaiian & Pacific Islander	2
Unknown/Missing/Declined	1
White	9
Gender	
Female	9
Male	15
Age	
18-34	8
35-64	16
65+	0
Geography	
Rural	18
Urban	6
Frontier	0
Spoken language	
English	20
Spanish	4

Results

Implementation question 1a. Did implementation of the CE and TME policies happen as expected, and what factors facilitated or impeded success?

Most implementation partners viewed CE and TME as policy successes.

Across interviews, implementation partners repeatedly framed continuity of coverage under CE and TME as one of the clearest indicators of policy success. They described CE's 0-6 continuous eligibility as especially valuable for supporting preventive care and continuity in early childhood. Participants also indicated that TME largely worked as intended because it maintained coverage for the target population until the launch of OHP Bridge.

> *"The fact that there were 24,000 people who were able to just start with Basic Health Program coverage on July 1, 2024, [is] a huge barometer of success. The seamless transition prevented members from having to apply for Marketplace coverage and likely helped them avoid delays in care, financial strain, and disruptions in provider continuity." - OHA*

The implementation process reflected both strong institutional support and the operational strain involved in coordinating complex policy change across multiple policy units, described below.

Implementation infrastructure and cross-agency coordination facilitated rollout.

Across implementation partner interviews, participants described CE and TME implementation as working best when policy development, operational planning, and communication channels aligned. Implementation partners repeatedly pointed to a strong OHA–ODHS partnership, executive prioritization, and implementation of recurring workgroups, forums, and webinars as important facilitators of rollout. One participant similarly described strong communication across teams during TME and OHP Bridge development, noting that the work required substantial collaboration across multiple offices and that a program design work group facilitated successful collaboration. Those supports created opportunities to ask questions, identify barriers, bring community experience back to state agencies, and adjust implementation in real time. Much of this enhanced collaborative infrastructure remained in place after initial policy implementation rollout.

> *"Both the TME and the development of Bridge required really significant collaboration...we were able to establish a great communication engine at the beginning. We had a program design work group that was a core place for staff members across the agency to come and meet and talk about issues that had popped up." - OHA*

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> *"OHA and ODHS had so many opportunities to partner and talk and really be thoughtful of talking through the impact...we have done amazing work with our administrators. So that partnership between the two agencies has been phenomenal...We were united in what problem we were trying to solve...and hopefully that has laid groundwork for the future." - ODHS*

Since CE extended an existing eligibility structure rather than requiring a more complex eligibility re-design, implementation partners described the policy as relatively straightforward to operationalize. One stakeholder explained that CE was implemented in multiple stages within the ONE system, including changes to renewal date logic, retroactive application

of CE to members who had already renewed, and updated assignment of future renewal dates. This technical infrastructure helped create a more efficient operational environment and reduced the frequency of full redetermination cycles for many members.

Coordination gaps, confusion about policy details, and staffing constraints complicated implementation.

Implementation partners also described coordination barriers that complicated policy implementation. Dissemination of demonstration-related information did not always move through policy units in a synchronized way, resulting in some teams receiving updates before others.

> *"Sometimes things were not released at the same time...It was a little bit of the telephone game because someone would have a conversation with someone they saw at a meeting and that person [would have] already had information...but meanwhile we haven't received any information." - OHA*

Implementation partners emphasized that demonstration language, waiver concepts, and notice content were often too technical for staff to easily interpret. They described confusion arising both from complex policy concepts and from the use of multiple formal, informal, and evolving program names for programs serving similar populations. Participants referenced terms such as "BHP," "OHP Bridge," and "Bridge to the Bridge," which they reflected made it difficult to distinguish among the programs and policies over time. One participant also noted that staff did not always understand whether someone was already enrolled in CE or only potentially eligible, which made it difficult to explain CE eligibility and redetermination windows to members.

> *"I wish that there was more lead time and more clarification of what it truly meant to be a TME member versus the 'Bridge to the Bridge', right? Technically they were under Bridge with different types of Medicaid benefits...It was not super clear what that meant." - CCO*

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> *"What I remember is there being like a 'Bridge to the Bridge'. And then we had BHP and then we had OHP Bridge and all the different names. They're so similar. It actually was incredibly confusing for folks just to keep them straight to what is what." - CCO*

The volume and complexity of coordinating work across OHA policy units during a time of overlapping initiatives also strained implementation

capacity, especially for already understaffed teams facing limited technical support for configuring and adjusting programmed processes. These coordination issues also affected staff outside of OHA. Staff from the ODHS Office of Aging and People with Disabilities (APD) described being brought into CE planning late and learning about key changes after important eligibility decisions were already made.

Implementation partner CE communication strategies focused on transcreation, plain-language summaries, and cultural responsiveness.

Translation of OHP communications to languages other than English was frequently described by implementation partners as insufficient because technical jargon and dialect nuances often did not produce language that felt clear once translated. Instead of translation, implementation partners identified transcreation—a process of functional verification in which trusted partners ensure materials are culturally accurate and readable—as a key facilitator of clear communication. Participants also emphasized the importance of integrating translation protocols early, rather than treating language access as an afterthought. They specifically noted communication barriers for Chuukese, Marshallese, and Mam-speaking communities, and highlighted trilingual application assistors as an important support for bridging access gaps.

> *"The waiver concepts and these very long documents were way too wonky. And when they were translated to languages like Chuukese for example, [community partners] couldn't understand them. They had no idea. [They told me] 'We don't think this is Chuukese language...You have to do transcreation...it's not just translation, it's transcreation, it's getting feedback from the community." - OHA*

One participant described plain-language review of the demonstration policies, along with the development of digestible mini-scripts for community health worker frontline staff, as important implementation supports for partner organizations.

> *"A core facilitator is the organization's practices of summarizing complex policy details for frontline staff in plain language health information...The organization takes long OHA documents, summarizes them into 'mini scripts' using a health literacy lens, to provide community health workers (CHWs) with materials that are truly digestible for the community." - Community Partner*

Some implementation partners described immigration-related fears affecting member enrollment or willingness to engage with CE-related outreach. These concerns were especially noted for mixed-status households and in communities concerned about state agency data-sharing practices. Implementation partners involved in member outreach shared that they often had to balance transparent communication with advising members to seek legal advice, especially when they worried that sharing incorrect or changing information could affect a member's immigration status or enrollment decisions.

> *"CHWs are really hesitant to share information that could change tomorrow because then it feels like you shared the wrong information or it could affect the client or it could affect their immigration status...So it's a balance of providing really clear, transparent information, which might mean encouraging them to talk to a legal advisor or a lawyer before making that decision." - Community Partner*

Members experienced coverage continuity through TME as financial protection and reduced stress.

Reflecting implementation and policy successes at the individual level, members described OHP not only as insurance coverage but also as a valuable form of financial protection during periods of health-related uncertainty or economic transition. During the time that TME was active, members valued having OHP coverage because it reduced uncertainty about what would happen if they suddenly needed hospital care, medications, or urgent treatment. Members described that OHP coverage reduced stress and provided reassurance that care would remain affordable if needed.

> *"Sometimes [my] income is not enough to cover all the expenses. And then [we are] worried about whenever we are sick, what is going to happen. But when the insurance is covered, then there's the economic empowerment of the family."*
> *- TME Member*

> *"[Having OHP has helped my family's] mental health because [we] weren't worried. A weight was lifted off our shoulders. Like, maybe I don't have a good job right now, but I have health insurance in case something happens...I know I can pay that bill, or get treatment, I can go to the doctor."*
> *- TME Member*

Implementation question 1b. What impact does the CE policy have on administrative burden related to redetermination for state agency and CCO staff?

CE reduced administrative burden by contributing to greater staff efficiency and supporting operational and system stability for CCO partners.

Across state agency and CCO interviews, participants described frequent redeterminations as a recurring source of administrative and logistical burden for staff. These implementation partners

noted that less frequent renewal cycles through CE reduced recurring administrative work, complemented automated renewal processes, and allowed staff and assistors to focus more time and attention on households whose circumstances were more complex.

> *"We have families and households and individuals whose circumstances do not change significantly in a year...[CE enables] efficiency because it allows us to then concentrate on the other folks who need our support and our care." - ODHS*

CCO staff emphasized system-level benefits of increased coverage predictability and continuity through CE and TME, including stabilizing CCO member enrollment, payment continuity, and revenue within CCO value-based payment models. These interviews framed coverage stability not only as a member benefit but also a system-stabilizing mechanism that reduced administrative burden.

> *"Having that continuity of coverage really helps [our CCO] with member attribution and ensuring consistent payment over time under those value-based payment arrangements...[CE helps with] stabilizing revenue, stabilizing membership…things like quality incentive measures are simpler because the denominator is more consistent." - CCO*

Longer coverage periods made pre-redetermination outreach and contact verification more demanding for some CCOs.

Findings from implementation partner interviews suggest that CE reduced some renewal-related administrative burden, though longer coverage periods also created additional outreach and contact verification responsibilities for some CCOs before redetermination. Longer periods of coverage continuity meant OHP members interacted less often with state agency and CCO staff, which increased the likelihood that contact information would be outdated by the next redetermination. In response, one implementation partner described building an outbound call process within their CCO to identify members approaching redetermination, to give them advance notice, and verify contact information ahead of time.

> *"When you have a two- or six-year gap [a lot can change during that time]…So we have a lot of issues with incorrect mailing addresses for members, a lot of return mail." - CCO*

> *"We built processes here to use state data to identify who was up for redetermination…and we built out an outbound call center for people to make phone calls and say, 'Hey, the state's going to be sending you a letter and if you want to keep your care, please pay attention to that." - CCO*

Implementation question 1c. What is the understanding of the CE and TME policies among OHP members?

OHP members generally understood their TME experience at the level of continued coverage, rather than at the level of named policy design.

Overall, TME members generally described their coverage simply as OHP or Medicaid and did not have a clear understanding of what TME was. A total of 21 of 24 member interviewees said that they were not aware that they received coverage under the TME policy, though some reflected on having continuous coverage during the time that TME was active.

> *"During the COVID lockdown period, there was a year or so without having to renew [my OHP benefits]...I was not aware of the TME program and I wasn't even aware of the Bridge program until you said it today, that's the first time I've ever heard of it..." - TME Member*

These OHP member accounts complement implementation partner reflections that TME was not a widely used term, even among agency staff who tended to internally refer to TME in other terms like "the Bridge to the Bridge." Apart from its inclusion in a few technical documents, TME was rarely referenced by name, especially in public agency communications to members. Even though moving from one category of eligibility to another required formal member notification, these agency notices emphasized the continuity of OHP benefits without the need for member action as opposed to details of the TME policy.

> *"I think [TME] was actually pretty seamless for folks, right?...They got to keep coverage longer...I think it was the right route to go. If you do a lot of marketing for it, you also have to be able to explain why you're not eligible for it, right?...I think it's really about letting people know when they need to engage." - ODHS*

Trusted local support facilitated members' understanding of their OHP coverage.

Members usually described seeking help with their OHP benefits more broadly rather than referring to TME by name. They described navigating coverage during the time that TME was active not as something they managed independently, but as something that locally available navigation support made easier. In interviews, members reflected on trusting local advocates, clinic staff, ODHS case workers, and ONE call center staff to help them understand, renew, and maintain their OHP benefits. Despite frequent long wait times, once members were connected to ODHS case workers or ONE call center staff, most felt that they were able to have their questions answered and receive any assistance they needed. These sources of support played an important role in helping members understand renewal requirements and coverage periods.

"At the beginning we had a case worker from ODHS who was helping orient us to the enrollment with all the documentation [which made the enrollment process easier]." - TME Member

"There is a person who helps us...She works in a clinic...And we always go see her there and she helps us with [understanding how to renew our OHP benefits]." - TME Member

These accounts add practical context to the implementation partner interview findings by showing that members were better able to understand and navigate their OHP benefits when information was paired with trusted local support. From the OHP members' perspective, OHP notices about their coverage were most useful when someone was available to help them interpret it and act on it, if needed.

CE and TME hypothesis 1. The CE and TME policies will improve the experience of enrollment in Medicaid for OHP members.

Evaluation question 1b. For OHP members eligible for the TME policy, what is the experience of transitioning from OHP under the public health emergency to TME, and from TME to OHP Bridge?

The TME-to-OHP Bridge transition was low-touch and often felt seamless to members.

A clear pattern in the TME member interviews was that the transition from TME to OHP Bridge involved little direct member action and little noticeable change in coverage. Members who were aware of the transition usually learned about it through a mailed letter or an OHP redetermination interaction. Several described no experienced differences between TME and OHP Bridge coverage, and a few characterized the transition as uneventful. These findings suggest that many members experienced the transition less as a distinct policy event and more as continued coverage.

"There weren't any real changes [once I transitioned to OHP Bridge]. Everything for me stayed exactly the same...I found out [about OHP Bridge] when I called and reapplied. The person I spoke to told me that I qualified for the Bridge program versus regular [OHP]." - TME Member

"I received a letter…that I could go beyond the [income] limit and still maintain OHP coverage through OHP Bridge." - TME Member

Similar to the communication strategy for members transitioning to eligibility under TME, implementation partners described the TME-to-OHP Bridge transition as involving limited direct member messaging. Several participants viewed this limited-messaging approach as a strength, noting that minimizing change to members reduced the risk of confusion, especially since members did not need to act to maintain coverage. They also noted, however, that limited messaging made the transition harder to explain when questions did arise, especially within the

broader context of PHE unwinding and other waiver-related communications already in circulation. Overall, these findings suggest that low member awareness of the policy transition from TME to OHP Bridge reflected the intended design of a transition meant to occur with as little disruption as possible. In this context, policy implementation interviewees largely viewed the transition as successful.

CE and TME hypothesis 2. The CE and TME policies will increase enrollment, improve continuity of Medicaid coverage, and reduce churn; and will decrease inequities in all these outcomes.

Evaluation questions 2a-c. How does the CE policy impact enrollment and renewal rates; rates of churn; and average days enrolled?

Enrollment data reflects relatively stable OHP membership following the end of the federal continuous coverage requirement.

In 2024, the first calendar year following implementation of CE, 153,501 individuals under age 6 and 1,562,949 individuals ages 6-64 were enrolled in OHP at some point during the year (Tables 5 and 6). Enrollment among members ages 6-64 grew over time, rising from 1,136,572 in 2019 to 1,562,949 in 2024. OHP enrollment for these members remained relatively stable between 2023-2024 following the end of the federal continuous coverage requirement on March 31, 2023. Enrollment counts among children under age six did not change notably between 2019 and 2024. The proportion of members enrolled in OHP in a given year who were also enrolled during the prior year (suggestive of continuity of coverage) remained high across both groups across all years.

Average annual days enrolled increased during the PHE and decreased in subsequent years when CE was implemented, though they remained above pre-pandemic levels.

In calendar year 2024, the year following implementation of CE, the mean number of days enrolled in OHP was 309 days among members under age six, and 318 days among members ages 6-64. Mean days enrolled was highest among both age groups in 2022, at 317 days among members under age 6 and 336 days among members ages 6-64. Mean days enrolled for both age groups declined slightly in 2023 and 2024, although averages remained above those observed prior to the pandemic.

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Table 5. Medicaid enrollment patterns, members aged <6 years

Characteristic	2019	2020	2021	2022	2023	2024
Enrolled in Medicaid during current year - N (%)	155,417 (100%)	149,910 (100%)	152,506 (100%)	153,140 (100%)	153,374 (100%)	153,501 (100%)
Enrolled in Medicaid during prior year - N (%)	121,065 (77.9%)	116,935 (78.0%)	118,414 (77.6%)	120,476 (78.7%)	120,809 (78.8%)	120,426 (78.5%)
Days enrolled during current year - Mean (SD)	297.6 (104.3)	310.9 (102.2)	315.4 (97.4)	316.8 (96.9)	316.7 (96.3)	308.7 (102.8)
Disenrolled during current year - N (%)	26,185 (16.8%)	9,521 (6.4%)	7,841 (5.1%)	7,945 (5.2%)	9,498 (6.2%)	14,730 (9.6%)
Disenrolled and reenrolled within 3 months during current year ('churn') - N (%)	5,352 (3.4%)	1,402 (0.9%)	757 (0.5%)	569 (0.4%)	773 (0.5%)	1,324 (0.9%)

Source: Oregon Medicaid Management Information System (MMIS) administrative enrollment and claims data.

Table 6. Medicaid enrollment patterns, members aged 6-64 years

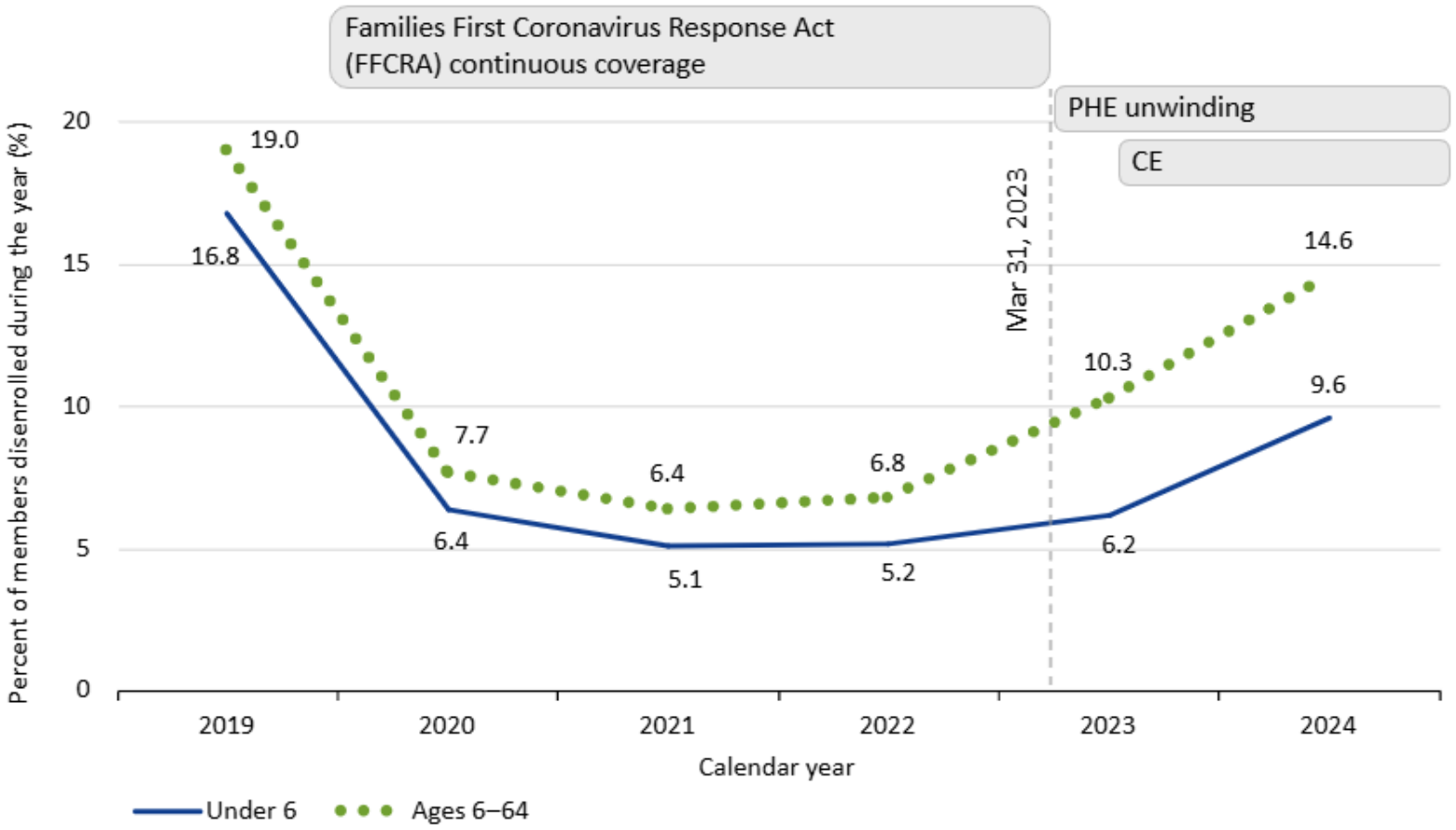
Characteristic	2019	2020	2021	2022	2023	2024
Enrolled in Medicaid during current year - N (%)	1,136,572 (100%)	1,186,498 (100%)	1,303,697 (100%)	1,407,223 (100%)	1,509,448 (100%)	1,562,949 (100%)
Enrolled in Medicaid during prior year - N (%)	1,000,105 (88.0%)	1,021,513 (86.1%)	1,148,616 (88.1%)	1,264,914 (89.9%)	1,361,474 (90.2%)	1,401,521 (89.7%)
Days enrolled during current year - Mean (SD)	309.9 (98.2)	322.4 (94.4)	334.0 (79.7)	336.0 (78.3)	333.7 (78.2)	317.7 (97.6)
Disenrolled during current year - N (%)	216,024 (19.0%)	91,912 (7.7%)	83,651 (6.4%)	95,462 (6.8%)	155,732 (10.3%)	228,512 (14.6%)
Disenrolled and reenrolled within 3 months during current year ('churn') - N (%)	34,081 (3.0%)	16,204 (1.4%)	14,251 (1.1%)	17,736 (1.3%)	19,844 (1.3%)	25,452 (1.6%)

Source: Oregon Medicaid Management Information System (MMIS) administrative enrollment and claims data.

OHP disenrollment declined during the PHE and rebounded during CE implementation, though without reaching pre-pandemic levels.

Between calendar years 2019 and 2024, we observed the most notable changes in OHP current-year disenrollment (Figure 7). Among members under age six, disenrollment dropped sharply from nearly 17% in 2019 to below 7% in 2020 and rose to under 10% by 2024 – remaining well below pre-pandemic levels. We observed a similar pattern among members ages 6-64, where disenrollment fell from 19% in 2019 to fewer than 8% in 2020, and rose to under 15% by 2024.

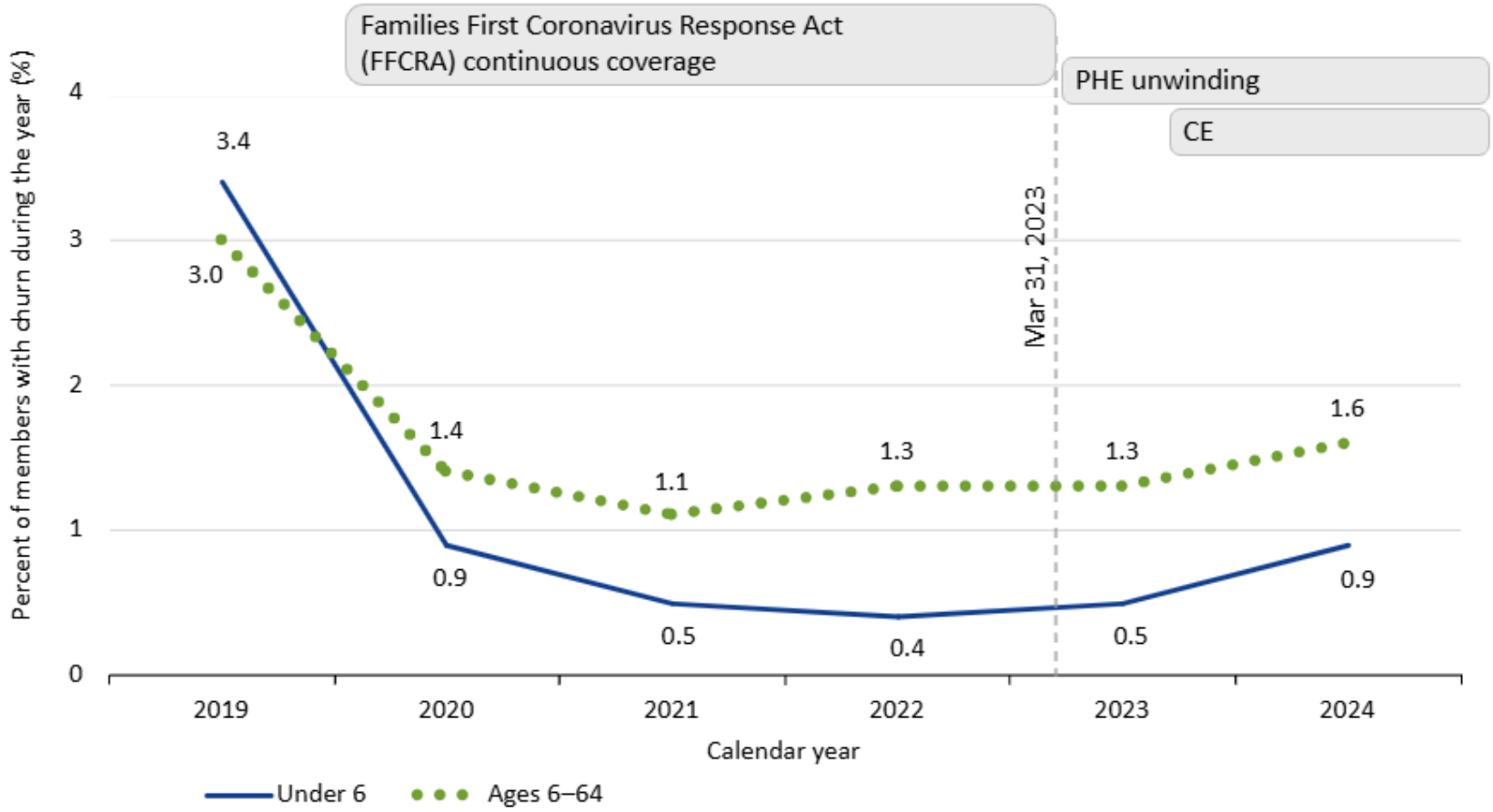
Figure 7. Disenrollment among OHP members, by age group



Rates of churn declined during the PHE and remained low in subsequent years when CE was implemented.

The proportion of members who experienced churn – any gap in coverage of up to three months – was highest in 2019 for both age groups (Figure 8). Among members under age six, churn fell from a little over 3% in 2019 to less than 1% in 2020 and remained well below pre-pandemic levels through 2024. Among members ages 6-64, churn fell from 3% in 2019 to slightly over 1% in 2020 and remained below pre-pandemic levels through 2024.

Figure 8. Churn among OHP members, by age group



Evaluation question 2d. Which members covered by the TME policy end up on OHP Bridge?

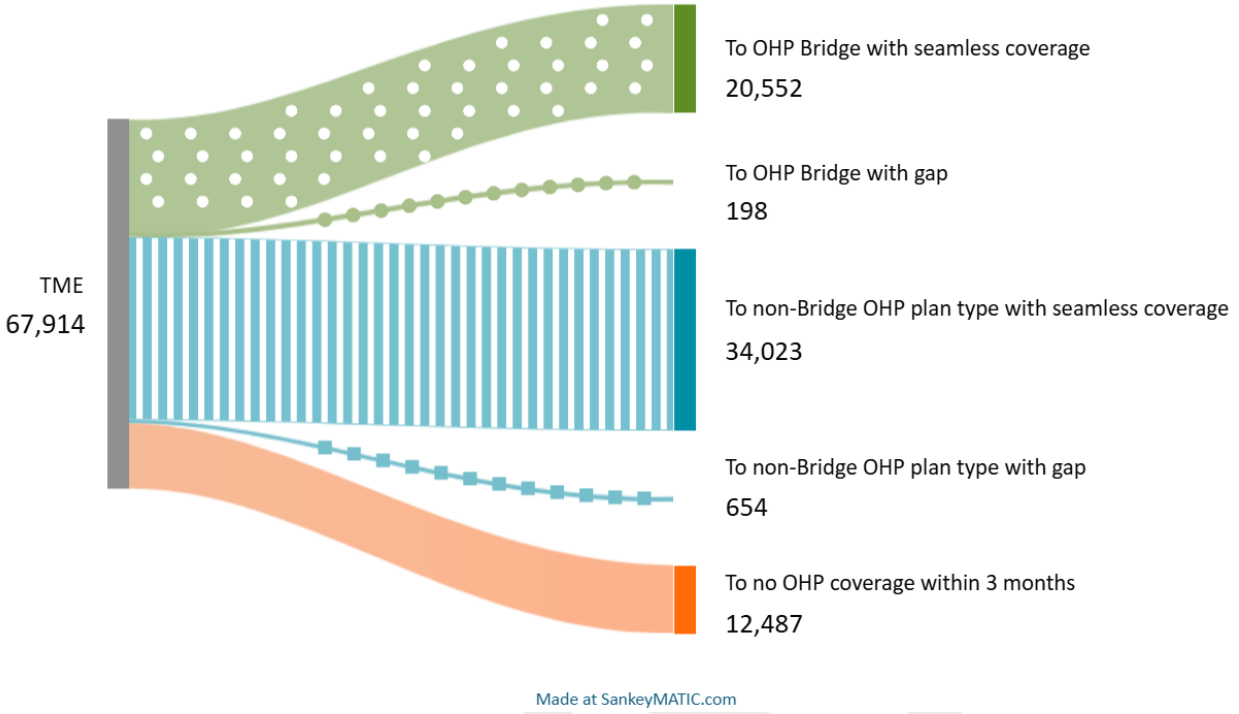
The vast majority (80.4%) of OHP members enrolled under the TME policy either transitioned to OHP Bridge or an alternate OHP category of aid with no interruptions in coverage.

Four in five TME members maintained coverage after the TME policy ended. During calendar years 2023 and 2024, 67,914 individuals were enrolled in OHP coverage through the TME policy at some point. Figure 9 illustrates enrollment patterns over the three months following the end of members' TME coverage. It differentiates between members who experienced seamless coverage transitions and those who experienced a gap in coverage after TME. Approximately one in three (N=20,552 or 30%) transitioned into OHP Bridge with seamless coverage, and approximately one half of TME members (N=34,023) transitioned from TME into a different OHP category of aid with seamless coverage. A small proportion of members exited TME with a gap in coverage before entering either OHP Bridge or another OHP category of aid, representing fewer than 2% of TME members combined. Nearly one in five members (18%) exited TME with no OHP coverage within three months of the end of the program.

These results were based on analysis of all members with TME at any point between the PHE unwinding and launch of OHP Bridge. While TME was intended to bridge coverage until OHP Bridge became available, some members transitioned out of TME before July 2024 due to temporary income fluctuations, CE protections, and eligibility processing changes related to ongoing ONE system refinements. As a result, TME disenrollments occurred throughout the program period rather than being concentrated at the launch of OHP Bridge. The summative evaluation will examine post-TME transitions separately for members who remained enrolled through July 2024 and members with earlier TME disenrollment.

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Figure 9. Transitions after end of TME coverage



Evaluation question 2e. How do the CE and TME policies impact inequities in enrollment, coverage continuity, and churn?

Sociodemographic compositions of OHP members in the continuously enrolled and churn populations were broadly similar.

In calendar year 2024, the sociodemographic composition of continuously enrolled OHP members was broadly similar to that of all enrolled members across both age-based eligibility groups (Attachment 5). Among members under age six, a higher proportion of those with continuous enrollment had limitations with self-care or independent living (3% vs. 2%). Among members ages 6–64, the sociodemographic composition of continuously enrolled members was similar to that of all enrolled members, except for a slightly higher proportion with limitations with self-care or independent living (21% vs. 19%).

Members with churn also did not differ greatly from total enrolled members in sociodemographic composition, though we observed a few modest differences. Among members under age six, a somewhat higher proportion of those with any churn identified as Latino/a/x/e (31% vs. 28%) or spoke Spanish at home (15% vs. 12%).

Health-Related Social Needs

Summary of Key Findings

Utilization of HRSN services

- From March 2024 to September 2025, 19,495 OHP members received HRSN services.
- After O&E, which is primarily used to help people connect to needed services, Housing (rent and utilities, tenancy support, hotel/motel stays, storage fees, and home accessibility modifications and remediation services) was the most commonly requested and received category of HRSN service in the time frame of this report.
- Receipt of Housing (home changes for health) devices and services peaked in summer 2024 but has since declined.[2]

HRSN implementation

- Implementation of Medicaid HRSN services leveraged existing infrastructure but also required new partners, roles, rules, systems, and workflows.
- HRSN Service Providers, CCOs, and OHA dedicated significant time and resources to capacity building, training, and technical assistance in support of implementation. They reported that clear communication supported collaboration.
- Designated State Health Program (DSHP) funds – delivered through CCBF grants - were critical for building HRSN infrastructure and for enabling the system to respond to developing needs.
- Detailed HRSN eligibility criteria, documentation requirements, and billing rules created a significant learning curve and workload for HRSN Service Providers and CCOs. HRSN guidance changes before and after benefit launch contributed to implementation burden.
- For some HRSN Service Providers, the financial risk of retrospective payment for services created barriers to participation.
- Strategies to address HRSN implementation barriers included changes to eligibility rules and communications, investments in system capacity, payment increases, and ongoing training and technical assistance.

HRSN service delivery

- There are multiple entry points to request HRSN services; CCOs also leveraged existing programs or data to help identify and refer participants.

[2] Different HRSN benefit categories had different start dates: O&E and Housing (home changes for health) began in March 2024; the remaining Housing benefits launched in November 2024 along with expanded O&E, and some Nutrition benefits – medically tailored meals and nutrition education – started in January 2025.

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- CCOs and HRSN Service Providers have adjusted their service delivery roles both proactively and in response to implementation experiences. Role flexibility, including having CCOs perform some HRSN service delivery when needed, appears to be a promising practice for increasing overall capacity to provide HRSN services.
- High demand for rent support and the complexity of benefit operations strained the capacity of HRSN Service Providers and CCOs at times and caused delays in authorizations and service delivery/rent payment, especially in the Portland metro area.

Beneficiary experiences and impacts to date

- Beneficiaries generally found the *initial request* process for HRSN accessible and encountered few difficulties.
- Especially in the first several months and in more urban areas, beneficiaries seeking rent support faced long wait times. These delays contributed to increased stress about housing and finances and, in some cases, limited the ability of the benefit to reduce eviction risk.
- After receiving HRSN services, many beneficiaries reported reduced stress and improvements in mental and emotional well-being.
- People receiving rent & utility benefits generally reported increased housing and financial stability and people receiving Housing (home changes for health) benefits generally reported improved quality of living environments.
- Some HRSN beneficiaries reported health improvements (such as breathing easier with an air filter) or increased time and capacity to focus on getting needed health and self-care; others reported no health changes.

Context and background

Staggered rollout. As noted in Section B and Figure 1, the rollout of HRSN benefits occurred in phases: initial O&E services and Housing (home changes for health) launched in March 2024; the remaining Housing benefits and expanded O&E services[3] began in November 2024; and medically tailored meals and nutrition education benefits started in January 2025. The remaining approved Nutrition benefits—pantry stocking and the fruit & vegetable benefit—began in July 2026. Under Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver, HRSN benefits include:

[3] Initial O&E services focused on identifying and connecting with OHP members who might be eligible for the HRSN services available at that time. Expanded O&E services can also include working with OHP members to obtain the information and documentation necessary to determine their HRSN service needs or receive other benefits and supports, helping members maintain OHP enrollment, and connecting members to other kinds of resources. See Oregon Revised Statutes 410-120-2005 Table 8.

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Housing (excluding home changes for health)

- Help with rent payments
- Tenancy support (help getting resources & services for renters)
- Help with utility setup & payments
- Storage fees
- Home accessibility modifications and remediation services (e.g. wheelchair ramps, grip bars, pest control, etc.)
- Temporary hotel stays during home remediation work

Housing (home changes for health)

- Air conditioner
- Air filter
- Heater
- Mini refrigerator
- Portable power supply

Nutrition Benefits

- Medically tailored meals
- Nutrition education
- Fruits & vegetables
- Pantry stocking

Outreach & Engagement

- Support to connect members to HRSN services & other resources

Eligibility. To be eligible to receive any HRSN service, Medicaid beneficiaries must be experiencing a life transition (e.g. experiencing housing instability or at risk of homelessness, recent exit from inpatient mental health treatment or incarceration, moving from Medicaid-only to Medicare-Medicaid dual eligibility, YSHCN status, and others) and must meet clinical and social risk factors that are benefit-specific (44). For example, conditions that make someone eligible for a device under the Housing (home changes for health) benefit include chronic cardiovascular disease, high-risk pregnancy, or use of medications that impact heat tolerance. Those seeking medically tailored meals must have low or very low food security and have a health condition for which medical nutrition therapy is an indicated treatment. Finally, some HRSN services come with additional eligibility criteria. Housing services are only open to renters who need financial support maintaining their *current* housing; financial support for utilities can only be covered for individuals also receiving rent assistance (Figure 10).

OHA updated HRSN eligibility in January 2026, narrowing the clinical risk factor criteria for rent and utility financial assistance specifically. As of that date, OHP members whose sole clinical risk factor was needing assistance with activities of daily living or high utilization of emergency or crisis services were no longer eligible for rent and utility payments. Also, people qualifying due to having a 'complex health condition' must be engaged in qualifying treatment or support.

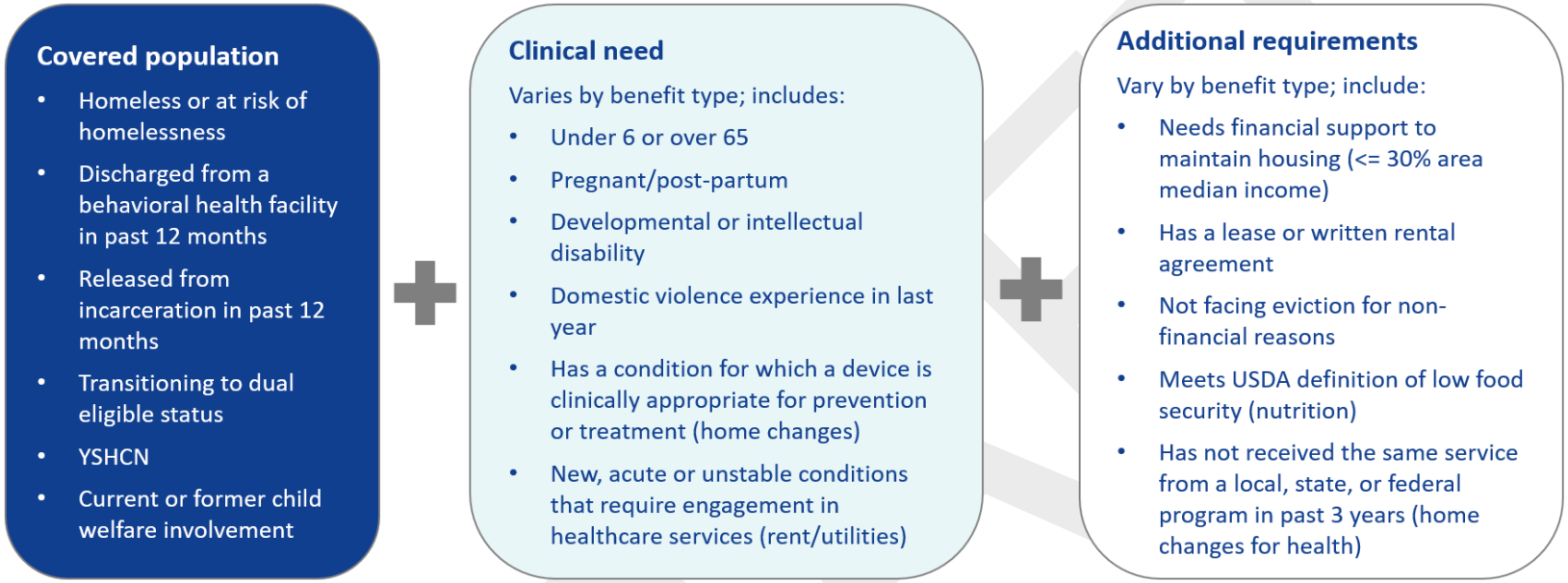
Screening. As an intentional strategy to remove access barriers, Oregon does not require population-level screening as a first step in determining who could or should receive HRSN benefits and did not create a single, standardized screening tool. Instead, OHA specified minimum information that must be collected as part of HRSN requests and provided example forms for organizations to use or modify. Using a 'no wrong door' approach, administrative rules require the state and CCOs to "ensure multiple pathways" to identify people as potentially eligible, including accepting member self-referrals and self-attestations of certain eligibility (44).

Payment and service limits. Oregon established a fee schedule for HRSN services and updated elements of it over time (45). Services such as rent, utilities, or Housing (home changes for health) devices are billed and paid at cost, up to a maximum of 150% of the "expected unit cost" established by OHA. Other services such as tenancy support or O&E services have flat rates per time increment (e.g. per 15 minutes). Service limits vary by service type. For example, Housing (home changes for health) devices can only be provided once per person except in exceptional circumstances. Both rent and utilities can be paid in arrears as well as 'forward,' totaling no more than six months per member for the duration of the demonstration and cannot be split across locations if the recipient/household moves (46).

HRSN infrastructure. For this demonstration, CMS authorized Designated State Health Programs (DSHP) funding to support the development of infrastructure needed to deliver HRSN services. OHA created a CCBF grant program and allocated money to CCOs, who in turn managed a grant application and administration process for prospective or active HRSN Service Providers. OHA made two rounds of CCBF awards, in 2024 and 2025. Funds could support technology, development of business or operational practices, workforce development, and outreach, education, and stakeholder convening.

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Figure 10. HRSN eligibility criteria overview, as of January 2026



Note: Not all criteria are shown. Each HRSN Service has specific eligibility criteria. Not all HRSN Covered Populations are eligible for all services.

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CMS-Approved Research Questions and Logic Model

HRSN Implementation Questions

1. Which key entities are collaborating to implement and operationalize the demonstration, and what are their main roles? How and why have the roles or participation of those key entities changed during the demonstration?
2. What are barriers for key entities implementing the demonstration? What strategies—including but not limited to use of infrastructure investments made possible by DSHP—have key entities used to overcome barriers? What suggestions do key entities have for improving the demonstration?
3. What facilitators and barriers to participation do beneficiaries experience? What does this information suggest about the need for refinements to member and provider outreach as well as demonstration implementation or design more broadly?
4. What strategies and tools do key entities use to identify OHP members with social risk factors and facilitate their participation in the demonstration? How, if at all, and why have key entities adapted these strategies? What did the state learn about promising practices for identifying and engaging potential beneficiaries?
5. How are key entities implementing HRSN case management and providing HRSN services through the demonstration? How do activities vary by service type? What did the state learn about promising practices for delivering services to address beneficiaries' HRSNs? • *5a.* How, if at all, did the demonstration establish a process to share and receive screening results among key entities? How, if at all, have health care providers modified their clinical practice in response to this information? • *5b.* How do key entities form and maintain organizational partnerships to promote integration of health and HRSN services? • *5c.* To what extent is the state integrating the demonstration with its existing programs and infrastructure? What did the state learn about promising practices to support this integration?
6. How is the DSHP program supporting key entities to develop the infrastructure needed to deliver HRSN services? What did the state learn about promising practices to build infrastructure to support HRSN screening, case management, and service delivery?
7. How is the local availability of and investment in social services outside of the demonstration (such as housing supports) changing during the demonstration project? • *7a.* How is enrollment in SNAP and WIC changing during the demonstration among OHP members who are eligible for SNAP or WIC and who receive nutrition-related HRSN services through the demonstration?

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HRSN Evaluation Questions

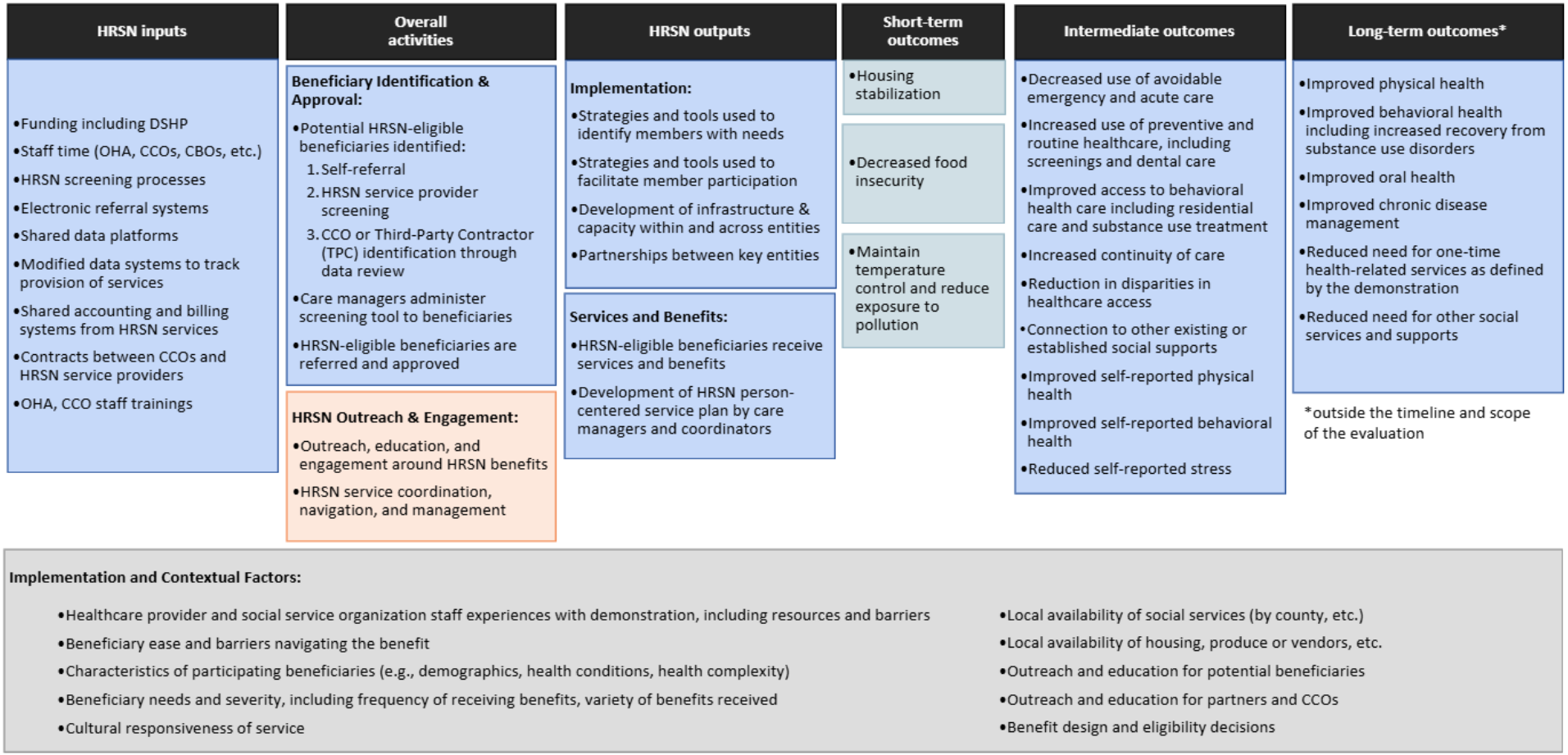
1. The demonstration will meet HRSN and/or reduce the severity of HRSN for beneficiaries overall and among subpopulations who experience inequities in HRSN.
   - *1.1*. How does the HRSN demonstration impact the use of HRSN services?
   - *1.2.* How does the HRSN demonstration impact rates of HRSN and their severities?
     - *1.2a.* How does the HRSN demonstration impact beneficiaries' use of HRSN services reflecting crisis events, such as stays in emergency homeless shelters?
   - *1.3.* How does the HRSN demonstration impact inequities in HRSN?
     - *1.3a.* Does the HRSN demonstration mitigate or reduce HRSN among groups who had high rates at baseline?
     - *1.3b.* Do any groups experience increasing or worsening HRSN compared to the baseline with the implementation of the HRSN demonstration?

2. By meeting or reducing the severity of HRSN, the demonstration will increase beneficiaries' use of preventive and routine care and reduce their use of potentially avoidable hospital care, leading to reduced health care spending over time. Impacts will be realized overall and among subpopulations who experience inequities in hospital care.
   - *2.1.* How does the HRSN demonstration impact the use of preventive and routine care?
     - *2.1a.* How does the HRSN demonstration impact the use of behavioral health services?
   - *2.2.* How does the HRSN demonstration impact the use of hospital and institutional care?
   - *2.3.* How does the HRSN demonstration impact inequities in the use of preventative, hospital, and institutional care?
     - *2.3a.* Does the demonstration reduce use of hospital or institutional care among groups who had high rates at baseline?
     - *2.3b.* Do any groups experience increasing use of hospital or institutional care compared to the baseline with the implementation of the HRSN demonstration

3. By meeting or reducing HRSN, the demonstration will improve physical and behavioral health outcomes among beneficiaries overall and among subpopulations who experience inequities in physical and mental health outcomes.
   - *3.1.* How does the HRSN demonstration impact beneficiaries' physical and mental health outcomes?
   - *3.2.* How does the HRSN demonstration impact inequities in health outcomes?
     - *3.2a.* Does the HRSN demonstration improve the physical and behavioral health outcomes of groups who had poor health outcomes at baseline?
     - *3.2b.* Do any groups experience worsening physical and behavioral health outcomes compared to the baseline with the implementation of the HRSN demonstration?

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Figure 11. HRSN logic model



Research questions included in this report

We present a descriptive overview of the population receiving HRSN services through September 2025, including number of HRSN service requests, number and characteristics of people receiving services, category and types of services received, and distribution of services (evaluation question 1). Quantitative analysis to answer the remaining evaluation questions will be reported in the summative report; it is not included in the interim report as full data are not yet available.

We also provide preliminary and/or partial findings for all HRSN implementation questions except question 7a, and for several of the HRSN evaluation questions related to the impact of HRSN services, specifically evaluation questions 1.2, 1.2a, 2.1, and 3.1. Preliminary qualitative findings are based on interviews conducted between August 2025 and March 2026 with OHP members who received HRSN services, two rounds of interviews and one round of an online discussion board with key entities involved in HRSN implementation in fall 2025 and early 2026, as well as a document review. This qualitative data collection will continue, and new findings will be included in the summative report, along with findings from a survey of HRSN recipients which is currently open and collecting responses. Finally, the preliminary HRSN results also include initial findings about the investment in and availability of social services outside the demonstration (implementation question 7), based on an environmental scan which will be repeated in future years.

HRSN implementation question 7a, which relates to changes in SNAP and WIC enrollment for OHP members who receive nutrition-related HRSN services, is not included in this interim report because the nutrition benefit had not been fully launched during the study period. We will address HRSN implementation question 7a in the summative evaluation report. Similarly, evaluation questions that require subgroup analysis (e.g. HRSN evaluation question 1.3) will be covered in the summative report once sufficient data has been collected.

For a complete overview of data and analysis included in the interim report, see Section C.

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Study Population

Quantitative data - OHP member study population. Between March 2024 and September 2025, OHA distributed HRSN services to 19,495 OHP members. Table 7 shows the demographic characteristics of OHP members receiving HRSN services. Over half of HRSN recipients were adults ages 35 to 64 and almost two-thirds were female. The largest racial identity was white (54.6%), followed by Latino/a/x/e (15.7%), and Black/African American (11.3%). HRSN recipients were most likely to report using English at home (89.0%), followed by Spanish (7.4%). Approximately two-thirds of HRSN recipients lived in urban areas.

Over a third of HRSN recipients report having an independent living/self-care disability (34.3%). Less than half of HRSN recipients reported being non-disabled (42.6%).

Figure 12 shows the CCO (or Open Card/fee-for-service) plan that an OHP member was enrolled in when they received their first HRSN service. It also shows the total proportion of the Oregon Medicaid population served by each plan, as measured in January 2025. A map of the geographical location of CCOs in Oregon can be found on the OHA website.

Health Share of Oregon had the largest share of HRSN recipients

Table 7. Characteristics of 19,495 OHP members receiving HRSN services, March 2024 – September 2025

	N	%
Age Group at First Service		
Under 18	1,379	7.1%
18 – 34	5,323	27.3%
35 – 64	10,528	54.0%
65 +	2,141	11.0%
Unknown	124	0.6%
Sex		
Female	13,013	66.7%
Male	6,474	33.3%
Unknown	8	<0.1%
Race/Ethnicity		
American Indian/Alaska Native	982	5.0%
Asian	623	3.2%
Black/African American	2,196	11.3%
Latino/a/x/e	3,061	15.7%
Native Hawaiian & Pacific Islander	315	1.6%
Middle Eastern/North African	208	1.1%
White	10,648	54.6%
Multiple/Other	145	0.7%
Unknown	1,317	6.8%
Language Used at Home		
Chinese (Cantonese or Mandarin)	64	0.3%
English	17,354	89.0%
Russian/Ukrainian	72	0.4%
Spanish	1,440	7.4%
Vietnamese	67	0.3%
Other language	472	2.4%
Unknown	26	0.1%
Geography		
Frontier	474	2.4%
Rural	5,828	29.9%
Urban	12,975	66.6%
Unknown	218	1.1%
Disability		
Non-disabled	8,307	42.6%
Independent living/self-care disability	7,297	37.4%
1 Limitation	1,961	10.1%
2+ Limitations	1,506	7.7%
Unknown	424	2.2%

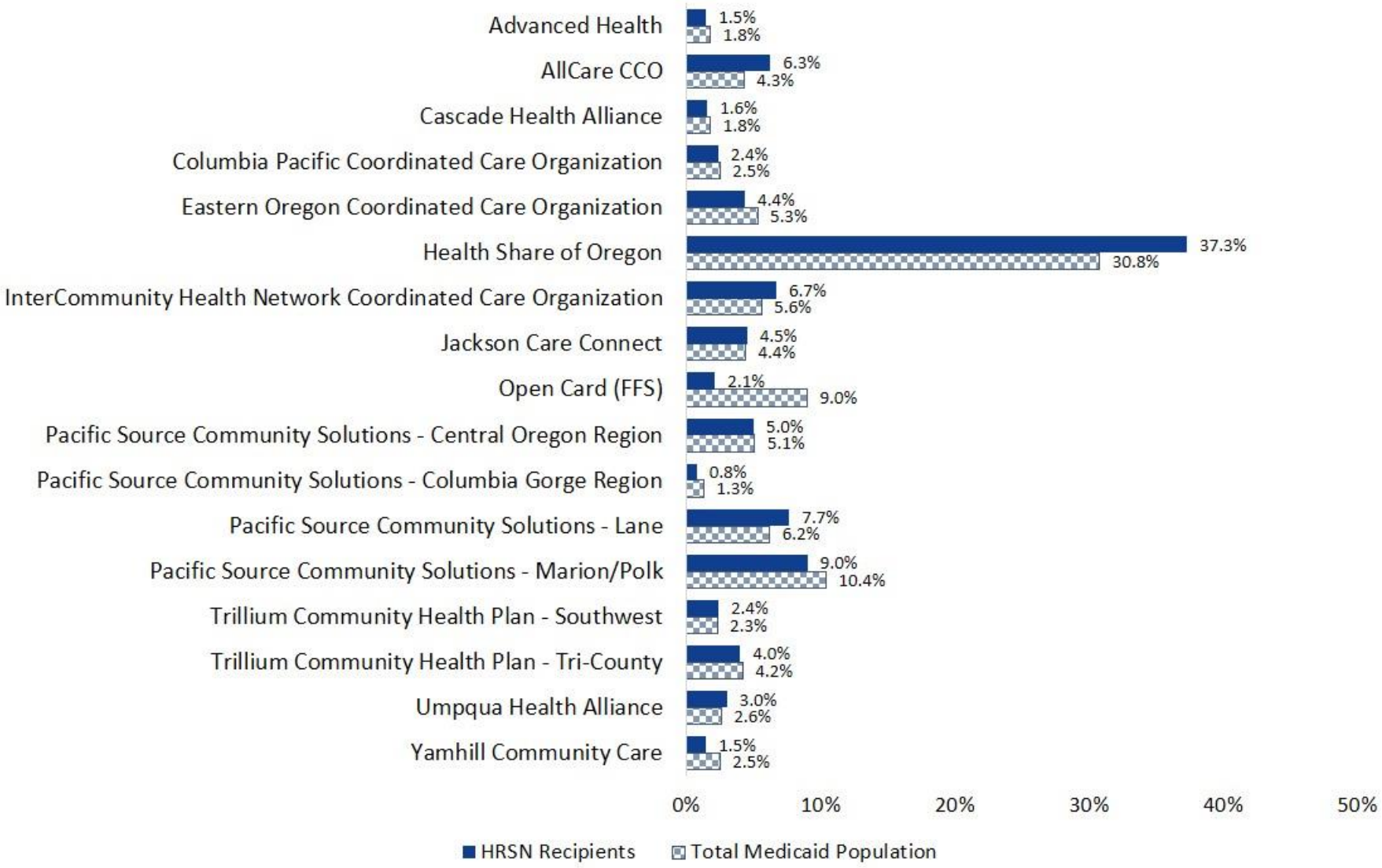
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(37.3%), followed by Pacific Source Community Solutions – Marion/Polk (9.0%), Pacific Source Community Solutions – Lane (7.7%), and InterCommunity Health Network CCO (6.7%). This is generally reflective of the distribution of the Medicaid population across CCOs, although Health Share, AllCare, InterCommunity Health Network, and Pacific Source Lane were slightly overrepresented in terms of their proportion of HRSN recipients relative to their proportion of Medicaid enrollees. Additionally, there is a substantially lower number of HRSN recipients on Open Card (2.1%) relative to the proportion of OHP members on Open Card (9.0%).

Of note, Pacific Source Community Solutions discontinued their contract and stopped serving OHP members in Lane County in Q1 2026; OHP members in this region will be absorbed into Trillium Community Health - Southwest.

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Figure 12. HRSN Recipient by CCO



Qualitative data - OHP member sample.

Between August 2025 and March 2026, we contacted 270 OHP members who had received HRSN services and conducted interviews with 49 people, for a response rate of 18%. Quotas were designed to match the distribution of services received by the full HRSN population, focusing on Housing (home changes for health), Housing benefits (excluding home changes for health), and Nutrition. No quota was set for individuals receiving only O&E benefits, but those individuals were not excluded from the sample. For geography and race/ethnicity, we set quotas to ensure a minimum representation of members in rural and frontier areas, and from diverse racial and ethnic groups, with the goal of having enough participants in these groups to allow for sub-group analysis in the summative report.

Characteristics of the 49 HRSN member interview participants are shown in Table 8. Among OHP member interviewees, the largest known racial identity was Latino/a/x/e (N=10), followed by Black/African American (N=6) and Native Hawaiian & Pacific Islander (N=5). OHP member interviewees were approximately evenly distributed across geography types, with a slightly higher number in urban areas.

Table 8. Characteristics of OHP member HRSN interview participants, August 2025 – March 2026

	N = 49
HRSN service category*	
Housing (home changes for health)	23
Housing (excluding home changes for health)	22
Nutrition	4
Outreach & Engagement	22
Race/Ethnicity	
American Indian/Alaska Native	6
Asian	4
Black/African American	6
Latino/a/x/e	10
Native Hawaiian & Pacific Islander	5
Middle Eastern/North African	2
White	3
Multiple/Other	4
Unknown	9
Gender	
Female	36
Male	13
Age Group	
18-34	7
35-64	40
65+	2
Language spoken at home	
English	44
Spanish	4
Other	1
Geography	
Frontier	15
Rural	15
Urban	19

* Members may have received more than one category of service

Qualitative data - Key entity sample.

Over the two rounds of HRSN key entity interviews, we recruited 55 individuals and completed 31 interviews with 34 people (some interviews had more than one participant), for a response rate of 62%.

Out of the 126 individuals for whom accounts were created on the discussion board platform, 60 posted to the online discussion board, for a response rate of 48%. The characteristics of HRSN key entities who participated in interviews and/or the online discussion board are shown in Table 9. CCOs and HRSN Service Providers made up 44% and 35% of interview participants respectively (N=15 and N=12), whereas OHA staff represented about 20% (N=7). Among HRSN Service Providers participating in either interviews or discussion boards, O&E and Housing (excluding home changes for health) were the most common service categories provided. Many HRSN Service Providers offer multiple types of service and so are counted in more than one category.

Table 9. Characteristics of HRSN Key entity interview and discussion board participants, August 2025 – March 2026

	Interviews	Discussion Boards
Key entity type	**N = 34**	**N = 60**
CCO	15	11
HRSN Service Provider	12	49
OHA staff	7	N/A
Benefit category provided (HRSN Service Providers only)*		
Outreach & Engagement	11	35
Housing (excluding home changes for health)	7	37
Housing (home changes for health)	6	9
Nutrition	7	7

* HRSN Service Providers may count in more than one category if they offer multiple services; benefit category represents the services organizations listed at provider enrollment and may not reflect services they are actively providing through HRSN.

Results

Evaluation question 1.1. How does the HRSN demonstration impact the use of HRSN services?

Between March 2024 and September 2025, 19,495 OHP members received HRSN services.

19,495 OHP members received HRSN services between March 2024 and September 2025

Between March 2024 and September 2025, OHA provided HRSN services to 19,495 OHP members. Figure 13 shows the number of recipients per month during this time frame. Individuals could receive some services (e.g. rent and utilities) in multiple months and could receive multiple categories of services (e.g. Housing and Nutrition services). Because of this, the overall line is not equal to the sum of each of the presented HRSN service categories but rather represents the overall number of individuals who received an HRSN service each month, regardless of how many services they received in that specific month.

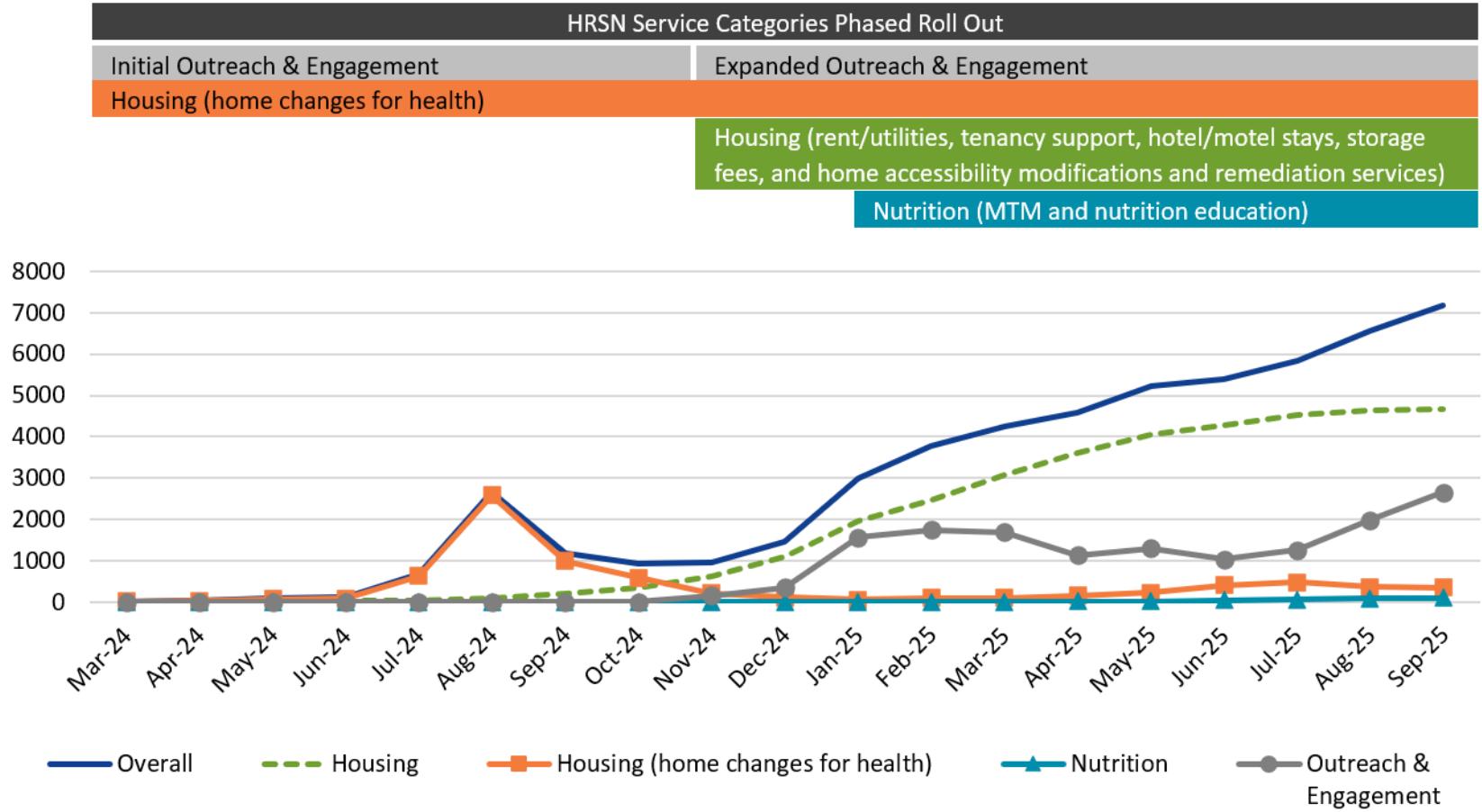
As discussed in the HRSN Context and background section above, HRSN benefits were rolled out in phases: initial O&E services and Housing (home changes for health) in March 2024; expanded O&E services and the remaining Housing benefits in November 2024[4]; and medically tailored meals and nutrition education benefits in January 2025. There was a peak in OHP members receiving Housing (home changes for health) devices during the summer of 2024, shortly after that service category launched. During each month of 2025, most individuals who received HRSN received some type of housing support (likely rent and utilities), with the number of recipients steadily rising. In contrast, nutrition remained low, likely due to both the narrower eligibility criteria for medically tailored meals and the fact that the pantry stocking and fruit & vegetable benefits had not launched during the evaluation window for this interim report.

Although Housing (home changes for health) devices are a subcategory of the Housing benefit, we present them separately from the remaining Housing services (rent/utilities, tenancy support, hotel/motel stays, storage fees, and home accessibility modifications and remediation services) in the quantitative results for two reasons: they launched eight months earlier than the remaining Housing services; and they represent a conceptually distinct subcategory of Housing services focused specifically on providing medically necessary devices used to support health during extreme weather.

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[4] Some Housing benefits appear on the figure before November 2024; this is because the rent/utility benefit could be used to pay for arrears.

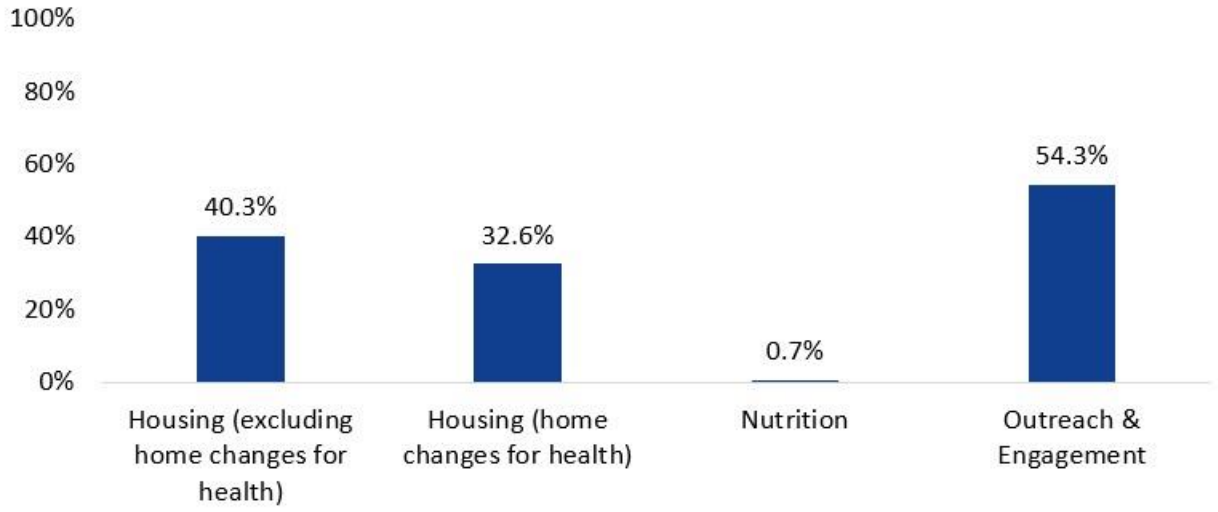
Figure 13. HRSN recipients by month



Housing (excluding home changes for health), Housing (home changes for health), and O&E services were all commonly received HRSN categories; Nutrition services had the lowest number of recipients.

Figure 14 shows the proportion of HRSN recipients who received each service category or subcategory of Housing (excluding home changes for health), Housing (home changes for health), Nutrition, or O&E. Members can receive multiple service categories and therefore may be represented in multiple bars on the graph. Fifty-four percent of HRSN recipients (N=10,590) received O&E; the next most common category was Housing (excluding home changes for health) at 40.3% (N=7,865). Nutrition was received by less than one percent of recipients (N=136); it was also the last of the service categories to launch and was only partially rolled out during the evaluation window of this report.

Figure 14. Percent of HRSN recipients who received each category or subcategory of services (N=19,495)



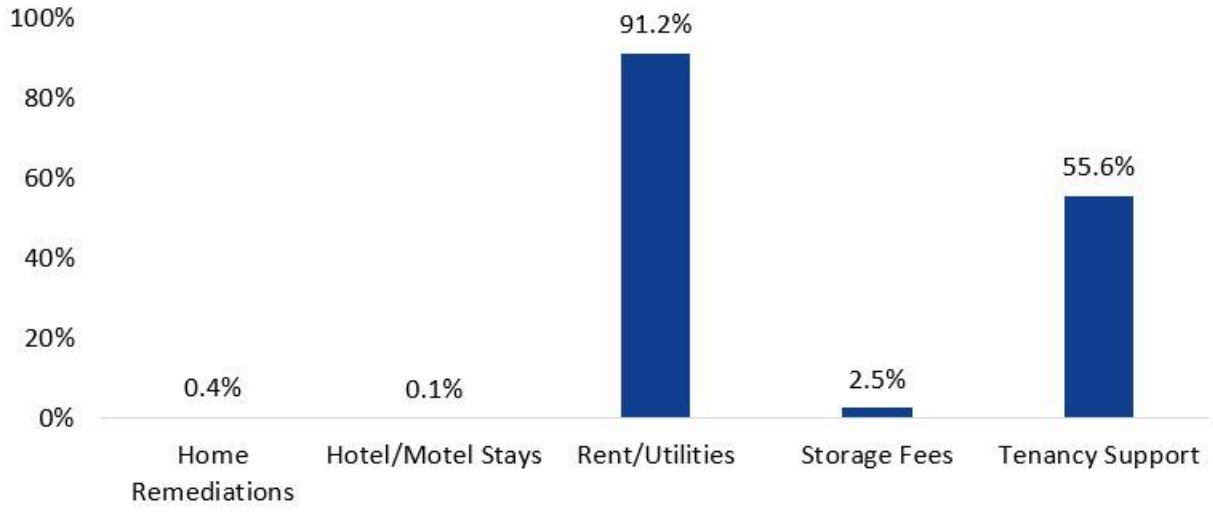
Full demographics of HRSN recipients by HRSN category type are available in Attachment 5.

Rent and utilities were the most commonly received Housing service (excluding home changes for health); air conditioners were the most commonly received Housing (home changes for health) devices; and medically tailored meals were the most commonly received Nutrition service.

Figures 15 through 17 show the types of Housing services, Housing (home changes for health) devices, and nutrition services received by HRSN recipients. HRSN recipients can receive multiple types of each device/service, and so can be represented on multiple bars within each graph.

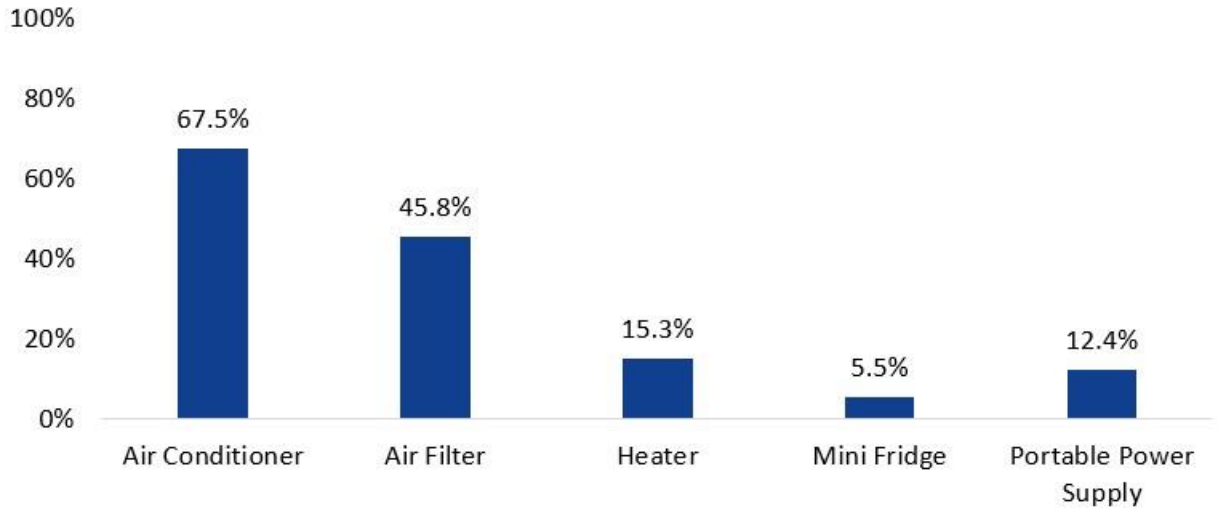
Within the Housing category (Figure 15), rent/utilities were the most commonly used service at 91.2% of Housing recipients (N= 7,170), followed by tenancy support services at 55.6% of Housing recipients (N=4,376). Forty-nine percent (N= 3,818) of Housing recipients received both rent/utilities and tenancy support.

Figure 15. Percent of Housing recipients (excluding home changes for health) who received each type of service (N=7,865)



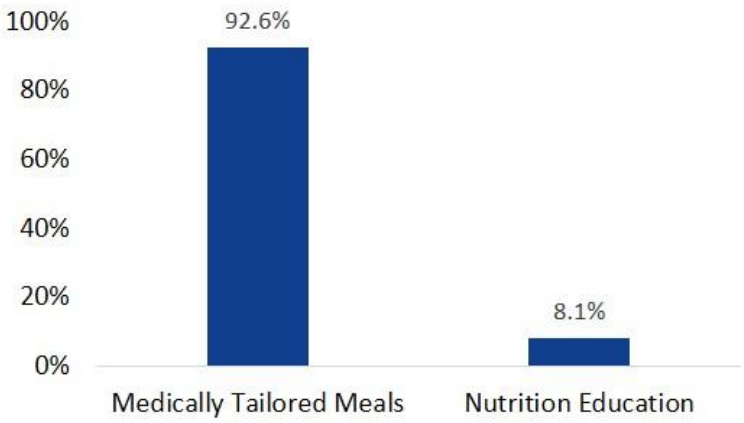
Within the Housing (home changes for health category) (Figure 16), air conditioners were the most common devices (67.5%, N=4,743), followed by air filtration devices and air filter replacements (45.8%, N=3,330). The most common combination of devices was receipt of an air conditioner and air filter (N=900, 14.0% of home changes for health device recipients), followed by receipt of an air conditioner, air filter, and heater (N=207, 3.3% of home changes for health device recipients). Approximately 1% (N=66) of Housing (home changes for health) device recipients received all five device types.

Figure 16. Percent of Housing (home changes for health) recipients who received each type of device (N=6,347)



Within the Nutrition category (Figure 17), almost all recipients (92.6%, N=126) received medically tailored meals, as this was the main nutrition benefit that had launched during the March 2024 – September 2025 data timeframe.

Figure 17. Percent of Nutrition recipients who received each type of service (N=136)



Implementation question 1. Which key entities are involved in implementing HRSN and how do roles change over time?

HRSN Service Providers, CCOs, and state officials have the largest roles, but many others are involved in HRSN implementation.

The three largest groups of key entities and their main roles in HRSN implementation are:

- **OHA—**with input from state agency partners such as Oregon Housing & Community Services—sets statewide policy (e.g. eligibility criteria, benefit design, data reporting

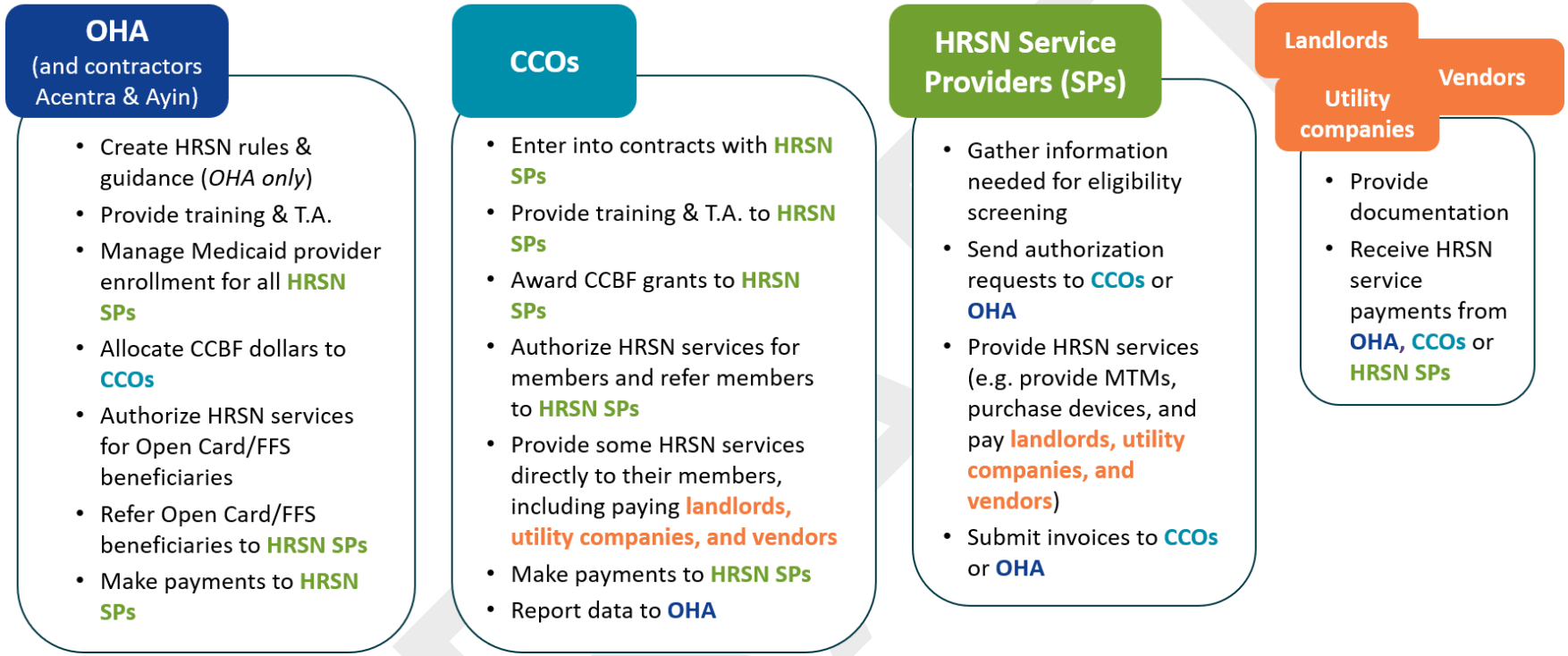
requirements), provides capacity building funds, offers training, guidance, and technical assistance to partners, does general communication and education about HRSN, and works with existing third-party contractors (Acentra and Ayin) to manage HRSN authorizations (Acentra) and payments (Ayin) for the Open Card/fee-for-service population.

- **CCOs** interpret and implement policy, make final HRSN eligibility determinations, HRSN service authorizations, and referrals for their members, establish contracted networks of HRSN Service Providers, offer training and support to service providers (including managing capacity building grants), receive invoices and reimburse service providers, and submit HRSN encounter and other data to OHA.
- **HRSN Service Providers** —typically community-based organizations and social service providers—often accept inquiries and gather information needed for eligibility screening (O&E support), deliver services (e.g., make rent and utility payments on behalf of authorized beneficiaries, provide tenancy support or medically tailored meals, facilitate home remediations), track and bill for their services, and receive and reconcile payments. OHA reporting indicates that the number of organizations providing HRSN benefits grew from 31 in July 2024 to 137 as of December 2025, with particularly rapid growth between October 2024 and April 2025 (47).

In addition, Unite Us has a major role as the community information exchange (CIE) vendor that many CCOs/regions are using for HRSN referrals and sometimes for billing. (A second CIE called Findhelp has a much smaller user base in Southern Oregon.) Other important key entities with narrower roles include landlords/property managers and utility providers who receive rent and utility payments, registered dieticians and other health care providers who refer or support clients to request HRSN services, state or community agency caseworkers who also assist with requests, vendors (including IT and business process vendors at CCOs and HRSN Service Provider organizations), and consultants (e.g., policy implementation consultants to OHA). See Figure 18 for an overview of key entity roles in HRSN implementation.

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Figure 18. Roles of key entities in HRSN implementation



Key entity participation was shaped by entities' assessment of capacity.

Just as they do for contracts with health care providers, CCOs made decisions about which HRSN Service Providers to include in their networks. CCOs reported weighing several factors in contracting decisions, including provider readiness to manage the complexities of HRSN eligibility and billing, the volume and types of clients that the provider could serve and the amount of reimbursement that would generate, as well as the CCO's own capacity for contract management and support.

> *"I think we heard a lot of that messaging from OHA right away, like, 'Find those little mom and pop providers and build them up to have the capacity they need.' For some organizations, that's just not realistic. They're not operating to the degree that they can be tracking, and monitoring, and billing, and doing this really high volume of documentation with the staff that they have on top of the work that they're doing and have it be worth it. They're not going to make enough money in reimbursement to be able to pay their staff in the long-term." - CCO*

For their part, potential HRSN Service Providers were often interested in participation because the demonstration aligned with their existing mission or programming and offered the potential for more stable revenue. But they had to consider whether they would receive enough referrals to hire and/or maintain needed staff and whether they could afford the risk of a "service first, reimbursement later" medical payment model.

> *"Our CCO was fabulous in getting us all online and equipped with the OHA forms and approvals, etc. However, we learned quickly that we are too small to be successful." - HRSN Service Provider*

In some cases, CCOs have elected to decline or delay contracts with smaller potential providers and/or ones with less operational infrastructure. To the extent that these providers focus on serving culturally specific populations, this may reduce access for some OHP members. At least one culturally-specific provider reported that they were unable to get a CCO contract and only provided HRSN services to Open Card/FFS beneficiaries. However, several CCOs also reported explicitly designing their HRSN networks to include providers trusted by different populations (e.g. Spanish-speaking OHP members.)

CCO roles differ by HRSN benefit category.

One notable role difference across HRSN benefit categories is that many CCOs have elected to manage the Housing (home changes for health) benefit themselves, rather than working with contracted HRSN Service Providers to deliver the service. In this case, CCOs typically use a vendor like Amazon, Lowe's, or a local hardware store to purchase and have the relevant device (e.g., air filter) delivered. An HRSN Service Provider or local contractor may be involved if the

member requested installation services. Many CCOs had prior experience providing environmental health supports as part of their community benefit activities or via member-level Flexible Services (48). (Flexible services are services not covered under the Medicaid State Plan that are intended to improve care delivery and overall member and community health and well-being. Flexible services are funded by CCOs under their global budgets.)

CCOs and HRSN Service Providers have adjusted their roles both proactively and in response to capacity constraints and implementation experiences.

Some key entities intentionally shifted their HRSN roles over time as an incremental implementation strategy. For example, one CCO decided to make rent and utility payments themselves for the first several months to build a good understanding of the process before contracting that function out to HRSN Service Providers. Similarly, some HRSN Service Providers started by offering one service (e.g., tenancy support) or working with one CCO before considering expanding to other benefits or populations (e.g., rent, or Open Card/FFS beneficiaries).

CCOs and HRSN Service Providers have also adjusted their roles when needed to increase capacity. For example, one CCO moved all HRSN services except tenancy support in-house for a period when its HRSN Service Provider network was at capacity.

> *"[We] jumped in when our network was pretty much closed to any new capacity. We ... started making members' rent payments and utilities payments ... Then, we would try to quickly move members to a CBO partner who could provide them that true tenancy support that they needed that we didn't have the expertise to provide." - CCO*

In 2025, several CCOs increased internal capacity for housing authorizations and payments in response to service backlogs (see also HRSN implementation question 6). Finally, some key entities reported making role adjustments as they learned more about what worked and what did not. For example, one CCO initially asked an HRSN network partner to help with indicating whether HRSN or Flexible Services would be the best mechanism to meet a beneficiary's request. The partners later determined that the role was not a good fit with the organization's existing resource referral model.

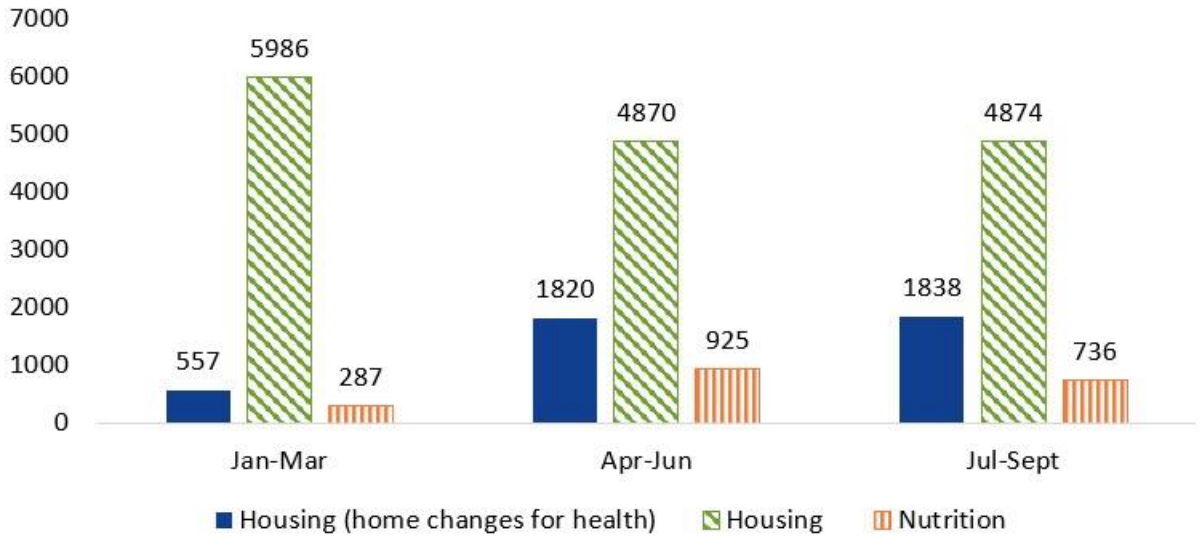
Implementation question 2. What barriers have key entities encountered in implementing HRSN and what mitigation strategies or improvement suggestions have they identified?

Demand for housing support quickly exceeded system capacity.

The level of demand for HRSN services, specifically rent support, was considerably higher than most key entities anticipated. Many CCOs and HRSN Service Providers received a very high number of requests or referrals and struggled to manage the volume. To illustrate the volume of services, Figure 19 gives the number of HRSN service requests per quarter for the nine months

from January through September 2025 (the months of the evaluation window for which data on HRSN requests is systematically available).

Figure 19. HRSN service requests by HRSN category/subcategory and quarter, January - September 2025



From January to September 2025, CCOs/OHA received a total of 15,730 requests for a Housing (excluding home changes for health) HRSN service, more than twice the number of OHP members actually receiving that category of service in that timeframe. This figure likely under-represents the demand because it does not include at least 7,000 members who were pre-screened but for whom a formal request for services was not logged (49). Demand for rent support (or need, as some key entities noted) was particularly strong in the Portland Metro region but key entities in other parts of the state also noted high demand. And while requests for other HRSN services were lower overall, there were times of acute demand for cooling devices during extreme heat.

"The sheer volume of applications, I don't even know what the right word is for that, was so overwhelming from moment one, from November 1st at midnight when this turned on." - CCO Staff speaking about the Housing benefit

"When we were actually forecasting how many staff we might need to process the intake, it was based on maybe 200 requests per week, not 1,000 requests per week. 50% of our contact volume any day of the week is about housing."
- HRSN Service Provider

Like many states, Oregon has a shortage of available rental housing and has experienced rapid increases in rent costs since the COVID-19 pandemic; these factors likely explain much of the high demand for housing supports (50). But some CCOs and HRSN Service Providers also felt

that early communications about HRSN did not contain enough eligibility detail and therefore encouraged non-qualified individuals to apply. State strategies such as not requiring a standardized screening tool and allowing member self-referrals (see HRSN Context and background) were important from an equity perspective but may have also contributed to the high demand.

HRSN benefits were complex to administer, especially early on.

Many key entities reported that HRSN rules and operations were complex to learn and implement. The complexity stemmed from multiple factors:

- *Learning new systems and ways of working*. Key entities involved in HRSN implementation faced an entirely novel set of benefits and new provider networks in every region of the state. Organizations had to establish new workflows and practices and adjust existing ones. Coming up to speed on all the new processes was a substantial effort for everyone involved. The learning curve was particularly steep for HRSN Service Providers with no previous experience of the exacting nature of Medicaid eligibility, service, and billing rules.

  > *"Turns out, when you medicalize something that's not medical, it's really challenging. At the same time, you're asking our social health networks and CBOs, social safety net providers, nonprofits to implement a benefit that's been heavily medicalized. The learning curve is very big." - CCO*

- *Complicated, multi-part eligibility and coverage rules that varied by service type*. The multi-step eligibility criteria for HRSN services (see HRSN Context and background) were tricky for CCOs and HRSN Service Providers to learn and to explain to applicants. Some CCOs and HRSN Service Providers found that people were getting different information from the different agencies they contacted in search of services. Coverage rules for utility services were particularly complex and difficult to reconcile with the service periods on utility bills (e.g., utility arrears can be paid only when the person is currently receiving rent assistance; ongoing or 'forward' utilities must cover a period equal to or shorter than forward rent; and utilities had to be paid for consecutive months).

  > *"Challenges with eligibility screening include the many levels of criteria and the differing criteria between benefits; it makes communicating to community members about the benefits very challenging and also creates a steep learning curve for staff wanting to provide O&E services." - HRSN Service Provider*

- *Changing rules and guidance*. OHA made adjustments and issued clarifications as design and implementation issues arose, but these "frequent changes" were also commonly described by CCOs and HRSN Service Providers as barriers, since they prompted

workflow and system reconfigurations and sometimes made it difficult to make informed decisions about contracting.

> *"It's been a lesson in adaptability because there have been so many changes before it rolled out and then during rollout. … We had to be adaptable because it was week-to-week changes in processes and in criteria for who's going to be included, including now with the RAC* [Rules Advisory Committee] *and the new rules that are going to roll out, they have a whole new set of criteria around housing that we're all going to have to now adapt to." - CCO*

- *Not fully leveraging the knowledge of experienced social service providers*. Some key entities, including but not limited to HRSN Service Providers, felt that implementation would have been smoother and processes less complex if people with on-the-ground experience had had a stronger influence in design and implementation planning phases.

> *"When I first started, I felt deeply confused at some of the lack of insight that was imbedded in this guidance, since I - as someone who has worked in housing social services for years - could have anticipated many of these problems at the outset." - HRSN Service Provider*

- *Differences between CCOs (managed care) and Open Card/fee-for-service*. Oregon's community-specific managed care model gives each region the flexibility to develop processes that work well locally. But HRSN Service Providers working with more than one CCO or serving both CCO members and Open Card/FFS beneficiaries sometimes experienced frustrating differences in workflows, guidance, and levels of support.

> *"We serve two CCOs. One is communicative, supportive, available, clear, and thorough in their communication and work. The other is CCO staff is non-responsive and has taken far longer to learn the HRSN rules and provides less support to HRSN Service Providers serving their members." - HRSN Service Provider*

- *Early data system shortcomings*. As described under HRSN implementation question 1, the Unite Us platform was widely used for HRSN screening and authorization, closed-loop referrals, and billing. But it took several months for Unite Us to incorporate HRSN-specific rules and functions, and the adoption date for new functionality differed across CCOs. Initial system shortcomings, such as fields necessary for a complete invoice not being required for data entry, created difficulties for HRSN Service Providers and CCOs. Some HRSN Service Providers also felt that Unite Us was not responsive to their concerns because community-based organizations do not contract with and pay Unite Us directly for access to the platform in the way that CCOs and health systems do.

> *"Some OHA requirements (submitting 2 modifiers) are not functional within Unite Us and require manual workaround and fixes on the back-end by the CCO. Other items that are required are not marked as such in Unite Us and result in invoice rejections to complete additional information. Unite Us aligning with OHA requirements and not allowing submission until those fields are completed would help with the back and forth." - CCO*

Combined, high demand and complexity created challenges and delays at almost every stage of benefit delivery.

- *Network development:* In some regions, there was a limited pool of organizations with the ability to handle the operational demands of HRSN and/or the large number of clients. Credentialing non-traditional providers required new processes at CCOs, and the complexity of the benefit meant that prospective service providers needed substantial on-boarding and training support before being ready to offer services.

> *"The biggest challenge we've faced [for network development] is definitely in terms of organization size, infrastructure available, readiness to take on the work." - CCO*

- *Outreach*: Because the volume of incoming referrals and requests alongside was often more than they could manage, CCOs and HRSN Service Providers had very limited capacity for proactive outreach to people who were potentially eligible for HRSN services. Housing (home changes for health) services were a partial exception to this finding (see HRSN implementation question 4).

- *Eligibility and authorization*: Deciphering and communicating HRSN eligibility criteria and obtaining the documentation needed for service authorization (e.g., a written lease for rent support) was often very time-consuming. These steps required clear and timely communication between service providers, OHP beneficiaries, CCOs, and landlords or utility companies, but people could be hard to reach and miscommunications were not uncommon. High demand put additional pressure on communications and eligibility processes, resulting in significant backlogs and delays in HRSN service authorizations (see also HRSN implementation question 3).

> *"The structure of them [eligibility criteria] are so complicated. With the different units of service and the time and the consecutive, and there's just so much. ... It is really pretty fascinating how much time it takes to figure out what the benefit should be for the person's circumstances." - OHA*

- *Service delivery*: HRSN Service Providers or CCOs making rent or utility payments on behalf of OHP members had to establish payment arrangements with numerous different landlords and utility providers and some encountered barriers as a third-party payor (see also implementation question 5). Providing medically tailored meals involved

several communication and logistics steps including personalized meal planning, meal preparation and packaging, storage, and delivery or shipping. Combined with high demand and network capacity constraints, complications at the service delivery stage contributed to significant wait times between authorization and receipt of HRSN services (see also HRSN implementation question 3).

- *Billing and payment*: Many HRSN Service Providers had not previously worked in a fee-for-service payment environment and found HRSN billing rules and processes complex and challenging to implement. It was not uncommon for HRSN Service Providers to experience a high number of rejected invoices/claims, at least in the first several months of their participation. Some HRSN Service Providers also found that reimbursements were slow to arrive.

  > *"It took many months for reimbursement payments to start being made to our organization. We are still owed a significant amount." - HRSN Service Provider*

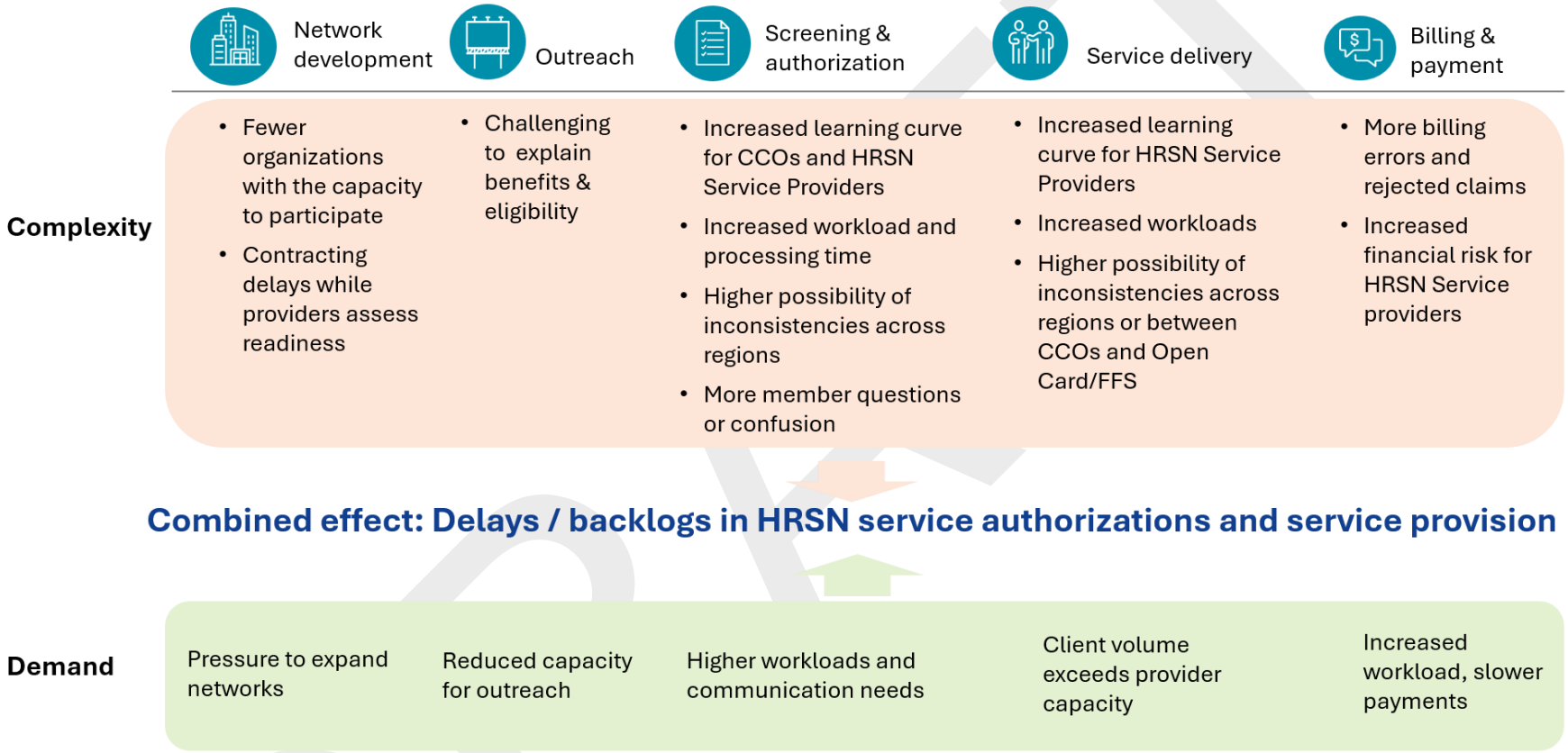
- *Across stages*: HRSN Service Providers also described having to perform duplicate data entry or manual-cross checks across different data systems. These data systems included HRSN Service Providers' own internal client management platforms, databases used for other, non-Medicaid programs (e.g., the Homeless Management Information System or HMIS), Unite Us or CCO provider portals, and separate interfaces with OHA's two contractors for the Open Card/FFS population.

As one CCO interviewee said, *"It [HRSN implementation] was and continues to be an extraordinary lift."*

Figure 20 summarizes how high demand and complexity affected different stages of HRSN service delivery, and the combined impact.

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Figure 20. How demand and complexity negatively impact HRSN service delivery, by stage



Financial risk and inadequate reimbursement were barriers for some HRSN Service Providers.

Many HRSN Service Providers were accustomed to receiving up-front funding to offer programs or services. In contrast, payment for HRSN services is retrospective. The advance expenditure (e.g., paying months of rent and utility arrears for multiple clients, or purchasing many Housing (home changes for health devices)) could be significant. This arrangement created financial risk for HRSN Service Providers that was compounded by authorization errors and billing difficulties.

> *"We are taking on a lot of risk with the current process and no financial safety net to help when a client is accepted but later denied. There is also a large amount of administrative burden with fairly low service payment." - HRSN Service Provider*

In addition, some HRSN Service Providers felt that reimbursement amounts and maximum service thresholds for O&E services were too low to fully cover the "indirect" administrative work that goes along with providing an HRSN service including preparing invoices, reconciling payments, and resolving rejected claims. Many relied on Community Capacity Building Fund (CCBF) awards to close the gap (see also HRSN implementation question 6).

> *"Without CCBF funding, we would not be able to provide this service. The fee for service revenue is inadequate to sustain our program. As it stands, we are at risk of not being able to continue implementation when CCBF funds are exhausted."*
> *- HRSN Service Provider*

Mitigation and improvement strategies.

Mitigation of HRSN implementation barriers included changes to communications and eligibility rules, investments in system capacity, process improvements, payment increases, and significant ongoing training and technical assistance. See Figure 21 for a visual overview.

In response to the high demand for housing support and associated delays, OHA updated public communications to emphasize that the Housing benefit was not intended for emergency situations and that not everyone would qualify. In January 2026, the state tightened eligibility for housing services by removing or modifying some of the qualifying clinical risk factors and requiring active engagement with relevant treatment or supports for people eligible because of a complex health condition. This change arguably makes eligibility criteria more consistent with the aims of HRSN but is also effectively a mitigation strategy for the large volume of requests.

HRSN Service Providers and CCOs added staff or contracted with other groups to help meet the demand by processing requests, services, and invoices. This workforce expansion was often achieved with the support of infrastructure investments made possible by DSHP, including an expedited release of funds and new flexibilities introduced by OHA in 2025 specifically to increase capacity to deliver housing services (see HRSN implementation question 6).

Figure 21. Overview of mitigation strategies

Implementation Barrier	Mitigation strategies
High demand	• OHA clarified communications around rent benefit and tightened eligibility • OHA expedited release of CCBF funds in 2025 to both HRSN Service Providers and CCOs to deal with backlog of rent requests • OHA conducted outreach & recruitment for HRSN Service Providers • CCOs and HRSN Service Providers expanded HRSN workforce • CCOs adjusted caseloads across providers where possible
Operational complexity	• OHA and CCOs offered extensive support, training, and guidance • HRSN Service Providers shared feedback and improvement suggestions • OHA worked with CCOs to assess root causes of complexities and introduced some coverage and payment flexibilities • Launch and improvements to HRSN-specific modules in Unite Us; plans to use Unite Us for closed-loop referrals for Open Card/FFS population
Financial risk and inadequate reimbursement	• OHA updated billing guidance and added some flexibility • OHA increased reimbursement for some HRSN services • Many CCOs worked closely with their contracted HRSN Service Providers to prevent and resolve billing issues

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Several CCOs monitored HRSN Service Provider caseloads closely and adjusted referrals between providers when possible to help manage demand. In some cases when members were not eligible for HRSN, CCOs and HRSN Service Providers were able to use other resources to address beneficiaries' needs. These resources included CCO Flexible Services, local eviction prevention funds, or existing utility assistance programs. One CCO used their Flexible Services mechanisms to rapidly distribute a large number of air conditioners during a 2024 heat emergency but then worked with OHA on a process to retroactively conduct eligibility review and submit HRSN claims for members who were authorized.

To address the complexity of HRSN operations, both CCOs and OHA dedicated significant time and resources to capacity building and technical assistance for HRSN Service Providers. CCOs actively supported their HRSN Service Provider networks via onboarding and ongoing trainings, regular 1-on-1 meetings with partners to answer questions, manage capacity, and resolve billing problems, and group convenings to facilitate learning across providers and receive feedback. OHA created a learning series and monthly office hours for HRSN Service Providers, continued a monthly HRSN work session with CCOs that began prior to the waiver, and produced guidance documents and related materials. CCOs and HRSN Service Providers who were able to successfully work through implementation barriers noted that transparent communication, especially when problems occurred, helped to build trust and contributed to problem solving.

CCOs and HRSN Service Providers generally reported that the build-out of HRSN-specific modules within Unite Us helped to make application and authorization processes run more smoothly. In spring 2026, OHA announced it was expecting to contract with the Unite Us CIE platform to support closed-loop referrals for the Open Card/FFS population (51); when implemented, this would reduce the number of different systems with which HRSN Service Providers must engage. Also in 2026, OHA contracted with a group to provide support and training for HRSN Service Providers using Unite Us (52).

OHA has also introduced a few flexibilities or attempted to reduce complications and variation in HRSN operations over time. For example, mail/fax was removed as an allowable mode for HRSN requests, and OHA clarified that leases must be in place for a rental support request to be considered "complete." In response to partner feedback, the state decided in spring 2026 that utilities could be paid in non-consecutive months (although still had to be concurrent with rent assistance) and could be paid even if the member's name was not on the bill, if other residency verification was provided. OHA also provided guidance for how to handle utility assistance when more than one household was at the same address (53). Some CCOs considered forecasting, advance payments, or manual reconciliation to ensure that the HRSN Service Provider partners remained financially stable.

Finally, OHA made several rounds of updates to the HRSN fee schedule. In 2024, allowable costs for some Housing (home changes for health) benefits were increased or changed from a flat fee to a rate and fees. In 2025, OHA began allowing providers to bill for time spent documenting their O&E and tenancy support services. OHA also adjusted regional expected rates for rent and utility support, increased payments for O&E and tenancy support, and allowed time for those services to be bundled across days in some instances to meet the minimum amount needed to bill.

Implementation question 3. What facilitators and barriers to participation do beneficiaries experience, and what does this suggest about needed refinements?

We draw on several data sources to address this question. The primary source is interviews with Medicaid beneficiaries who were successful in accessing at least one HRSN service. Interviews with HRSN Service Providers and CCOs also provided secondary data about barriers and facilitators to beneficiary participation. Lastly, we analyzed a small number of documents from public meetings in which beneficiaries who had applied for but not yet received HRSN benefits shared their experiences. But because most of our data represent beneficiaries who ultimately received services, our understanding of barriers to participation may not be complete.

Beneficiaries generally found the *initial* HRSN request process accessible.

Relatively few beneficiaries reported encountering difficulties with the *initial* application or request process for HRSN services. Interviewees described several different application points and routes (via referral, online, by phone, etc.) and some members who received Housing (home changes for health) devices reported being contacted proactively about their potential needs, rather than having to make a request themselves. People who were already working with case managers (from a CCO, a state agency, or a community organization) regularly reported that their case manager was helpful in telling them about the benefit and supporting them through the steps after initial application (e.g., assisting with documentation when needed or facilitating communication among the beneficiary, CCO, and other relevant parties such as a landlord).

> *"Everything went pretty smoothly. It was when it just started, so we caught it in the beginning of everything. It didn't take very long for us to hear back or anything like that. They were on top of it, completely on top of it, because we were literally days within having to go to court for eviction. They came over here personally and dropped off the check. They were extremely helpful with that." - HRSN Recipient*

However, some CCOs and HRSN Service Providers noted that recent immigrants and refugees were reluctant to make HRSN requests—or to seek care and services in general—in the context of increased federal immigration enforcement. When asked about groups that faced participation barriers, key entities commonly mentioned people born outside the U.S., people

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who speak languages other than English, and those who don't have access to the internet/a computer.

Beneficiaries in need of rent and utility support often faced lengthy delays.

As described under implementation question 2, a large demand for HRSN services and operational complexity overwhelmed system capacity in some regions. Application backlogs slowed authorizations, and limited referral options and/or provider capacity caused delays between authorization and receipt of service. OHA reported in January 2026 that, in the first four months of the Housing benefit, 23-34% of authorized individuals waited more than 60 days between authorization and receipt of rental support. They also reported average wait times between authorization and service delivery declined steadily over time, from 58 days in February 2025 to 28 days in September 2025 (54).

Some people in the Portland metro region, where demand was particularly high, waited several months after authorization for their rent or utilities to be paid due to severe backlogs. The delays compounded beneficiaries' stress and financial and/or housing instability. Many beneficiaries who experienced these severe delays also had difficulty getting updates about their application or reaching someone who could help, with some reporting being on hold for almost eight hours to get an update.

> *"I went through a mental health crisis last year, which resulted in hospitalization. I applied for the HRSN housing stabilization program way back in December. I got approved in February, and I am now facing eviction because I am still in payer procurement. There's been hours wasted on the phone just to hear there are no payers or that my case has been escalated. I've gotten late notice after late notice. There's been no support between myself and my landlord. I'm scared if I don't get this help soon, I'll be evicted on the streets next month while still trying to recover from mental health crisis." - OHP Member public testimony*

Potential refinements. Interviewees suggested several communication improvements that would improve beneficiary participation or at least plainly acknowledge participation obstacles. These included: creating a centralized portal for members to check their application status without having to make a phone call; more transparent communication around eligibility requirements and the reasons for processing or service delays; and notifying members when payments have been made or devices have been ordered.

Strict eligibility criteria and low awareness may limit participation in medically tailored meals.

CCOs and HRSN Service Providers noted that requiring a formal assessment and nutrition care plan from a registered dietitian creates a significant hurdle for beneficiaries to access medically

tailored meals. Some felt that beneficiaries did not always know the difference between medically tailored meals and more general meal provision services, and observed that community-based health care providers, dietitians, and meal providers may not be aware of Medicaid coverage for medically tailored meals.

Potential refinements. Additional outreach to the outpatient health care and nutrition provider community might support participation in this benefit type. One interviewee suggested that OHA and CCOs engage directly with hospital discharge planners, since people leaving inpatient care may be more likely than the general Medicaid population to need medically tailored meals.

Implementation question 4. How are key entities identifying and engaging OHP members with social risk factors and what promising practices are emerging?

Key entities have created multiple entry points to request HRSN services.

OHP members may self-refer for services or may be referred and/or assisted to apply by an outside agency, including community connectors such as 211Info, health or social service providers, and contracted HRSN Service Providers. CCOs created HRSN application or request forms on their websites (often building from existing screeners) and directed enrollees to contact the Member Services department or Community Health Workers with questions or assistance completing request forms. Open Card/FFS beneficiaries can also submit requests by phone or online. Both HRSN Service Providers and CCOs regularly assist people to complete the HRSN application or request process.

> *"I have several team staff who literally call members and just help them fill out that Unite Us application, help them with the process, identify their needs, make sure that they really are in this situation, they have a lease. Besides doing our social determinants screenings with these members, really help them initiate the process. A lot of members are savvy enough, and we take referrals 24 hours a day. They are logging on at any time and making referrals, but we do have a very significant number who need that one-to-one [support]." - CCO*

Proactive outreach to date has largely focused on Housing (home changes for health) needs.

During the first two years of HRSN, proactive identification and outreach to members occurred predominately for the Housing (home changes for health) benefit. Several CCOs used diagnostic, utilization, and/or health risk assessment data to flag members particularly at risk during extreme heat or poor air quality events (this strategy pre-dated the HRSN benefit at some CCOs). CCOs would then "pre-authorize" those individuals for HRSN services and/or have case managers or customer service staff conduct targeted outreach. This proactive outreach for was generally described as successful and data about use of Housing (home changes for health) services in late summer 2024 suggest that uptake was high.

Coordinating with other programs and stakeholders can help identify members with HRSNs.

Many CCOs also leveraged their staff and processes from existing programs like Flexible Services and in-lieu-of services, converting Flexible Service requests into HRSN applications when appropriate and referring HRSN recipients to their Flex Service teams for needs that went beyond the covered benefit.

> *"We work very closely with our flex services team. We've had cases that we've had to work closely with flex services on exceptions here or there and get our flex services. It's not an infinite pool. We really do want to reserve flex services for people who can't get HRSN at all." - CCO*

Some HRSN Service Providers explained that having good working relationships with landlords/property managers helped to facilitate member participation, since landlords could get their questions answered quickly and trust that they would be paid.

Implementation question 5. How are key entities implementing HRSN case management and services and what are they learning about promising practices for service delivery?

Case management is most often provided to support O&E and tenancy support activities.

HRSN Service Providers delivered case management and 1-to-1 assistance when helping individuals to understand HRSN benefits, complete applications, and compile the documents necessary for service authorization (e.g., a written lease). Once eligibility had been established, HRSN Service Providers described providing case management via tenancy support e.g., helping individuals negotiate with their landlords or complete applications for new rental housing and benefits) connecting beneficiaries with health care providers, and either delivering or referring people to complementary non-Medicaid services (e.g., financial literacy training).

> *"A dually eligible couple in their 70s who had fallen behind on rent after it increased beyond their means. They were referred to an HRSN Housing Provider and qualified for payment for 2 months of back rent and 4 months of forward rent, which prevented eviction and kept them housed. A caseworker from the HRSN [Service] Provider then worked with the landlord to reduce the rent to a level that the couple could afford without HRSN assistance. Additionally, the caseworker assisted the members in applying for utility assistance programs, connected them with Aging and Disability Services, and supported the installation of accessibility features in their home to make daily tasks, like bathing, safer. As of today, they are stably housed and no longer require support and are able to live independently in a safe and secure home." - CCO*

> *"While helping a client get caught up on past-due rent, we were also able to use Tenancy Support to help the client find a PCP and organize an interpreter to attend their appointments." - HRSN Service Provider*

HRSN service delivery varies by category and benefit type.

- *Initiating rent payments was sometimes challenging.* Once an individual is authorized for rent support, HRSN Service Providers and/or CCOs must work with the landlord to acquire documentation needed for tax purposes and determine the specific rent payment method (e.g., check, direct deposit, online payment via property management portals). Interviewees reported that landlords were sometimes reticent to accept payments from a third party and/or to provide W-9 tax forms.[5] HRSN Service Providers noted that the consistent monthly amount generally made rent payments fairly straightforward after initial set-up.

- *Date-of-service rules complicate the delivery of utility payments.* HRSN Service Providers described many challenges making utility payments. Determining the allowable payment involved first aligning the authorized date spans for rent and utility coverage, then aligning allowable timeframes for HRSN utility payments with actual utility service and billing periods. Key entities noted that phone and internet bills often do not coincide with rental periods, lack line-item breakdowns, and may include pre-paid or non-covered services (e.g., purchase of a phone, not just the mobile service). If HRSN benefits cover the phone service portion of a bill but payment for other items on that bill is still delinquent, then the beneficiary's phone service may still be cut off. Key entities also consistently reported that it was difficult to contact utility providers, especially large national companies, when they needed copies of bills or had questions about making payments on behalf of beneficiaries.

- *Delivery of Housing (home changes for health) services was generally straightforward.* For Housing (home changes for health), delivery of the relevant modification or device (e.g., an air conditioner or portable power supply) is typically the extent of the service. Many CCOs order devices directly from a vendor and have them sent to members' homes, although a few contracted HRSN Service Providers deliver devices and can assist with installation if needed.

- We conducted relatively few interviews with medically tailored meals providers in the time period for this report, and no data collection with organizations providing home remediations. Utilization of these service types has been low so far, and we will explore promising practices for delivery of these services in the summative report.

[5] Oregon law includes protections related to a tenant's source of income, including housing assistance, and addresses landlord participation in rental assistance programs; see Oregon Revised Statutes 659A.421 and 90.395

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Flexibility and strong communication facilitate implementation across all service types.

Because demand for HRSN services has been so high, preserving some role flexibility among key entities appears to be a promising practice for increasing overall service delivery capacity. For example, CCOs reported that closely monitoring HRSN Service Provider caseloads and adjusting assignments or stepping in themselves when needed helped with backlogs. Some HRSN Service Providers also felt that taking a whole-person approach to assessing needs and having other services co-located with HRSN benefits was a key to their success.

> *"With only a couple months of [Medicaid] support, we have to go fast and quick. Having [other services] at our site makes it a little more controllable, where we can control those things as well. I think that's also a benefit." - HRSN Service Provider*

Key entities frequently stressed the importance of strong communication between partners.

> *"I will tell you, our relationship with [CCO name] has been great. I think we have developed a strong communication style between the two of us at leadership levels. Where we can have difficult conversations but understand each other and know that at the end of the day, we just want to make sure that these members are served to the best of our capacity. We all have that mutual goal." - HRSN Service Provider*

> *"Our CCO has implemented a regular monthly check-in for CBO partners and I feel that makes a huge difference in clear and appropriate communication. … The main takeaway: collaboration is everything." - CCO*

Implementation question 5(a). How are screening results being shared among key entities and how, if at all, have health care providers modified their clinical practice in response to this information?

Note that interviews with health care providers whose patients include HRSN beneficiaries will take place in 2026 and 2027 and so the second part of this question will be addressed in the summative evaluation report.

Key entities are typically sharing service-related data rather than screening results.

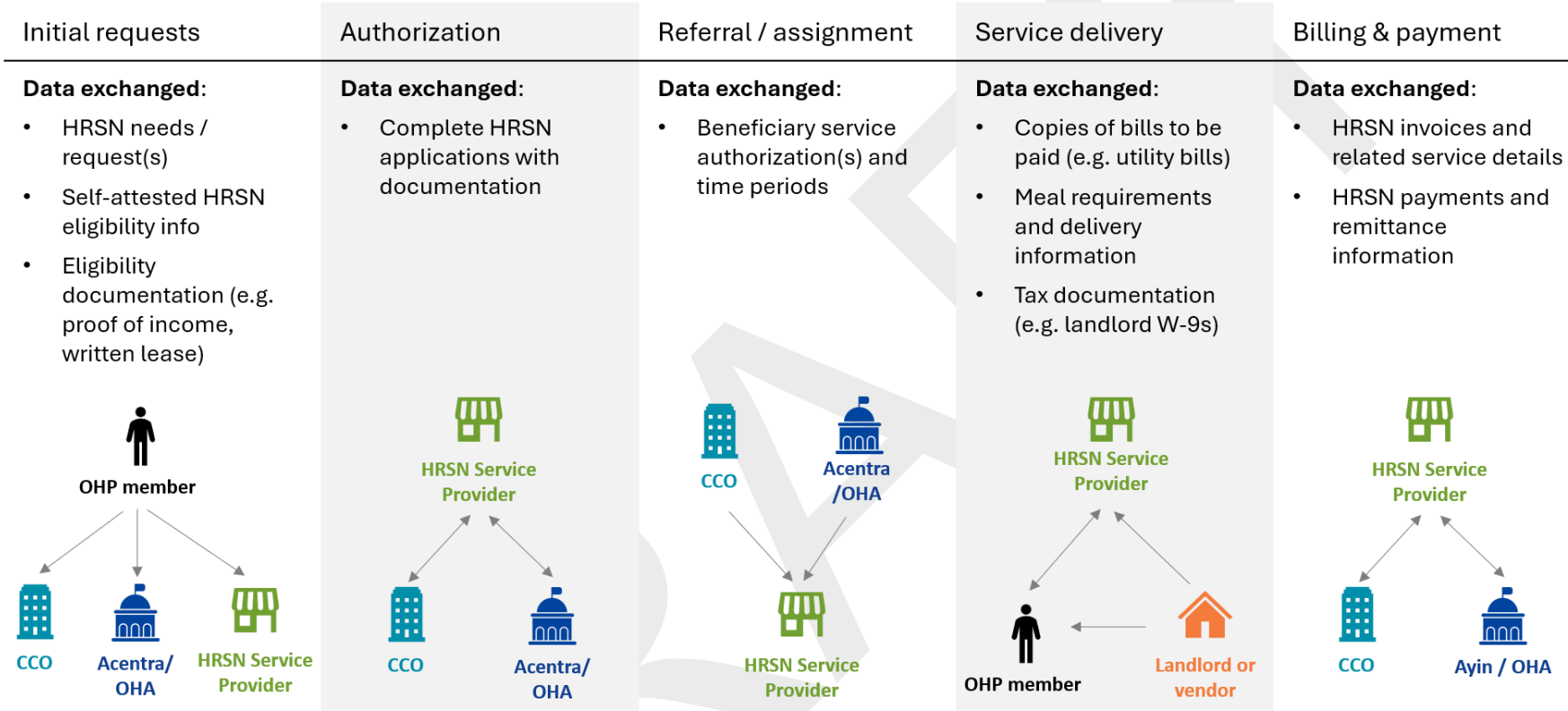
Because Oregon did not require a standardized screening tool for social needs, data being shared among key entities is primarily service-related, and sharing of "screening results" varies. Service data include HRSN requests as well as eligibility documentation, authorizations, referrals, and service/billing records.

While there is substantial variation, the most common points of data exchange are: (1) when initial requests are submitted via an online request/application form or sent from a community connecter to either a CCO or an HRSN Service Provider for further screening; (2) when complete

requests/applications are sent to CCOs for final eligibility determination and service authorization; (3) when approved cases are assigned to an HRSN Service Provider; (4) when documents such as leases, W-9s, or utility bills are exchanged between key entities; and (5) once services are rendered and the HRSN Service Provider bills for the service. (Figure 22). The specifics are different for the Open Card/FFS population and vary by CCO and service type. For example, there are fewer hand-offs when CCOs manage delivery of a benefit in-house, and more when multiple forms of documentation are necessary for authorization or service provision.

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Figure 22. Data/information sharing among HRSN Key Entities



Note: Figure is simplified to show only the most common types of information shared and usual points of exchange. Many variations exist.

Implementation question 5(b). How do key entities form and maintain organizational partnerships to promote integration of health and HRSN services?

To date, organizational partnerships have focused on HRSN service *delivery* rather than integration of HRSN services with health care.

Given the level of demand and the significant operational requirements for HRSN services, most partnership development to date has centered on the immediate priority of *delivering* HRSN services. Statewide, more than a dozen contracted HRSN Service Providers are also health care systems or providers (e.g., Federally Qualified Health Centers). But we have heard relatively little to date about partnership building that is intended to facilitate integration of medical and social care, which could include activities like integrated assessments or joint care/service plans.

> *"Us as a housing provider are no closer to understanding what [health] challenges exist. We just know that there's a diagnosis code in the referral, and it qualifies them for this benefit." - HRSN Service Provider*

However, key entities have shared some examples of health and social care integration. One CCO contracted with a patient-centered primary care clinic (PCPCH) that offered ancillary medical-legal services to also serve as an HRSN Service Provider, so that patients at that clinic could receive health care, legal, and HRSN services from the same entity. Some HRSN Service Providers are co-located with other entities that can provide health care services, and HRSN case management often includes support with finding a health care provider (see HRSN implementation questions 5 and 5a).

> *"We have one active PCPCH Clinic that we're integrated as an HRSN Service Provider so that if a member of that clinic requests HRSN services, they get assigned back to that clinic for care continuity. They go in, they see their PCP, their PCP is aware of their HRSN needs. They have a case manager that's specific to HRSN navigation. They have medical-legal partnership in that clinic. They get everything there, including HRSN services from the same PCP office." - CCO*

Implementation question 5(c). To what extent is the demonstration integrated with its existing programs and infrastructure and what practices support this integration?

Medicaid HRSN services leveraged existing infrastructure but also required new roles, rules, systems, and workflows.

Many key entities reported that they built on their existing processes and infrastructure where possible. However, most acknowledged that providing HRSN services as a Medicaid benefit was always going to require adaptation. Medicaid entities such as OHA and CCOs had to adjust their rules and processes to accommodate non-medical services and organizations, and experienced

social service providers had to adjust their service delivery models and workflows to meet Medicaid authorization, billing, and reporting requirements.

Both OHA and CCOs updated existing systems for HRSN implementation. For example, OHA relied on an existing financial reporting form for CCOs to report HRSN encounter information until updates to the state's claims data system (MMIS) could be made and both medical and HRSN encounters could be submitted via the same mechanism. Similarly, many CCOs used their existing processes and teams for provider contracting but had to issue new solicitations for HRSN Service Providers, adjust their credentialing processes, and develop novel guidance and support for HRSN Service Providers. Both OHA and CCOs described creating new teams and roles dedicated to HRSN.

> *"I think one of our core foundational values in setting up HRSN is alignment with other benefits and really thinking of this as a medical benefit. To the best of our ability, the setup involved really understanding how to best think about claims, and billing, and processing HRSN in the same way, using the same rules and the same policies that we do for a surgery or immunization. [But] we certainly did find that there are things that simply do not map in the way that we needed them to. I think that we have gotten a little more flexible and adaptable with the ways in which especially this provider network looks different than a traditional Medicaid medical provider network." - CCO*

HRSN Service Providers almost all had existing social service delivery infrastructure, and many leveraged that to provide Medicaid-paid services. However, many also reported that they had to create new, Medicaid-specific operational workflows for steps such as intake, screening, client tracking/documentation, and billing.

> *"A lot of our policies and procedures found their way over here to the HRSN program as well too. Certain things have changed based on the requirements and things like that. I think that component of it was really seamless. … We did mimic things that have worked for us in the past."*
>
> *- HRSN Service Provider*

> *"We hired an HRSN Specialist to work on internal capacity building (coordinating our Finance, IT, HR, and other departments), hired an external consultant with Medicaid experience, and developed a rollout plan. Then we built out an electronic case management system, developed workflows for service delivery, and planned and executed staff trainings."*
> *- HRSN Service Provider*

Implementation question 6. How is the DSHP program supporting key entities to develop the infrastructure needed to deliver HRSN services; what promising practices are emerging for infrastructure development?

CCBF were critical for HRSN infrastructure development, including workforce capacity.

Key entities reported that DSHP investments disbursed via the CCBF grant program (see HRSN Context and background) were indispensable for establishing HRSN infrastructure and bolstering service delivery capacity. HRSN Service Providers described using CCBF grants to bring on new staff (e.g., case managers, coordinators, finance, and administrative roles) and invest in necessary training for those personnel, and to develop HRSN workflows. Service providers also used these funds for technology/software licenses and sometimes equipment (e.g., computers, cellphones, tablets, or additional refrigeration capacity for medically tailored meals), and for community outreach.

In a December 2025 presentation, OHA reported that workforce capacity was by far the most common planned use for CCBF grants, representing more than $65 million in awards across 2024 and 2025 grants combined, and that housing providers received the largest share of funding. One CCO interviewee reported that HRSN Service Providers who applied for a second CCBF grant in 2025 were often seeking additional support for staff performing accounting, payment reconciliation, and other financial functions.

"They hired me as an FTE for the first 6 months and then, hired another FTE. Now we have 5 FTE to help with the HRSN program. We are using some of the CCBF funding to pay for other staff positions to support need as well as technology/internal database enhancements." - HRSN Service Provider

"What we learned probably in the last six months is every provider needs somebody or a portion of an FTE dedicated to finance and billing and claims reconciliation because it is not as easy as just submit it and hope you get paid." - CCO

"I think we are pretty lucky, as the first round of the CCBF awardee[s]. As a result of the award, we were provided some technical assistance. They provided some kind of template of policy procedures we would need to think about, how you think about planning the business, and et cetera. … After we start taking more cases, and then we really can put more meat on the bone about our processes." - CCO

OHA used DSHP funds responsively to address backlogs in housing authorization and service provision.

In mid-2025, OHA permitted CCOs to award up to 20% of their 2025 CCBF allocation in an expedited process to rapidly increase housing provider capacity, and to access another 20% of the allocation to support HRSN Housing benefit delivery at the CCO level. (Previously, CCOs were

not permitted to keep CCBF dollars in-house.) CCOs used the newly available funds to hire internal staff for eligibility and authorization work and to contract with groups to offer training, convening, and support for HRSN Service Providers. HRSN Housing providers also hired additional staff and used funds for billing oversight and management. In some cases, the expedited housing funds helped providers cover previous HRSN revenue shortfalls.

> *"We do have some shortfalls because the program at that time wasn't paying for itself. The billings that we were able to bill for every 15-minute increment, it was a $20 payment. At that time, it never penciled out. We were able to get some emergency CCBF money, which is great." - HRSN Service Provider*

Implementation question 7. How is the local availability of and investment in social services outside of the demonstration changing during the demonstration project?

Medicaid-funded HRSN benefits are a very new and relatively small part of the full picture of social supports in Oregon. To understand how broader funding and accessibility of social services is changing over the course of the demonstration, and how that might affect the setting for HRSN implementation, we conducted a brief environmental scan of agency reports, news articles, and other existing documents (see Analytic Methods in Section D).

Investment in rental assistance and eviction prevention appears to be declining in Oregon.

The environmental scan indicated substantial reductions in state funding for rental assistance and eviction prevention programs in Oregon, even though eviction rates remain high/have been climbing (55,56). This comes alongside a shift in state funding toward shelter operations and housing construction. For example, the 2025-27 state biennial budget cut rental assistance and emergency eviction prevention funding by roughly 74% (about $130 million to $44.6 million statewide) (57,58), while lawmakers approved nearly $470 million for affordable housing construction to support the Governor's goal of constructing 36,000 new homes per year. The federal, pandemic-era Emergency Housing Voucher program started winding down in 2025 and housing authorities anticipate further cuts to federal rental assistance programs (59). Taken together, there appears to be a widening gap between rental assistance need and available resources in Oregon.

Oregon made investments in energy assistance programs.

State-level investment in energy assistance increased during the first two years of the demonstration; for example, a 2025 bill doubled funding for the Oregon Energy Assistance Program from $20 million to $40 million per year (60). This was reportedly to mitigate potential reductions or delays in federal LIHEAP (Low-Income Home Energy Assistance Program) funding, which has become increasingly uncertain (61). Local utility companies agreed to pause disconnections for income-qualified and medically vulnerable customers during the federal

shutdown in late 2025 and offered expanded discount and protection programs (62). However, the state investment is unlikely to fully replace federal LIHEAP support which typically supports tens of thousands of households each year (63). Note that HRSN benefits can cover water and internet payments, whereas existing programs typically focus on energy costs only.

Many pre-demonstration investments in Housing (home changes for health) and improvement services are being maintained or increased.

Oregon has made targeted investments in recent years in home repairs, accessibility modifications, and home environment improvements. OHA's Healthy Homes Grant Program was established in 2021 to serve seniors, people with disabilities, and low-income households and has awarded almost $20 million so far to agencies that provide repair and remediation services (64). The state added $3 million to the Healthy Homes Repair Fund for the 2025-27 biennium (64). As part of a larger "emergency housing stability and production package" in 2024, the state allocated $3.5M to distribute emergency portable cooling devices and air filters (65), but funds were fully expended in 2024 (66). Some localities in Oregon also operate their own programs for Housing (home changes for health). For example, Cooling Portland delivers and installs heat pump cooling units to Portlanders most at risk for heat-related illness. In December 2024, Portland City Council approved adding $10.3 million to the Cooling Portland program, allowing it to help an estimated 10,000 additional households through 2026 (67).

Federal policy changes have reduced the availability of nutrition services.

During the first two years of the demonstration, the most significant changes in the nutrition assistance landscape in Oregon were at the federal level. These include cuts to USDA food programs (68), loss of SNAP benefits during the 2025 federal shut-down, and restrictions in SNAP eligibility and coverage that began in late 2025. In Oregon, approximately 29,000 households are expected to lose benefits because of SNAP changes, with average benefit reductions of about $58 per month for those who remain enrolled (69). Local investments have increased in response but at a scale well below the previous federal resources. For example, Oregon declared a 60-day food security emergency during the temporary federal shut-down in 2025 and directed $5 million to food banks and $1 million to the nine federally recognized Tribes of Oregon; philanthropic donors matched that investment for a $12 million response in total. This response helped to mobilize the Oregon Disaster Funders Network, which raised an additional $6 million for food banks, pantries, and community organizations (70).

Evaluation questions 1-3. How does the demonstration impact health-related social needs, use of health care, and health outcomes?

In this section, we discuss preliminary findings related to the impact of having received HRSN services, with all potential impacts addressed together for the sake of readability. Note that HRSN implementation question 3 discusses OHP beneficiaries' experiences *applying for and*

accessing the different HRSN benefits, including process barriers and their consequences. This section focuses on what occurred *after* services were received. (As described in Section D, we were generally speaking to beneficiaries between 3-9 months after receipt of service.) The findings presented here relate to the impact of the Housing (home changes for health) and remaining Housing services only and do not address the Nutrition benefit nor evaluation questions related to inequity because the number of member interviews is not yet sufficient to support analysis.

HRSN services helped reduce stress and improve mental and emotional health.

The HRSN impacts described most frequently were reduced stress and anxiety, improved emotional well-being, and better overall quality of life. Some beneficiaries reported improved peace of mind, better sleep, or a sense of hope that their situation was improving. Interviewees did not report substantive changes in their use of crisis services such as shelters (largely because few had used those services in the past) but some reported worrying less about needing that kind of emergency assistance. In some cases, members reported that not having to worry about next month's rent or having their power shut off gave them the mental and emotional space to address other issues such as finding a new job or regaining custody of their children.

"When I wasn't able to pay my rent before, I would worry about, okay, so I don't have it for next month, what happens then? Then I would start looking up shelters. I would start asking family, if I'm not able to pay it this month, and we get kicked out, can we stay with you? Stuff like that." - HRSN Recipient

"Overall, I was not stressed about rent. I wasn't stressed about paying the bills. I was able to heal properly, emotionally, mentally, and physically."
- HRSN Recipient

"With everything going on with my wife having to go to the doctor and me having to go to the doctor and appointments like that, then it's just been not having to worry about our rent being paid has been really helpful. We also have a [child]. Our biggest goal is to make sure that [they] stay housed, then that we stay housed. It's been really helpful to not have to worry about [rent] every day." - HRSN Recipient

People receiving rent and home changes for health benefits generally reported improved housing and financial stability.

Members who received rent and utility payment support reported that the benefits helped them maintain their housing, find better housing, and prevent evictions. In one instance, "better" housing meant physical safety for a member and their children who had previously

experienced domestic violence. Financially, some members reported that having their rent and/or utilities covered enabled them to repay debts, build savings that could go towards future rent or other expenses, and prioritize spending on other monthly bills and necessities such as food. When members received Housing (home changes for health) devices, they reported being more comfortable at home during heat or smoke events and worrying less about important equipment (e.g. a CPAP machine) failing in the case of a power outage.

"Yes, it [the HRSN service] stopped my eviction. … It stopped the eviction completely. They just stopped it."
- HRSN Recipient

"The six months did allow me to be able to save up, where I could get back on my feet and be able to afford to pay my own rent."
- HRSN Recipient

"We have seen many positive outcomes as a result of clients receiving this benefit. Clients have maintained housing, found employment, connected to other services, paid for items that they needed but couldn't afford due to rent burden, had surgeries without the stress of paying rent while unable to work . . . We have clients share appreciation with us on a regular basis." - HRSN Service Provider

However, some recipients found that the positive effects of receiving HRSN services were diminished by the delays and difficulties they encountered when trying to access the benefit (see HRSN implementation questions 2 and 3).

"It took about six months just to get it. … Honestly, instead of helping me, it put me more in a bind because I was three months behind when I applied for it, and because it took them six months just for me to get it … I was just about $10,000 behind on rent."
- HRSN Recipient

Some impacts on health care utilization and health status are beginning to emerge.

Some members who received devices such as air conditioners described slightly more direct health care and health impacts. For example, improved indoor temperature or air quality allowed some individuals to wait longer between chronic care appointments or to have fewer ED visits for asthma exacerbations. Some reported improved outcomes such as easier breathing, reduced swelling, or better mobility.

"Like I said, when she first came in, I was completely bedbound. I wasn't doing really well… I was able to get an air conditioner where it cooled me down, which helped stop the swelling. Then I was able to get up and get in my chair. I've gone from where I could barely make it to my chair, which was about 20 feet … to I can go outside and garden now a little bit." - HRSN Recipient

Others reported that having their rent and utility costs covered gave them more time and capacity to attend medical appointments, get needed treatment, and focus on self-care, resulting in better health.

> *"Yes, it gave us a lot of extra time to be able to focus on our health. I was on a lot of different medications, like mental health medications, and have done a lot of work with therapy and psychiatrists and stuff like that and been able to get off quite a few of my medications." - HRSN Recipient*

However, many participants reported no changes to their use of health care in the wake of receiving HRSN benefits, and/or explained that they did not have a regular need for care.

> *"I don't think [my use of health care has] changed. I don't go to the doctor any more or less than I would if I just needed to go or would go." - HRSN Recipient*

For some, HRSN benefits did not last long enough.

Along with positive impacts, both beneficiaries and key entities noted that the time-limited HRSN services may not be enough to fully address underlying needs. For some, the rent benefit provided temporary relief but did not fully resolve their housing or other needs.

> *"It wasn't enough benefits to get me through the end of my disability. … It did [help] at the time, but right now, I'm going through it. Right now, we're being evicted on the 15th, and we don't have a place to go. Yes, it helped me in the past, but like I said, it's not enough funding for my circumstances." - HRSN Recipient*

HRSN Service Providers commonly reported that they had few options to offer participants after the benefit ended. Some reflected that individual assistance can only go so far in light of rising housing costs and insufficient supply, cost of living increases, and reductions in other community supports (e.g., changes to SNAP benefits). These contextual factors are explored in HRSN implementation question 7.

Young Adults with Special Health Care Needs

Summary of Key Findings

YSHCN policy implementation

- The YSHCN policy established a new OHP eligibility category and benefit package but required few new processes or operational policies. CCOs made minimal changes to their workflows, which contributed to smooth implementation.
- The biggest changes occurred at the State level. OHA and partners developed eligibility rules, passive enrollment mechanisms, a YSHCN screener embedded into the ONE system, and payment systems, and created new materials to support outreach efforts and rollout.

YSHCN OHP member enrollment routes and characteristics

- 33,855 YSHCN OHP members were enrolled during calendar year 2025; of these, 422 (1.2%) were new Medicaid enrollees. Over 90% of YSHCN OHP members were already eligible for Medicaid outside of the YSHCN policy.
- The majority of YSHCN OHP members were identified and enrolled passively via qualifying behavioral health (BH) diagnoses or Pediatric Medical Complexity Algorithm (PMCA) scores.
- There were some notable demographic differences among YSHCN OHP members across the three different identification routes (passive via BH/PMCA scores, passive via ODDS or active via screener).

YSHCN policy outreach and communication

- Awareness of the YSHCN policy was limited among some members and community partners. There are opportunities to expand outreach in frontier and rural areas and at colleges and universities.
- YSHCN OHP members and eligible individuals face unique barriers to outreach. YSHCN OHP members may be less responsive to mail and phone outreach due to their age, and less responsive generally due to their qualifying conditions.
- To address outreach barriers, some CCOs report developing new outreach methods, such as text messaging, robocalling, and online patient portals.

YSHCN OHP member access to and utilization of health care

- YSHCN OHP members largely noted few to no disruptions to their care and cited a range of health services utilized while under YSHCN OHP coverage. Some YSHCN OHP members reported being able to access more services, or being able to access existing services faster compared to their previous coverage.

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- Some YSHCN OHP members reported difficulties finding providers who accepted OHP and noted the additional challenge of having to orient a new provider to their complex health history. This is potentially due to low provider availability, particularly providers who are willing to take on complex cases and providers located in rural areas.

Context and background

Overview of eligibility. The YSHCN policy under Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver created a new eligibility category and benefits package to facilitate the transition from pediatric to adult care for young adults with complex physical and behavioral health needs. To be eligible for the benefit, a person must have a qualifying condition that began before the age of 19 and an individual or family income up to 205% of the federal poverty level (FPL). The qualifying conditions include physical, intellectual and developmental disabilities; long-standing medical conditions like asthma, diabetes, or spina bifida; and/or mental health conditions like depression or substance use disorders (71). The policy had a staggered rollout: 19- and 20-year olds were eligible in 2025; 21-year olds became eligible in 2026; 22-year-olds will be eligible in 2027; and the remaining age groups (i.e. ages 23-25) will become eligible after the end of the waiver demonstration period, depending on budget availability (Figure 23).

Types of YSHCN OHP coverage. There are two types of YSHCN OHP members: standalone and supplemental (Figure 23).

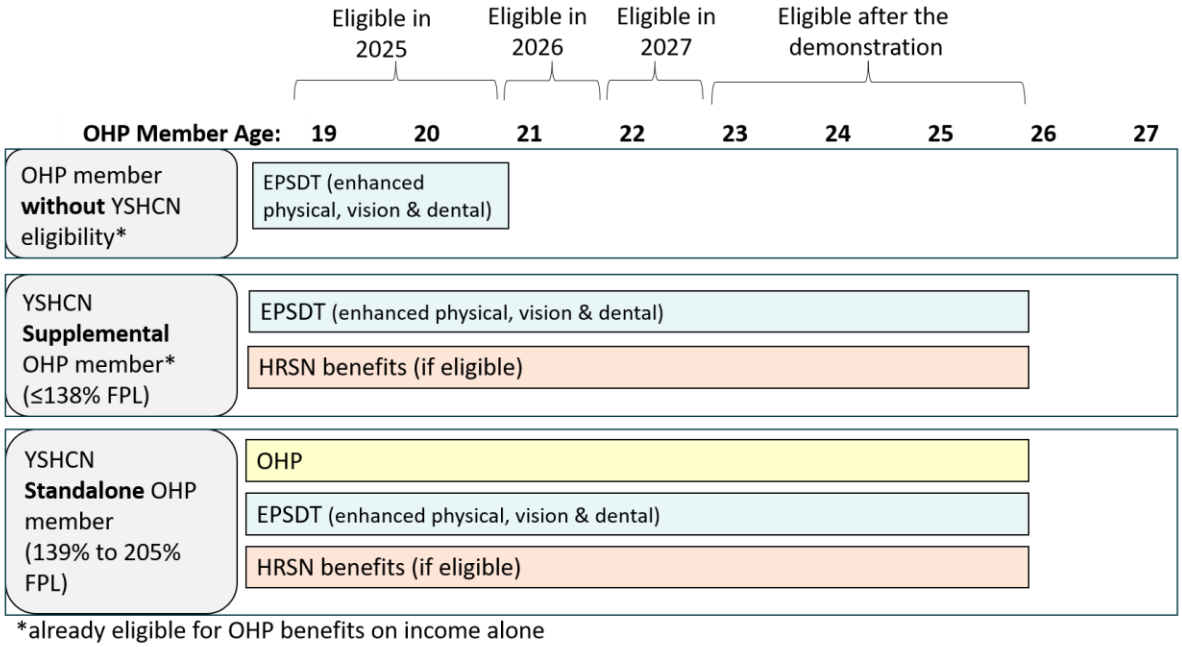
1. **Standalone** YSHCN OHP members are those who would not qualify for OHP without the YSHCN policy, i.e., their income is above the 138% FPL limit for OHP (and below the 205% FPL limit for the YSHCN policy). Under the YSHCN policy, these individuals are now eligible for OHP (Figure 23, yellow bar) and the extended EPSDT, including vision and dental services, and are eligible for HRSN services as well.
2. **Supplemental** YSHCN OHP members are those who qualify for OHP regardless of the increased FPL cutoff for the YSHCN policy (i.e., those with an income ≤138% FPL).

YSHCN identification route*.* There are three routes through which individuals can be identified and enrolled in YSHCN.

1. **Passive enrollment: healthcare data review.** For individuals already enrolled in OHP, OHA staff review health data for qualifying complex health conditions based on the PMCA score or a pre-specified list of behavioral health diagnoses.
2. **Passive enrollment: service eligibility and intellectual or developmental disabilities (IDD).** YSHCN policy eligibility is determined for individuals with an IDD through a review of their IDD plan with ODDS and/or referral by ODDS.

3. **Active enrollment.** Individuals complete a screener, embedded within the OHP application, to assess their YSHCN policy eligibility. This can be a physical application completed in-person or sent via mail, or they can apply through the ONE system. Those who have two or more (out of six) affirmative responses in the screener are considered to have elevated service needs and thus are eligible.

Figure 23. YSHCN policy implementation plan and benefits



*already eligible for OHP benefits on income alone

YSHCN policy benefits. The YSHCN policy includes three main benefits:

1. **Increased income eligibility.** As described above, YSHCN OHP members remain eligible for OHP with an income up to 205% FPL.
2. **Extended EPSDT, including enhanced vision and dental services.** OHP has covered comprehensive EPSDT benefits since 2023, which include age-appropriate medical exams, screening and diagnostic services, and medically necessary services to treat any physical, dental, developmental and mental health conditions discovered, and enhanced vision and dental services up to age 21 (72), even if the service is not in the State Plan. Under the YSHCN policy, YSHCN OHP members now maintain these benefits until age 26.
3. **HRSN eligibility.** YSHCN OHP members are a covered population for the HRSN benefit, meaning they may be eligible to receive Housing (home changes for health) services, the remaining Housing benefits, Nutrition supports, and O&E services if they meet specific clinical and social risk factors and apply through the standard HRSN channels (see HRSN Context & background section for more information on these benefits).

CMS-Approved Research Questions and Logic Model

YSHCN Implementation Questions

1. How is the YSHCN policy being implemented?
    - *1a.* What progress has been made towards implementing the YSHCN policy and what factors facilitated or impeded success?
    - *1b.* How do OHA staff, and organizations who assist with enrollment, conduct outreach to the YSHCN population and what successes and barriers have they encountered?
    - *1c.* What efforts did OHA and partners make to center equity in the identification of YSHCN? How effective were these efforts?
2. How were YSHCN enrolled in Medicaid under the new policy and what was their experience with the process?
    - *2a.* How many YSHCN enroll in Medicaid over time?
    - *2b.* Through what routes are YSHCN being identified and enrolled to Medicaid?
    - *2c.* What is the experience of Medicaid enrollment for YSHCN and their families / caregivers?
    - *2d.* Are there inequities in Medicaid enrollment under the YSHCN policy?
3. How did Oregon's Coordinated Care Organizations (CCOs) and Fee For Service (FFS) program engage and support the newly defined YSHCN population of members?
    - *3a.* How did engagement and support for this newly defined population differ across all 16 CCOs and FFS?
    - *3b.* How, if at all, did coordination of care change for these young adults?
    - *3c.* How did CCOs and FFS program seek to make their services for these members culturally and linguistically appropriate?
    - *3d.* How were adult providers supported in providing care to these young adults?
    - *3e.* What new policies or processes did CCOs and FFS program put in place to support this population?

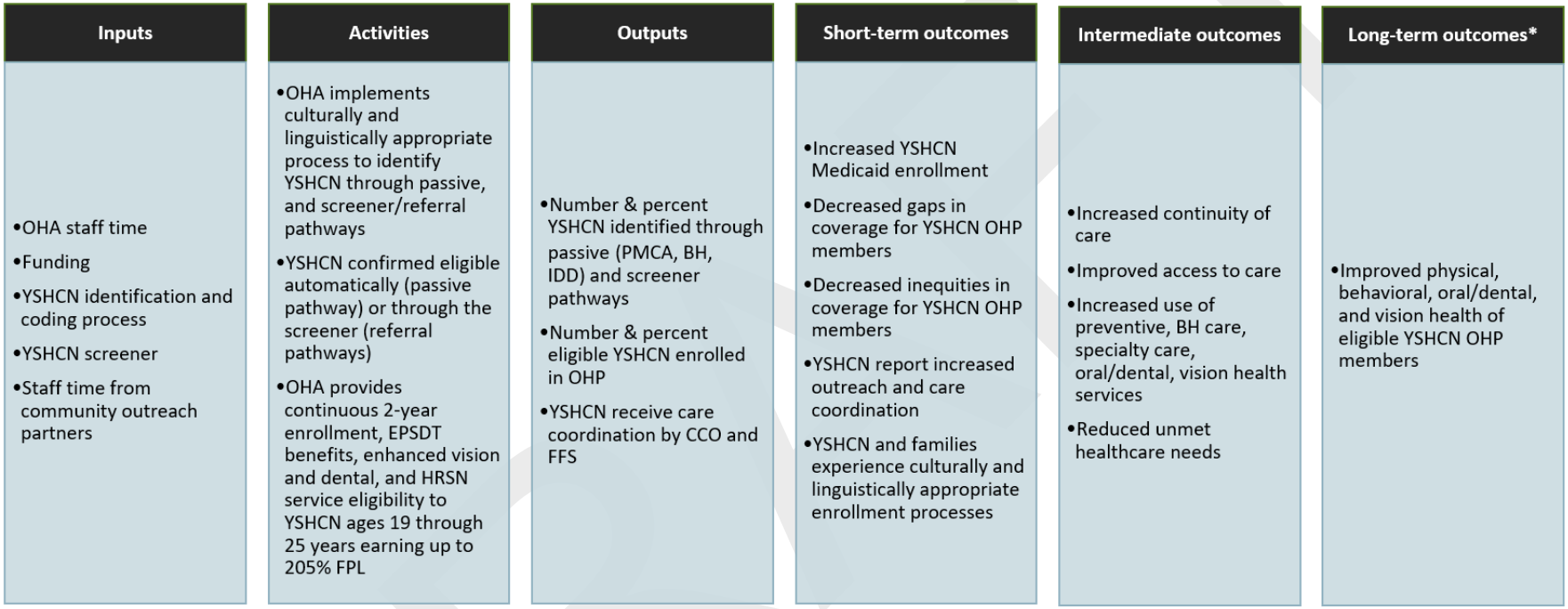
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YSHCN Evaluation Questions

1. The YSHCN policy will improve continuity of Medicaid coverage for YSHCN.
    - *1.1.* What changes in rates of churn are observed after two years of YSHCN policy implementation?
    - *1.2.* What changes in inequities in churn are observed after two years of YSHCN policy implementation?
2. The YSHCN policy will improve continuity of care for Medicaid-enrolled YSHCN.
    - *2.1.* How does the YSHCN policy impact self-reported continuity of care for YSHCN OHP members?
    - *2.2.* How does the YSHCN policy impact the experiences of providers, including both medical and social (e.g., navigators, social workers, traditional health workers) providers, in caring for YSHCN?
    - *2.3.* How does the policy impact inequities in continuity of care for YSHCN OHP members?
3. The YSHCN policy will improve health care access and utilization for Medicaid-enrolled YSHCN.
    - *3.1.* How does the YSHCN policy impact self-reported access to and use of preventive and primary care for YSHCN OHP members?
    - *3.2.* How does the YSHCN policy impact self-reported use of acute and costly care, especially potentially preventable emergency department visits and hospitalizations for YSHCN OHP members?
    - *3.3.* How does the YSHCN policy impact self-reported access to and use of specialty care, including behavioral health care for YSHCN OHP members?
    - *3.4.* How does the YSHCN policy impact self-reported access to and use of oral health care and vision benefits for YSHCN OHP members?
    - *3.5.* How does the YSHCN policy impact inequities in health care access and utilization for YSHCN OHP members?

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Figure 24. YSHCN logic model



*outside the timeline and scope of the evaluation

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Research questions included in this report

We present preliminary findings for several YSHCN implementation and evaluation questions. Interviews with key entities, including OHA and CCO staff, provide information about progress towards implementing the policy and conducting outreach to potential YSHCN OHP members (implementation questions 1a, 1b, 1c), as well as how CCO staff engage with and support the YSHCN population (implementation question 3). Questions that rely specifically on interviews with health care providers (implementation question 3d and evaluation question 2b) are not included as interviews with health care providers had not yet started at the time of this report.

We also present quantitative findings on how many YSHCN OHP members were enrolled in Medicaid (implementation question 2a) and how they were identified (implementation question 2b). Findings from interviews with YSHCN OHP members provide information on the experience of enrollment, as well as initial self-reported impacts on access to, and continuity of, needed health care (evaluation question 3). Quantitative analysis on continuity of coverage (evaluation question 2) will be reported in the summative report; it is not included in this report as full data is not yet ready.

For a complete overview of data and analyses included in the interim report, see Section C.

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Study Population

Quantitative data – OHP member population. A total of 33,855 YSHCN OHP members were enrolled in Medicaid during calendar year 2025.

Table 10 shows the demographic characteristics of these YSHCN OHP members. The YSHCN policy was rolled out to 19- and 20-year-olds during 2025; YSHCN OHP members who enrolled at 19 or 20 but turned 21 during the calendar year also retained their coverage. Therefore, as expected, nearly all YSHCN OHP members were 19 or 20 during 2025.

More than half of YSHCN OHP members were female (59.7%), with the largest racial identities being white (47.3%) or Latino/a/x/e (25.6%). YSHCN OHP members were most likely to use English at home (83.5%); this was followed by Spanish (14.4%). All other language categories represented around 2% of the population. More than half of the YSHCN OHP member population lived in urban areas (59.6%). Over half of YSHCN OHP members (57.4%) reported being non-disabled, while 20.5% reported an independent living/self-care disability.

Qualitative data – OHP member population. Table 11 shows characteristics of YSHCN OHP member interview participants. A total of 245 YSHCN OHP members were contacted

Table 10. Characteristics of 33,855 YSHCN OHP members enrolled in Medicaid during calendar year 2025

	N	%
Age at YSHCN Enrollment		
18	<20*	--
19	22,720	67.1%
20	11,120	32.8%
21	<12†	--
Sex		
Female	20, 203	59.7%
Male	13,652	40.3%
Race/Ethnicity		
American Indian/Alaska Native	1,783	5.3%
Asian	1,225	3.6%
Black/African American	1,827	5.4%
Latino/a/x/e	8,657	25.6%
Native Hawaiian & Pacific Islander	366	1.1%
Middle Eastern/North African	188	0.6%
White	16,011	47.3%
Multiple/Other	342	1.0%
Unknown	3,456	10.2%
Language Used at Home		
Chinese (Cantonese or Mandarin)	52	0.2%
English	28,278	83.5%
Russian/Ukrainian	130	0.4%
Spanish	4,891	14.4%
Vietnamese	85	0.3%
Other language	352	1.0%
Unknown	67	0.2%
Geography		
Frontier	885	2.6%
Rural	12,379	36.6%
Urban	20,172	59.6%
Unknown	419	1.2%
Disability		
Non-disabled	19,416	57.4%
Independent living/self-care disability	6,933	20.5%
1 Limitation	2,716	8.0%
2+ Limitations	1,681	5.0%
Unknown	3,109	9.2%

*Value suppressed to prevent backward calculation of other suppressed values.
†Value suppressed to protect confidentiality.

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for interviews. Members were sampled using four quota criteria: YSHCN subgroup, eligibility route, race/ethnicity, and geography. The standalone subgroup, who represent less than 10% of the population, was oversampled to represent 50% of the sample. These are members who would not be eligible for Medicaid if not for the YSHCN program and for whom the YSHCN policy is likely to have the most visible impact, therefore this group was oversampled to ensure their perspective was comprehensively evaluated. For the eligibility route, there were equal minimum interview recruitment targets set for each YSHCN identification route. For geography and race/ethnicity, there were quotas set to ensure a minimum representation of members in rural and frontier areas, and from diverse racial and ethnic groups.

A total of 10 YSHCN OHP members participated in interviews between November 2025 and early March 2026, for a response rate of 4%. Table 11 presents the characteristics of YSHCN OHP member interview participants. Six of ten participants were supplemental members; the remaining four were standalone members. Four were enrolled passively via BH/PMCA or ODDS; the remaining six were enrolled via the active pathway by completing the screener. Most interview participants so far live in urban areas (N=7) and are Black/African American (N=3).

Table 11. Characteristics of YSHCN OHP member interview participants, August 2025 – March 2026

	N = 10
Coverage Type	
Standalone	4
Supplemental	6
Identification Route	
Passive Enrollment via BH or PMCA	3
Passive Enrollment via ODDS	1
Active via Screener	6
Race/ethnicity	
American Indian/Alaska Native	2
Asian	0
Black/African American	3
Latino/a/x/e	2
Middle Eastern/North African	0
Native Hawaiian & Pacific Islander	1
White	0
Multiple/Other	0
Unknown	2
Age	
19	4
20	6
21	0
Gender	
Female	7
Male	3
Language spoken at home	
English	8
Other	1
Unknown	1
Geography	
Urban	7
Rural	3
Frontier	0

Qualitative data – Key entity sample. The key entities include state program staff (i.e., OHA, ODHS), CCOs, and staff at community partner organizations. To identify key entities, CORE consulted the YSHCN program lead at OHA, who provided a list of individuals at OHA, ODHS, and recommended community partner contacts. All CCOs were included for recruitment.

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Open Card/FFS contacts were included in recruitment, but so far have not yet agreed to participate. Our partners at OCCYSHN were consulted for community partner contacts as well. Community partner organizations are those who work with and support YSHCN OHP members and eligible individuals and their families. These are non-profits, disease or condition specific organizations, county partners, organizations that offer application assistance or those associated with health care institutions and/or universities.

Table 12. Characteristics of YSHCN Key entity interview participants, August 2025 – March 2026

	N = 27 Interviews (participants)
CCO Interviews	9 (12)
State staff interviews	8 (8)
Community partner interviews	7 (7)

We contacted 86 key entities and conducted 27 interviews, for a response rate of 31%. See Table 12 for breakdown of the interviewees.

Results

Implementation question 1a. What progress has been made towards implementing the YSHCN policy and what factors facilitated or impeded success?

YSHCN policy communication used a variety of approaches.

State program staff described a variety of outreach efforts conducted before and around the launch of the YSHCN policy. These included engagement with other state staff, as well as presenting at meetings with a variety of partners (e.g., CCOs, advisory meetings like Clinical Connections, regional advisory meetings, All Come webinars, FFS provider convenings) to increase awareness of the policy. OHA created and continues to maintain online resources for OHP members, providers, and CCOs, and continues to send out monthly newsletters.

There was a significant initial lift required at the State to establish enrollment systems.

Prior to the launch of the YSHCN policy, OHA worked to build systems to automate enrollment based on YSHCN criteria (e.g., PMCA score, BH diagnoses) and to capture additional screening data for new enrollees or people re-enrolling. This involved implementing processes for passive enrollment and updating the OHP application and ONE system to include the YSHCN screener questions. In particular, passive enrollment was designed to be the primary enrollment route, and there was a significant amount of effort invested to make this system function well and to keep the burden off OHP members. While key entities reported that this took time and resources upfront, these processes are now running as expected.

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Implementation at CCOs was relatively smooth, although did require some effort.

CCO staff reported not experiencing any major issues in the first year of implementation. Some key entities noted that they implemented the YSHCN policy as if they were adding a new eligibility category, which is a common practice.

> *"Honestly, it's been fairly smooth. We add new eligibility categories all the time. To us, this one was not unique, only that it expanded the scope of who would be eligible for the program and added that new eligibility category. The way that we've tried to implement it is to integrate that into the broader OHP administration." - CCO*

CCO staff described the creation of a YSHCN flag in their systems, which is used to flag when an OHP member is enrolled through the YSHCN policy to indicate that the individual may need post-enrollment outreach and care coordination (described further in YSHCN implementation questions 1b and 3, respectively). Similar to the OHA system set-up, this required significant time and resources initially but is now functioning as expected.

> *"There's a flag at the top. It just says YSHCN. There's an actual blue bar across the top of the screen, and it'll say YSHCN and yes or no. It took a lot of work. I just described to you like six-plus months of work." - CCO*

The staggered roll-out by age caused some confusion, although CCOs understood the intent.

Although CCO staff noted they understand that the staggered approach to the YSHCN policy rollout was intended to prevent overwhelming the system, some reported they may have preferred a complete age roll-out instead. The staggered roll-out added some confusion when communicating with current and potential OHP members, particularly around having to clarify that the benefits were not yet available for the older age range of YSHCN OHP members.

> *"I think we probably could have done more, and it would have been clearer if we had just rolled it out to the entire population. That by doing it incrementally, it actually created, I think, for the CCOs, potentially confusion and fragmentation of being able to serve the population...They hear that they're eligible, 'Oh, no, not this year. Sorry, you're a little bit older.' Well, that population is going to be, 'Screw it. I'm not going to come back. When you call me again, I'm not going to answer, because I heard I was eligible, and you're telling me I'm not.'" - CCO*

Implementation question 1b. How do OHA staff, and organizations who assist with enrollment, conduct outreach to the YSHCN population and what successes and barriers have they encountered?

Despite significant initial outreach by OHA, there remain opportunities for new and repeated engagement to address gaps in awareness.

While OHA staff do not conduct direct outreach to members, they maintain public-facing documentation on their website, including member FAQs and an informational video. In addition, at the start of the policy, OHA employed a train-the-trainer model, where they provided training on the policy to an initial group of enrollment assisters, who can assist with identifying potentially eligible YSHCN OHP members, provide pre-enrollment information on the policy and included benefits, and help individuals navigate the application process. These initial enrollment assisters then taught other enrollment assisters across the state. OHA also partnered with OCCYSHN to reach the members and their families that OCCYSHN serves.

Despite these outreach efforts, there are organizations that have not yet been reached. For example, one state program staff member specifically mentioned a perceived gap in engaging organizations located in rural and frontier areas. In addition, CCO and State staff suggested further opportunities for organizational outreach with university health services, given the age range for the YSHCN policy. Other community partners who serve YSHCN OHP members and their families were unaware of the policy and were therefore not using their networks to circulate YSHCN policy information. This is a critical gap, as these are the organizations who are poised to reach potential YSHCN OHP members and encourage enrollment, versus CCO outreach which is typically only conducted after enrollment has occurred. Further, while some CCO and community partner staff reported receiving information about the YSHCN policy initially, they did not receive any follow-up information or repeated engagement, which resulted in the policy not being front-of-mind.

> *"Overall, what could be improved is, we could have access to more organizations, talk to more people, but we're limited by the reach of our network, which is already quite expensive, honestly. It would be great to talk to more rural and frontier organizations... I think there's a concentration of the knowledge about YSHCN in the metropolitan areas, in Portland, in Salem. I don't know how much of the program's information reaches far into the depths of our state. That probably could be somewhere where we may go a little bit further." - OHA*

> *"I actually haven't heard a whole lot about it since being told of it initially a while ago… I remember being told about it, oh, I can't even remember, was it a meeting or some presentation or something, and it was some time ago. I've really seen nothing about it since." - Community Partner*

Many community partners and some CCO staff were interested in receiving a flyer or similar resource that they could easily send out to their listservs or hand to YSHCN OHP members, eligible individuals and their families, presenting a future opportunity to bolster outreach efforts.

> *"What I think would be really helpful for us in terms of getting the word out to the community is some type of a flyer, a simple flyer, not overloaded with text about, hey, this program exists, here's some basics, and here's how to sign up, here's a link for more information, that kind of thing. Because what we do a lot of is putting information out to the community. For a flyer like that, I could share it in the newsletter. I can share it on our social media." - Community Partner*

CCO staff also mentioned specific organizational roles, like provider relations representatives, that could be an avenue for YSHCN OHP member outreach, but do not believe these have been utilized yet. A staff member at an urban/metro CCO described working with a variety of organizations in the larger system (e.g., clinics, FQHCs, school-based services) to share information about the policy, whereas other CCOs, both urban and rural, have said they have not conducted YSHCN OHP member-specific outreach to other organizations.

Processes for outreach following enrollment at CCOs did not change significantly as part of the YSHCN policy, as these outreach processes are not specific to this population.

In general, the outreach following CCO enrollment is not specific to YSHCN OHP members. CCO staff report that when members are identified as elevated risk, the organization undertakes more intensive O&E to ensure these members receive necessary support and are connected to services. Outreach efforts also often occur around redetermination periods to ensure members are able to reenroll without gaps in coverage. However, this approach is not specific to the YSHCN population as most YSHCN OHP members would be typically classified as medium or high risk regardless of their YSHCN designation.

> *"We don't have any outreach that is specific to YSHCN. It would just be part of our typical onboarding and outreach activities that we would do for any new member, and then, as part of that risk assessment screening, we could potentially identify health needs that are specific to that individual that made them eligible for YSHCN, and we would connect that individual to supports and services that are part of the program." - CCO*

The YSHCN population faces additional unique barriers to effective outreach, and this may require the development of different outreach methods.

All key entity groups (i.e., State staff, CCOs and community partners) describe YSHCN OHP members and eligible individuals as being a uniquely hard population with whom to conduct outreach. Generally, young adults are less receptive to the more traditional forms of outreach, like mailing and phone calls. In addition, YSHCN OHP members may require additional assistance due to their complex health conditions or a lack of medical literacy to ensure they are receiving and understanding all the information.

> *"Our engagement in trying to reach these members has proven really challenging. Our 'unable to reach' is really high. They don't answer phones. They don't really return calls. They're not very engaged overall as a population. That is definitely one of our big challenges." - CCO*

> *"It's a big concept for what do we mean by youth, young adults with special health care needs, what kind of health care needs qualify, and how is this program going to benefit me if I do go through the hassle of screening myself, what do I have to gain from it? It's just really difficult to explain that to people, especially if they have disabilities or barriers. We put it in plain language. Our notices are fairly brief, and there's always the risk that the message just isn't getting through. To me, that's the biggest risk." - OHA*

Another unique challenge with the YSHCN population is that typically at 18 years old a person is presumed capable of making their own medical decisions; however, this is not always the case for this population. For some YSHCN OHP members there are multiple people involved in their care, such as a parent or caregiver, and this can complicate outreach and care coordination efforts.

> *"The biggest difference is that once someone hits 18, they're presumed eligible to make their own decisions. With this particular population, we may have someone who is not in that spot. A lot of times, we're maybe navigating or helping a family navigate, making sure that they can still advocate for or provide or speak to care that someone is needing depending on what the special need is." - CCO*

In response to the outreach challenges, some CCOs are in the process of developing digital methods to conduct outreach to members, including options like text messages, robocalling, social media posts, and patient portals. This response aligns with thoughts from YSHCN OHP members who also said that they did not think potentially YSHCN-eligible community members knew about the program because communication has not been 'right' for this population; they suggested that placing flyers in central locations, using social media, or billboard outreach could be more effective.

YSHCN OHP members generally had low awareness of the policy.

During interviews, YSHCN OHP members typically referred to their coverage as OHP; few were aware of the YSHCN policy itself.

A few YSHCN OHP members recalled hearing about the YSHCN policy from a parent, community center, or therapist, while the majority of members we spoke with were not aware of the YSHCN policy prior to enrollment in OHP (i.e., the member did not recall any YSHCN-related information before receiving the enrollment letter) or were not aware they were enrolled under

the YSHCN policy until the interview. This was consistent across interview participants in this sample with standalone and supplemental members and passive and screener identification routes; this will continue to be assessed as sample size increases for the summative report.

Key entities all agreed that they are likely missing eligible YSHCN eligible individuals in the population. One community partner attributed this partially to this being a new policy, and the individuals best positioned to inform families and members are not well informed either.

> *"I think the biggest factor is it's a new program. Not all providers know about it...The primary care system is under stress, so I don't know how many primary care providers have heard about this and have researched it, and are willing to recommend it to their families. I think care coordinators at different providers' offices, traditional health workers who are supporting families, and peer support specialists in the behavioral health, those are the people that are going to help spread the word."*
> *- Community Partner*

Implementation question 1c. What efforts did OHA and partners make to center equity in the identification of YSHCN? How effective were these efforts?

OHA prioritized equity in outreach to other organizations.

As part of the outreach efforts described above in YSHCN implementation question 1b, OHA prioritized engaging groups in different languages and with different cultural backgrounds. This included Black and Latino/a/x/e communities, LGBTQIA+ groups, and culturally-specific provider groups.

> *"[We are] making sure that we reach out to minority communities, communities of folks who don't speak English as a first language, and folks who live with a disability or have high needs in a way that precludes them from participating readily into the program for a lack of getting the information, being able to use it, or being able to enroll." - OHA*

YSHCN OHP member materials were designed with members in mind.

OHA was intentional around centering equity in the development of the YSHCN OHP member screener and member-facing educational materials. OHA contracted with OCCYSHN to assist with the development of the screener questions. OCCYSHN held focus groups to make sure the questions were relevant and appropriate for members and caregivers both in terms of content and phrasing. The questions were also transcreated in other languages. For member-facing materials, the YSHCN OHP member FAQs on OHA's website is available in 12 languages, and the YSHCN OHP member informational video is also available in multiple languages to make the information accessible to a diverse population. Additionally, the imagery in the member handbook was updated to be more diverse in terms of race, disability, and body type.

YSHCN OHP member population composition is similar to the general OHP population.

The demographics of the YSHCN OHP members (Table 12 above) reflect the intentional efforts made by OHA; the YSHCN OHP member population is diverse and proportionally aligns with the broader OHA population for this age range, indicating that certain groups were not underrepresented.

Implementation question 2. How were YSHCN enrolled in Medicaid under the new policy and what was their experience with the process? Through what routes are YSHCN being identified and enrolled to Medicaid?

A total of 33,855 YSHCN OHP members were enrolled in Medicaid during calendar year 2025. Of these, 422 (1.2%) were new to Medicaid, i.e. they had not been enrolled in Medicaid prior to receiving YSHCN Medicaid status. This includes both standalone and supplemental YSHCN OHP members.

YSHCN OHP members primarily experienced passive enrollment due to qualifying behavioral health diagnoses or PMCA scores; and over 90% had supplemental coverage.

Table 13 gives the route by which individuals are identified to become YSHCN OHP members. YSHCN OHP members primarily experienced passive enrollment due to a qualifying behavioral health diagnosis or PMCA score (BH/PMCA) (85.7%); this represents individuals who were already enrolled in Medicaid at the age of 18 and were automatically assigned YSHCN status when they turned 19 years old. The next most common route was by completing a screener (12.0%) that automatically appears for individuals in this age range when they apply for Medicaid. Only 2% of YSHCN OHP members were enrolled via referral from ODDS. Over 90% of YSHCN OHP members had only supplemental coverage, indicating they were already eligible for Medicaid outside of the YSHCN policy; their YSHCN status meant they were additionally eligible to receive HRSN benefits and, once they turn 21 years of age, they will continue to be eligible for EPSDT benefits (Table 13).

Table 13. Route and type of YSHCN coverage for 33,855 YSHCN OHP members enrolled in Medicaid during calendar year 2025

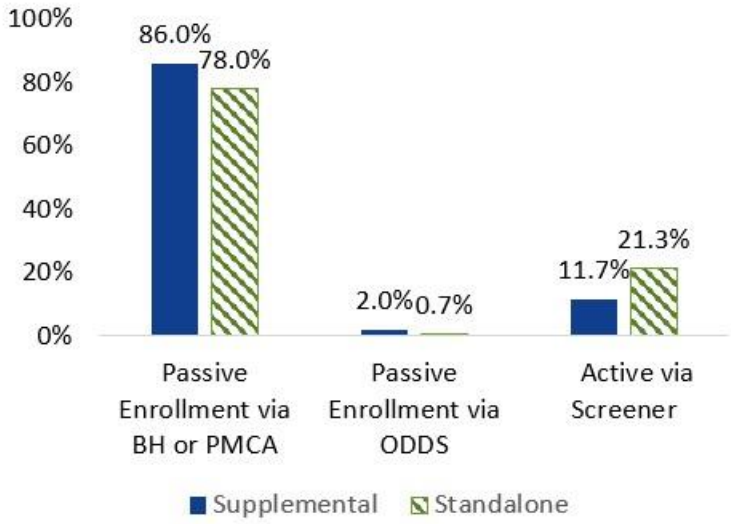
	N	%
Identification Route		
Passive Enrollment via BH or PMCA	29,010	85.7%
Passive Enrollment via ODDS	682	2.0%
Active via Screener	4,056	12.0%
Unknown	107	0.3%
Coverage Type		
Supplemental Only	31,558	93.2%
Standalone Only	473	1.4%
Both Supplemental and Standalone	1,824	5.4%

BH: qualifying behavioral health diagnosis
PMCA: pediatric medical complexity algorithm
ODDS: Office of Developmental Disability Services

In contrast, 1.4% of YSHCN OHP members had only standalone coverage, indicating that without the YSHCN policy, they would not have been eligible for Medicaid at all. The difference between these two eligibility groups is income level; 5.4% of YSHCN OHP members switched between standalone and supplemental coverage during calendar year 2025, indicating that they experienced a change of income during that timeframe. This was primarily due to YSHCN OHP members switching from supplemental to standalone (N=1,678), indicating an increase in income; relatively few YSHCN OHP members switched from standalone to supplemental coverage (N=146).

Identification route was associated with type of coverage (Figure 25). Compared to those with supplemental coverage, YSHCN OHP members with standalone coverage were almost twice as likely to have been identified by completing the screener, suggesting that they were less likely to have been enrolled in Medicaid prior to becoming eligible for YSHCN.

Figure 25. YSHCN identification route by type



There are a few notable differences in YSHCN OHP member demographics across the three identification routes, suggesting that the three different routes are identifying somewhat different populations.

While YSHCN OHP members identified via BH/PMCA or actively enrolled through the screener were majority female, 68.0% of those identified via ODDS were male (Figure 26). This is unsurprising, as ODDS' caseload is disproportionately male.

There were also differences by language spoken at home, specifically for Spanish (Figure 27). YSHCN OHP members identified via BH/PMCA were approximately twice as likely to indicate Spanish as their preferred language, compared to the other two identification routes.

Finally, there were differences by self-reported disability status (Figure 28). Over 70% of YSHCN OHP members identified via ODDS had independent living or self-care disability; compared to only 27.5% of those identified via the screener and 18.2% identified via BH/PMCA. Again, this difference is expected since YSHCN OHP members would have been identified by ODDS specifically because they have an Intellectual or Developmental Disability plan in place.

Figure 26. Sex by YSHCN identification route

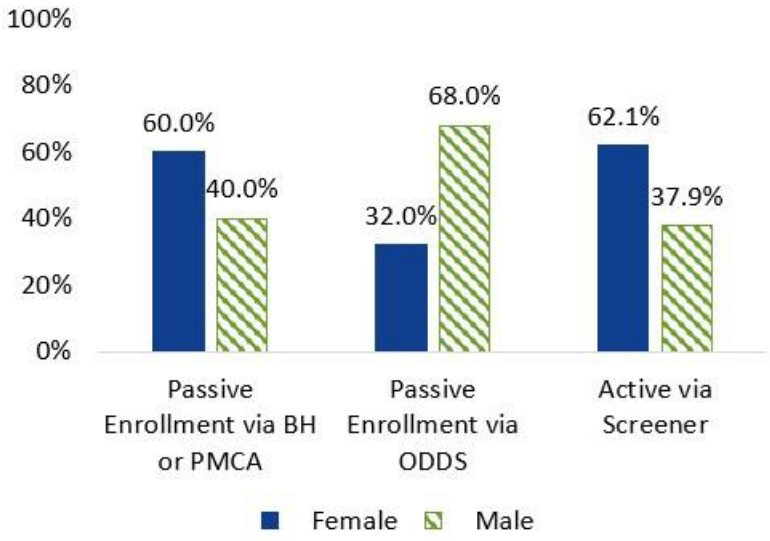
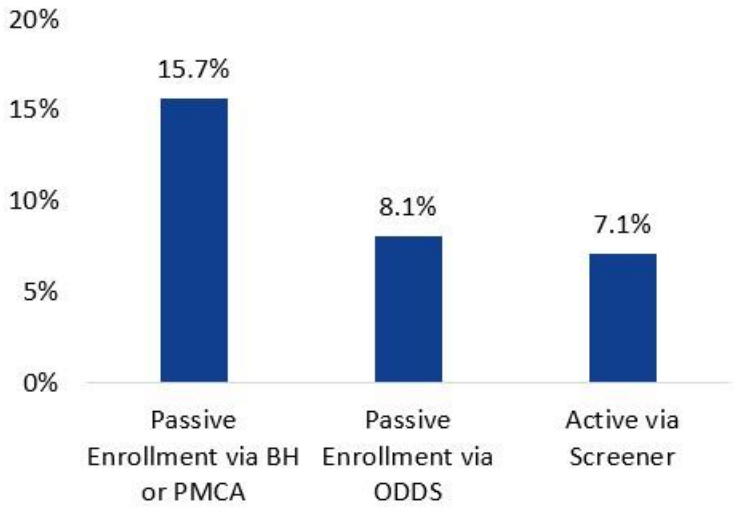
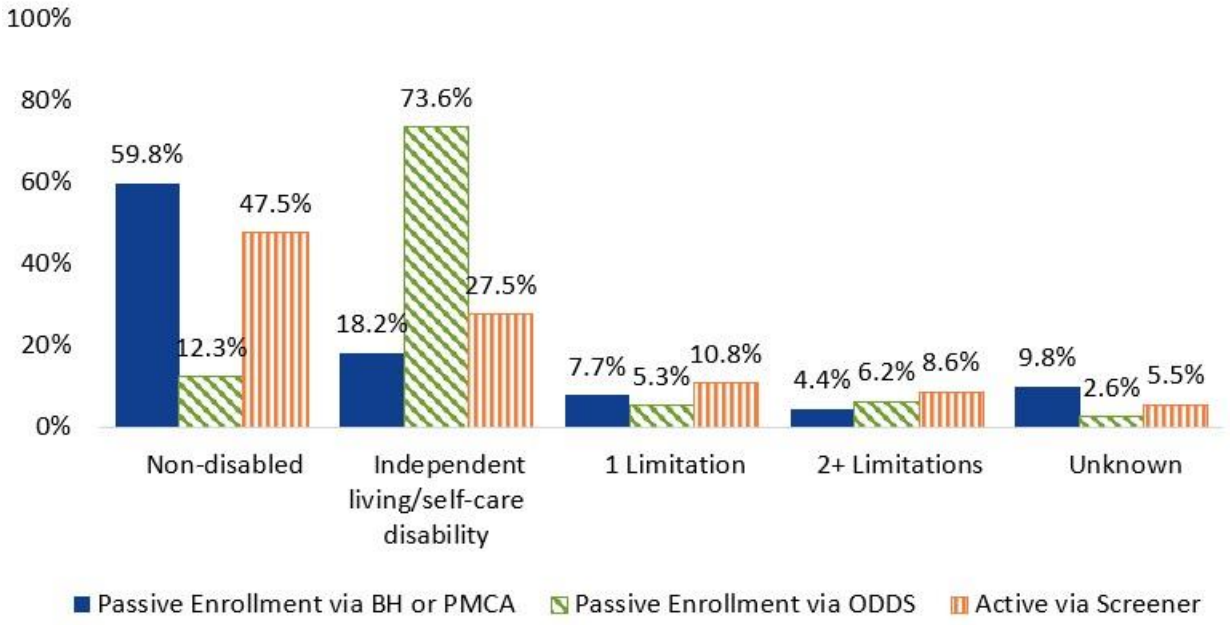


Figure 27. Spanish language spoken at home by YSHCN identification route



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Figure 28. Disability status by YSHCN identification route

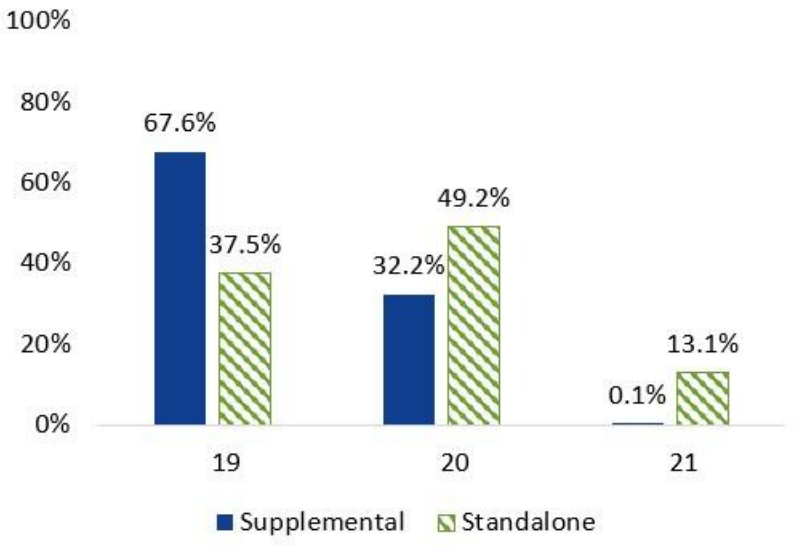


There were some demographic differences by YSHCN coverage type.

There are two notable differences when comparing characteristics of individuals with supplemental versus standalone YSHCN coverage.

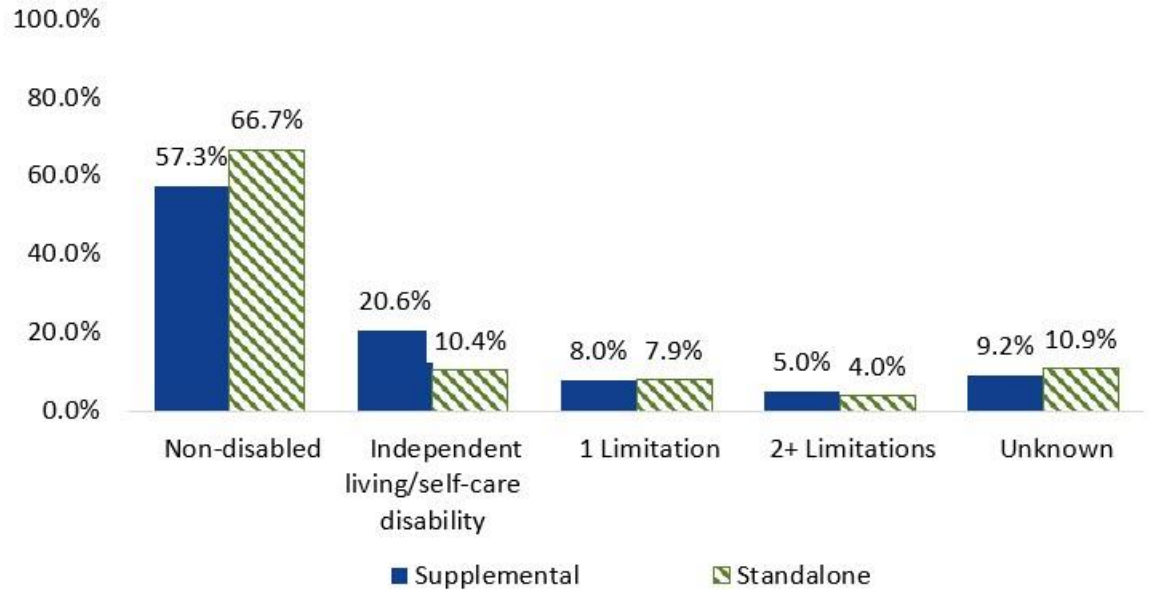
First, YSHCN OHP members with standalone coverage were older (Figure 29).

Figure 29. Age by YSHCN coverage type



Second, YSHCN OHP members with standalone coverage were more likely to report being nondisabled, and less likely to report an independent living or self-care disability (Figure 30). This is promising, as the standalone coverage was intentionally designed to reach individuals without reported disability (because those with a reported disability would likely already be eligible for OHP).

Figure 30. Disability status by YSHCN coverage type



Full demographic tables are provided in Attachment 5 (Appendix Tables 3 and 4).

Implementation question 2c. What is the experience of Medicaid enrollment for YSHCN and their families/caregivers?

The Medicaid enrollment process is lengthy and not memorable.

Generally, the OHP enrollment process was described as long but relatively easy, though it is important to note that we only spoke to YSHCN OHP members who successfully enrolled in OHP.

> *"My only problem was it was so long... it was about an hour's worth of paperwork...they wanted a lot of details about me that, you know, asking so much... But other than that, I mean, I had no problems with enrolling onto it and filling out all the work that they had me do." - YSHCN OHP Member*

YSHCN OHP members sometimes were unclear whether they handled enrollment or if another person such as a parent completed it on their behalf. This may be because some participants already on OHP were passively enrolled, so the recall time from their original enrollment date could be quite long. YSHCN OHP members who recalled the enrollment process reported they did not feel that changes needed to be made to the system to better accommodate them. One member in particular appreciated the use of their preferred name in the process.

> *"I do remember I go by a preferred name, and within the process, it would automatically show up as my preferred name. I remember that was nice." - YSHCN OHP Member*

The YSHCN screener did not stand out in the Medicaid application process

For the participants who actively enrolled in YSHCN using the screener, they did not differentiate the specific YSHCN questions from the rest of the OHP application. One community partner who assists with ONE system navigation also did not specifically recall the screener as part of the application. This likely means that the questions fit well in the existing language and flow but could have contributed to the low awareness of the policy amongst YSHCN OHP members.

Implementation question 3. How did Oregon's CCOs and FFS program engage and support the newly defined YSHCN population of members?

There were minimal changes needed for coordination of care policies and processes at CCOs

Generally, CCOs report that the care coordination processes are similar to how they worked before the waiver period and there was not much variation between CCOs. As noted in the study population, interview recruitment attempts for multiple Open Card/FFS contacts have been made without resulting participation, therefore the findings do not speak to their processes yet.

The engagement and support for YSHCN OHP members is similar to other OHP members who are identified for case management through the risk stratification process. The CCOs report working with many systems to coordinate care and support members, though this is how they approach care coordination for all their members and is not specific to YSHCN OHP members.

> *"Using our risk stratification model, someone that is YSHCN eligible is probably more likely to be on the rising risk or higher risk part of our stratification for care coordination. They would just be on our radar based on that screening criteria or historical claims experience. Again, nothing specific to YSHCN. It would just be how their patterns of care and clinical needs would show up within our systems, the way anyone else's would." - CCO*

Some CCOs indicated that the relatively few changes to date are largely due to the limited impact of the initial rollout on CCO operations. Specifically, the YSHCN policy currently functions primarily as a new eligibility category and does not introduce new benefits beyond those already available under EPSDT for the first cohorts. As a result, administration of the YSHCN policy has closely mirrored existing EPSDT processes. However, stakeholders anticipate that additional process changes may be required next year as the eligible age range expands to include individuals who are not currently covered under EPSDT.

"It will change for those who are 21 and over and in YSHCN because right now, people who are 21 and over, nobody has EPSDT, but for YSHCN who are 21 and over, they will have EPSDT. In that case, care coordination or any kind of service, it might change based on the medical necessity and appropriateness. We will see that change in the future. Right now, those who are YSHCN are also EPSDT, so it's no different from how they were receiving services before." - OHA

CCOs leveraged existing policies, practices, and partnerships to deliver culturally and linguistically appropriate care

Most CCOs report not having to adapt processes for outreach or care coordination to be culturally or linguistically appropriate or to be specific to YSHCN OHP members because they already have strategies and training to engage groups in a culturally or linguistically specific way. These policies and practices were in place long before the YSHCN policy. One urban CCO reported updating policy and guidance language to be inclusive of YSHCN terminology, but other CCOs did not report making changes. Additionally, many CCOs report that accessibility and reading levels are reviewed for member-facing materials and care managers/coordinators are matched to members based on language and other characteristics whenever possible, but again these processes are for all OHP members.

"Maybe some of the language, we've updated some of our policies to make sure we're inclusive of the YSHCN population with enrollment or health risk screening, care coordination, I can't think of anything that was major that was changed in our processes." - CCO

"It would be the same as anyone else enrolled in the Oregon Health Plan that has culturally and linguistically specific needs. Again, reminding providers and community-based organizations around health care interpretation supports that are available at no charge. We provide translations for written materials. Then we have a number of partnerships, as I mentioned earlier, with community-based organizations that provide culturally specific services and linguistically specific services." - CCO

Implementation questions 2-3. The YSHCN policy will improve continuity of care for Medicaid-enrolled YSHCN. The YSHCN policy will improve health care access and utilization for Medicaid-enrolled YSHCN.

Continuity of care experiences were varied among YSHCN OHP members.

Most members were unaware that they were enrolled in the YSHCN eligibility category, and therefore when talking about their experience, they typically are speaking about OHP broadly,

and not YSHCN specifically. Of note, the sample size for this interim report is small, and these experiences will be further analyzed in the summative report.

For some YSHCN OHP members, including both supplemental and standalone YSHCN OHP members, they reported maintaining the same providers they had prior to being on OHP under the YSHCN policy. Some additionally reported that their ability to get timely care improved once they were enrolled in OHP under the YSHCN policy.

> *"There were waitlists that were a little bit harder to get into. Then when I got into the program, the waitlists weren't even really waitlists anymore. I got in very quickly."*
> *- YSHCN OHP Member*

Other members reported a change of providers since being a YSHCN OHP member. For some members, this was a smooth transition, but others cited concerns that they had or would have to start anew and provide their full, complex health history to a new provider who is not familiar with their needs.

> *"I got added to this program about a year ago, from my memory. I switched. I'm not sure if it's with this program or all the doctors leaving certain hospitals, but I did end up switching to somewhere they accepted everything, and they got me more access to stuff. I think it was PeaceHealth something. From then, the new doctors, they recommended me different places that gave me more access to things." - YSHCN OHP Member*

> *"I was annoyed that I had to change my primary care doctor because I didn't really know who else in the area would be as, I wouldn't want to say efficient, but who would work for my needs specifically. That's pretty much it. It was fine, though, otherwise. It wasn't the biggest deal." - YSHCN OHP Member*

For some, there were challenges finding providers who accepted OHP.

> *"It's really hard because anywhere that's open with a PCP accepting new clients doesn't accept the Oregon Health Plan." - YSHCN OHP Member*

Key entities also cited the lack of "willing and able" adult care providers as a challenge for continuity of care, particularly in rural areas.

Key entities, primarily CCO staff, report that finding adult care providers that have the capacity and ability to take on YSHCN OHP members transitioning from pediatric to adult care can be a challenge.

"One of the biggest barriers in that continuity of care is being able to get a member, especially in that population, the services and the access to the providers that they need or once had can be a huge barrier." - CCO

"We have some phenomenal pediatric clinics down here who are able to manage quite a bit of complexity, whether it's physical health complexity or even more behavioral health complexity without physical health issues. When that person needs to transition to someone who's going to be more of the long-term provider, that can be very difficult. It isn't always because the providers who treat adults don't want to take on the complexity. I think there's some truth to that. I think our network is full." - CCO

Some key entities noted that this is a particular challenge in rural areas, where there are fewer providers, generally, and particularly fewer specialists to meet YSHCN OHP members' needs.

"I think our biggest barrier to serving our members is access issues and access in particular to specialty care that is local." - CCO

Changes in access to and utilization of health care services varied amongst YSHCN OHP members.

YSHCN OHP members cited several different health care services they currently utilize primary care, prescription drugs, dental, vision, therapist, psychiatrist, emergency department, and OB/GYN. The YSHCN policy had varying impacts on their care.

- *No change*: Some members report no change in their health care access and utilization since being enrolled in the YSHCN eligibility category for OHP. Given that many YSHCN OHP members were previously on OHP and were passively enrolled on their birthday, it is reasonable to expect that their access and utilization did not change substantially.
- *Improved access & experience*: Some members report that their health care utilization experience improved, that they find it easier to get connected to new services, the system is easier to navigate, and that they are listened to more during care appointments.
- *Decreased access*: Some YSHCN OHP members mentioned difficulty finding providers who accepted OHP (see continuity findings above).

"The health care services I use now, I feel, I navigate more smoothly than I did with my previous health care that I've been a part of, because I understand what I qualify for, what exactly this program entails in terms of the health care services I can receive. I'm more confident in reaching out to certain services." - YSHCN OHP Member

Lack of awareness of benefits provided by YSHCN policy may impact utilization.

As previously mentioned, many YSHCN OHP members interviewed were unaware they were under the YSHCN policy until the interview. Multiple members did not know about certain services that are available to YSHCN OHP members, such as expanded dental and vision or HRSN, and therefore did not utilize these services.

Decreased financial burden could facilitate access and utilization of care.

Two YSHCN OHP members cited the financial strain and related stress being lighter now they are on the benefit, which has improved accessibility.

> *"I think it's made it a lot more accessible, like financially easier to do. I know sometimes, a lot of times, it's quite expensive for these necessary things, a lot of out-of-pocket, but it makes it easier." - YSHCN OHP Member*

DRAFT

Cost and Sustainability

Summary of Key Findings

Administrative costs to implement and operate the demonstration

- Between 2022 and 2024, OHA spent $60.2 million on the demonstration; non-grant CCO spending is not yet reflected in these numbers.
- Of this, $23 million was spent on demonstration administration including: staffing, equipment, and overtime; consulting and contracting; information technology projects; outreach and operations; evaluator costs; and other administrative expenditures related to demonstration implementation and operation.
- In October 2024, OHA and Oregon CCOs awarded the remaining $37.2 million through CCBF investments to organizations supporting delivery of HRSN services.
- The largest identified investments were associated with HRSN implementation and activities classified as not specific to any one policy component, while substantially smaller expenditures were attributed to CE, TME, and YSHCN. Costs reported align with approved funding allocations to each of the components and may not reflect actual hours spent on components.
- HRSN drove the highest component-specific spending, consistent with the novelty of the benefit and the upfront investment required to build HRSN Service Provider networks, infrastructure, data systems, and internal capacity.

Context and background

Overview of evaluation requirements. The CMS-approved evaluation design includes a mixed-methods assessment of the administrative costs associated with implementing and operating the demonstration. CMS Special Terms and Conditions specify that these cost assessments must include, at a minimum, administrative spending, Medicaid health service expenditures, and provider uncompensated care costs, and that these findings be used to inform broader assessments of fiscal sustainability over time.

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CMS -Approved Research Questions and Logic Model

Evaluation Questions and Hypotheses

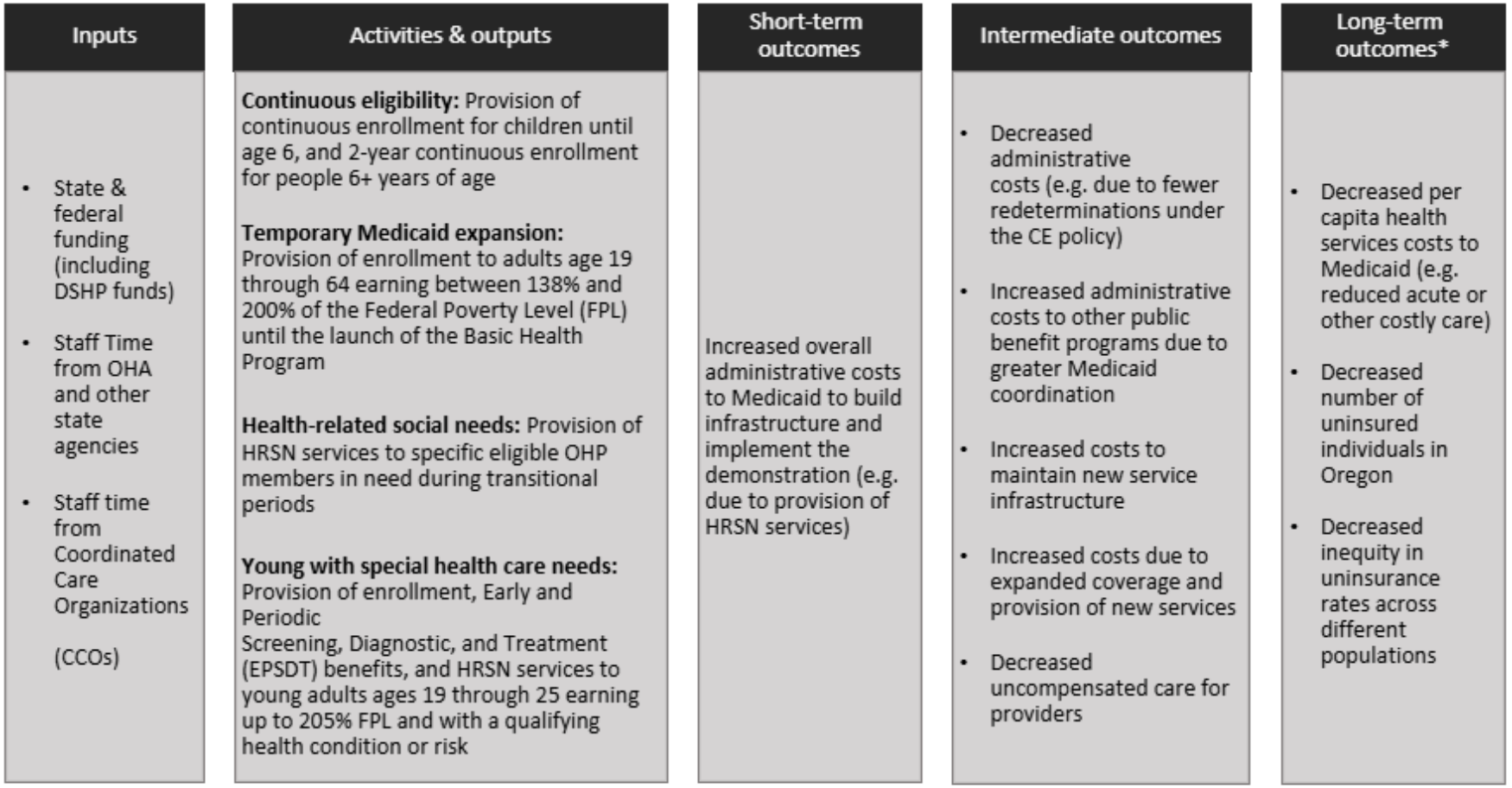
1. Continuous eligibility (CE) redeterminations are anticipated to decrease certain administrative costs. However, overall administrative costs to the state and Medicaid partners will increase. This increase is due primarily to the provision of new services under the HRSN policy, and the investment in HRSN infrastructure in the form of DSHP-financed community capacity building funds (CCBF) grant program.
    - 1.1 What are the administrative costs to implement and operate the demonstration?

2. The demonstration will increase health expenditures in the short-term, due to both an expansion of eligibility to new populations and the provision of additional (HRSN) services; and then ultimately decrease per capita health expenditures in the long-term as increased access to care and addressing health-related social needs (HRSN) result in a decrease in acute and costly care such as emergency department visits and inpatient stays.
    - 2.1. What are the short- and long-term effects of eligibility and coverage policies on health service expenditures, including HRSN service expenditures?

3. The demonstration will reduce total uncompensated care for providers by expanding eligibility to new populations, thereby reducing the number of uninsured individuals in Oregon; and by reducing hospitalizations, thereby reducing uncompensated care provided by hospitals.
    - 3.1. What are the impacts of eligibility and coverage policies on provider uncompensated care costs?

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Figure 31. Cost and sustainability logic model



Research questions included in this report

The evaluation questions and hypotheses outlined above define the full scope of the evaluation plan. This interim report relies on currently available data; this is partial data limited to evaluation question 1 only. The interim report uses this data for a descriptive analysis of administrative spending reported by OHA. In addition, we include results from several key informant interviews. The summative evaluation will build on these interim findings by expanding cost data collection to CCOs, conducting additional interviews, and using more complete data. The analysis will more deeply explore costs as well as examine the remaining two evaluation questions with robust quantitative analyses.

Study Population

Our assessment of administrative costs is at the state level, not at the level of the Medicaid enrollee. To collect these data, we relied on accounting and financial data provided by OHA administrators.

Qualitative Data – Key entity sample. To complement these analyses, we collected qualitative data through interviews with OHA staff with relevant fiscal and budgetary expertise. Qualitative insights were used solely to contextualize quantitative results and clarify implementation complexity, rather than to validate quantitative estimates or identify systematic patterns. Interviewees generally noted that they were not able to speak to specific trends or patterns in administrative spending by demonstration component, detailed internal drivers of staff time allocation across waiver components, financial metrics or benchmarks OHA may use to assess long-term sustainability or return on investment, or component-specific administrative costs for certain initiatives (e.g., TME), due to overlap with other concurrent policy efforts and operational unwinding activities.

We contacted nine individuals recommended by OHA demonstration leads and conducted two interviews with three unique individuals, for a response rate of 33%; the remaining contacts either declined to participate (N=3) or could not be reached (N=3).

Results

Evaluation question 1. What are the administrative costs to implement and operate the demonstration?

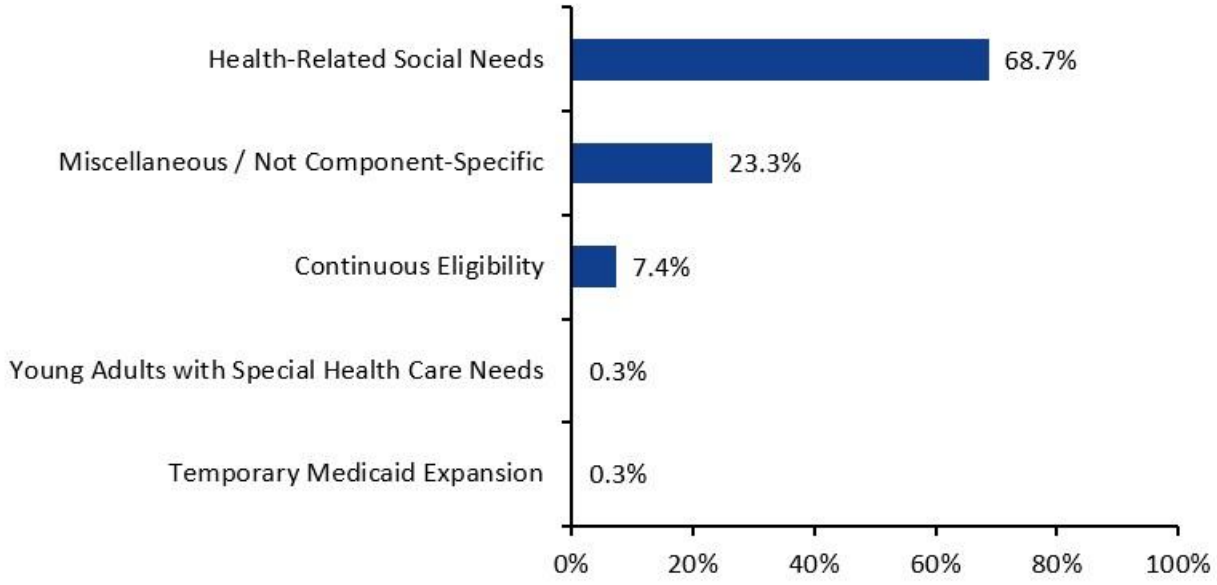
Between the start of the demonstration through calendar year 2024, OHA spent approximately $60.2 million to plan, implement, administer, and operate the demonstration. Of that, $23 million was spent on staffing, employee support costs, indirect administrative costs, consulting and contracting (including evaluation spending), information technology projects, and outreach and operations. The remaining $37.2 million dollars was used for CCBF grant spending allocated

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in 2024 to support implementation of HRSN services. These investments supported provider capacity, workforce development, technology, and other infrastructure needed to deliver HRSN benefits under Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver.

Across demonstration components, the largest share of implementation-related spending was attributed to HRSN (68.7 percent, $41,335,056), followed by Miscellaneous / not component-specific activities (23.3 percent, $14,016,809), CE (7.4 percent, $4,434,776), YSHCN (0.3 percent, $200,834), and TME (0.3 percent, $190,321) (Figure 32). HRSN spending included both administrative expenditures and CCBF investments reported by OHA and CCOs during 2024.

Figure 32. Administrative spending by policy component, OHA 2022-2024



Interviewees noted that the novelty of the HRSN component drove a higher need for consultative support early in the waiver period, with that need decreasing as waiver implementation progressed. Higher spending on HRSN reflected the intensity of early-stage activities, including policy development, cross-agency coordination, and systems setup. Systems setup included the development, review, and execution of contracts; design and implementation of necessary systems changes; establishment of billing and reimbursement methodologies; and coordinated efforts to build, onboard, and prepare the HRSN Service Provider network for service delivery. There was an intentional effort to build HRSN Service Provider capacity to manage and oversee new benefits. OHA created new, distinct positions (OHA or contracted) for corresponding HRSN subject-matter areas to ensure there was the necessary expertise as new systems (e.g., CIE) and services were designed. Contracting supported urgent needs related to project management, coordination, gathering extensive data and documentation, drafting protocols and technical operational plans, negotiations, and

communications. OHA also established a dedicated HRSN team, developed new staff expertise, refined internal workflows, compliance monitoring structures, and strengthened cross-agency partnerships needed to support long-term operational success.

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Section G. Conclusions

Oregon's demonstration is still in progress. This report provides an interim overview of progress towards the demonstration's goals through Q2 2026 (although the timeline of the data included in this report varies by policy area). Oregon has shown significant progress in implementing the demonstration, including:

- Successful transition to 24-month continuous eligibility for people ages six and older under CE
- Implementation of TME for eligible members for the OHP Bridge program completed
- Launch of O&E and Housing under HRSN; partial launch of Nutrition benefits
- Rollout of YSHCN benefits for 19–21 year olds

As described in the body of the report, a tremendous amount of work was put into implementing the majority of these policies. It is still too early in the analysis to determine whether the implementation of these policies met the goals of the demonstration. That assessment will be included in the summative report. Below, we provide a brief overview of the progress towards the demonstration goals for each specific policy area.

CE and TME

Implementation partners described how inter-agency collaboration, system supports, and technical infrastructure helped translate the CE and TME policies into operational practice. CE reduced renewal-related administrative burden for state agency staff through less frequent redetermination cycles, which allowed staff and assistors more time to help households with more complex circumstances. Both policies created more predictable coverage continuity periods which supported stability for CCO partners but also created additional challenges for CCOs around redetermination outreach. Implementation partners also described barriers to CE and TME rollout including coordination gaps, confusion about policy details, and staffing constraints. Culturally responsive, transcreated, and plain language summaries, along with trusted local navigation assistance, helped members understand coverage.

In 2024, the first calendar year after CE implementation, 153,501 individuals under age six and 1,562,949 individuals ages 6–64 were enrolled in OHP at some point during the year. Enrollment data reflected relatively stable OHP membership following the end of the PHE federal continuous coverage requirement in 2023. Disenrollment increased during CE implementation but stayed below pre-pandemic levels, and churn remained low during CE after declining during the PHE. Additionally, average annual days enrolled decreased slightly after unwinding of the PHE but remained above pre-pandemic levels. Sociodemographic compositions of continuously enrolled members and members experiencing churn were broadly similar.

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Four in five OHP members enrolled under the TME policy either transitioned to OHP Bridge or an alternate OHP category of aid with no interruptions in coverage within three months of the end of the program. Approximately one in three TME members seamlessly transitioned to OHP Bridge, and approximately one half of TME members seamlessly transitioned to an alternate OHP category of aid. Less than 2% of TME members entered either of these new plans with a gap in coverage. These data were consistent with our qualitative findings that most TME members did not experience coverage disruptions during the TME-to-OHP Bridge transition. Assuming all else equal, roughly twenty thousand people who moved seamlessly from TME to OHP Bridge would have lost coverage without the TME policy in place.

Taken together, these early findings indicate that preventable coverage loss was largely avoided under the demonstration. Other resources show that Medicaid enrollment declined substantially in most other states during the Medicaid unwinding period, but the share of Oregonians who were disenrolled from Medicaid during the unwinding was the second lowest in the country (73). Formal comparisons of Oregon to other states will be made in the summative report.

HRSN

Implementation of the HRSN portion of the demonstration was an enormous undertaking, involving an entirely novel set of benefits, new provider networks in every region of the state, and numerous original or modified systems, workflows, and processes. While there were significant challenges with HRSN implementation, OHA, CCOs, and HRSN Service Providers have made and continue to make adjustments to improve operations and beneficiary experience. Specifically, HRSN Service Providers, CCOs, and OHA all dedicated significant time and resources to training, capacity building, and technical assistance. OHA adjusted rules and requirements, increased rates for some HRSN services, and refined their communications about who was eligible for HRSN and what circumstances the benefit was intended to address. DSHP funds were also critical in building and maintaining the infrastructure needed to deliver HRSN services.

Between March 2024 and September 2025, 19,495 OHP members received HRSN services. Housing support was the most commonly requested category of HRSN. Overall, demand for HRSN services, especially rent support, was higher than some key entities initially anticipated. The volume of requests combined with the complexity of HRSN operations strained the capacity of service providers and CCOs and caused sometimes lengthy delays in authorization and provision of rental support. Delays increased OHP member stress related to housing and finances and, in some cases, limited the ability of the benefit to mitigate eviction risk. However, once they had received HRSN services, OHP members almost uniformly reported reduced stress and improvements in mental and emotional well-being, including relief stemming improved financial stability (rent/utility support) and better quality of their living environment (Housing

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(home changes for health)). Some beneficiaries reported positive changes in health status and health care utilization after receiving HRSN services while others reported no impacts. Examples included cooling or air quality devices relieving some beneficiaries' health concerns or individuals having more time and capacity to attend medical appointments, get needed treatment, and focus on recovery because their rent or other costs were covered.

YSHCN

At the start of YSHCN implementation, there was a significant amount of effort to update the systems to passively enroll OHP members and to design the YSHCN screener and embed it into the OHP application and ONE system. CCOs reported a fairly smooth implementation; adding the YSHCN eligibility category was like adding any other eligibility category, which is a common workflow for CCOs. There were no changes to CCO engagement or care coordination processes. Key challenges included the difficulty in reaching the YSHCN population because of their generally lower responsiveness and broad lack of awareness about YSHCN across partners and members. To address this, CCOs are working on digital methods for outreach to eligible participants. To increase awareness, requests for a flyer or one pager were made by community partners to send through their networks, as well as the use of social media to reach more young adults.

In 2025, a total of 33,855 YSHCN OHP members were enrolled in Medicaid, the majority of which (31,558) were supplemental members (i.e., those who would be eligible for OHP without the YSHCN policy). Approximately 1% were new to Medicaid. The total enrolled far exceeds OHA's estimates at the beginning of 2025. As anticipated, the majority of YSHCN OHP members were passively enrolled with only ~12% enrolled through the screener. Members noted that the OHP application process was long, but not difficult, and they did not specifically recall the YSHCN screener. When asked, none of the members reported that changes to the application process were needed to accommodate them or to make the process more culturally or linguistically appropriate.

YSHCN OHP members reported varying experiences with continuity of care and utilization. The majority members maintained their same providers, whereas others reported challenges in finding a provider that accepts OHP. Similarly, there were varied reports of changes in utilization; some members reported no change in utilization of health care services, some reported being able to access additional services or access services quicker, and some reported reductions in utilization. Lack of awareness of the full benefits provided may influence utilization.

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Cost and Sustainability

Early investments supported the infrastructure, staffing, and readiness activities essential to implementing Oregon's 2022-2027 1115(a) Medicaid Demonstration Waiver. The administrative costs differed across demonstration components. Coverage expansions —CE, TME, and YSHCN — required less investment than HRSN. This was expected due to the novelty of the HRSN benefit and the upfront investment required to build HRSN provider networks, infrastructure, data systems, and internal capacity. The state anticipates that the cumulative impact of these foundational activities — including provider network development, systems readiness, and the maturation of internal expertise — will be reflected more fully in the next budget period, as the demonstration transitions from planning and phased launch to broader implementation and sustained operations. Future analyses will incorporate CCO spending, trends over time, and a broader qualitative sample to support more complete interpretation of demonstration costs and sustainability.

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Section H. Interpretations, Policy Implications and Interactions with Other State Initiatives

We worked with our OHA partners to gather their input on interpretations of the interim results and implications for broader state policy and planning. Their insights are reflected below.

HRSN benefits are critically important to meet the needs of the Medicaid population. Between March 2024 and September 2025, there was significant demand for HRSN services, especially rent and utility support and Housing (home changes for health) devices. In some regions of the state, health system partners experienced challenges keeping up with the demand at times. Program learnings to date and the high need for HRSN services suggest that the adverse social conditions experienced by OHP members—conditions that heighten their risk of poor health outcomes—are not sufficiently addressed by other programs and HRSN benefits play a critical role in supporting the acute needs for this population. This is especially true as federal investments in other social programs such as emergency housing vouchers and nutrition assistance decline (see HRSN results and information provided by Oregon Housing and Community Services below).

The needs that HRSN benefits help address have started to emerge through preliminary results presented in this report, HRSN recipient testimony, as well as OHA's own analyses, available on Oregon's public-facing dashboard and other public presentations of data on OHA's website. Learnings are also emerging about which groups and communities Oregon's HRSN benefits may be particularly supporting. For example, OHA's preliminary data suggest that members receiving HRSN services are about twice as likely as the general OHP member population to have more than one disability, while additional analyses show the Housing benefit made a particularly high impact in rural communities.

Oregon Housing and Community Services (OHCS) has stated that HRSN tenancy support and rent assistance should be prioritized. Direct member services like rent support and utility assistance are critical eviction prevention interventions and are available to fewer households through the OHCS provider network because of the reduction in funding. The need for these supportive services remains and HRSN tenancy support services could potentially help fill some of that gap.

Implementation of the novel HRSN benefits requires considerable time and effort, particularly around the creation of new partnerships. HRSN services represent a unique approach to person-centered, whole person care in Oregon. Implementation was a substantial feat, reflecting the magnitude of effort required to bridge social service providers and systems (e.g., HRSN housing providers) and health plans (CCOs) in an unprecedented way. This work included development of new partnerships between health plans and social service providers, new

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contracts and rules, significant new system implementations and modifications, and considerable staff resourcing and training. The development of new provider partnerships is particularly notable; according to OHA's public data dashboard, as of September 2025, 138 HRSN Service Providers across the state were actively delivering services to members. This included community action agencies, housing agencies, and community organizations that did not historically deliver Medicaid services. As demonstrated in some HRSN Service Provider and CCO interviews, the effect has been a strengthened partnership between housing and health plans (CCOs).

Upfront investments in infrastructure, training, and capacity are important for successful implementation of complex policies. DSHP funds invested in HRSN infrastructure were essential to build the needed processes and systems to implement the complex policy. Significant support and training were needed to enable HRSN Service Providers to effectively participate in the Medicaid delivery system, particularly because most of the HRSN Service Providers were new to Medicaid. Similarly, while health plans had some experience with supporting their members' access to social services, the implementation of HRSN benefits required a substantial level of effort and had a steep learning curve on their part as well. This is a key consideration for future implementation of similarly complex policies such as HR1.

Sustainability considerations also need to include how to subsidize ongoing implementation of new policies. While upfront investments are a major support for implementation, ongoing funding needs should be factored into transformation efforts to support longer-term sustainability. This has implications for all large transformation efforts locally and nationally.

Implications of decreased administrative burden of longer eligibility periods. Qualitative data demonstrated that the administrative burden of renewals was decreased under CE, which allowed staff to spend more time supporting OHP members with more complex needs. With redetermination increasing to every six months under HR1 alongside new requirements for meeting work or activity rules, states will face administrative and compliance burdens that could detract from the goal of ensuring access to care and improving health of vulnerable populations.

Implications for ensuring that coverage leads to better access. Policies that aim to improve coverage should simultaneously aim to increase provider networks and provide additional supports to help with access to care (such as transportation). Particular attention should be paid to communities with additional barriers such as rural communities. Recent federal investments through the Rural Health Transformation Program could focus on improvements in these areas to complement policies that help prevent loss of coverage.

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Section I. Lessons Learned and Recommendations

In this section we provide an overview of lessons learned and recommendations for each policy area (CE and TME, HRSN, and YSHCN).

CE and TME

- **Connect temporary coverage policies to a defined next-step coverage pathway.** TME's connection to OHP Bridge has important policy implications for future coverage-continuity efforts. Temporary coverage extensions may be most useful when they are paired with a longer-term coverage option, which provides members with a clear pathway once the temporary policy ends. For states considering similar approaches, the alignment between TME and OHP Bridge offers a useful example of how temporary coverage can help smooth transitions during periods of eligibility change.
- **Invest early in cross-agency coordination and shared implementation infrastructure.** Implementation partners described cross-agency collaboration, recurring workgroups, forums, and communication channels as key supports for CE and TME rollout. At the same time, coordination gaps, uneven information flow, and staffing constraints created implementation challenges. Future demonstrations should build in regular communication processes early, and sufficient staffing capacity to support implementation, especially when policies require coordination across agencies and implementation partners.
- **Prioritize plain-language and culturally responsive communication as part of implementation planning.** CE and TME implementation showed that translation alone is not always enough to make complex Medicaid policy understandable. Implementation partners emphasized the importance of transcreation, plain-language summaries, community feedback, and culturally responsive materials. States implementing similar policies should use accessible language and community review early in the process.
- **Supplement existing communication efforts with short scripts and talking points that help staff and partners explain coverage changes during member interactions.** Members often relied on trusted local support, including clinic staff, ODHS case workers, ONE call center staff, community health workers, and other local navigators, to understand and maintain their coverage. Implementation partners also described developing their own short scripts and summaries to translate complex policy information into more usable guidance. Future implementation efforts should build on these partner-led strategies by providing clear scripts, short summaries, FAQs, and other tools that help staff and community partners explain policy changes in ways members can understand and act on.

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- **Pair longer continuous eligibility periods with strategies to keep member contact information up to date.** Longer continuous eligibility periods can reduce renewal-related burden, but they may also mean that member contact information becomes outdated before the next redetermination. States adopting longer coverage periods should consider proactive contact verification strategies, especially before redetermination, to reduce returned mail, missed notices, and avoidable coverage loss.

HRSN

- **Along with phasing in benefits, consider starting with narrower eligibility criteria or referral routes.** HRSN benefits launched over a period of more than two years, which spaced out some of the initial demand and allowed learnings from one phase of implementation to inform the next. While this postponed implementation of some HRSN benefits and created uncertainty for some potential HRSN Service Providers, the staged launch was likely advantageous for a novel benefit as complex as HRSN. Another incremental implementation option would be to begin with narrower eligibility criteria and/or referral routes (e.g., no member self-referrals) and widen them over time as feasible, rather than starting broad and having the delivery system and new provider network struggle to serve the volume of members in need.
- **Early infrastructure investments, especially in workforce development, are critical to successful implementation.** CCBF grants allowed HRSN Service Providers to hire and train new staff and develop internal processes before they began to offer services. They were also vital for ensuring ongoing capacity, supporting HRSN Service Providers and CCOs to add more staff to meet demand, to update processes and re-train when rules and guidance changed or when staff turned over, and to offset the non-reimbursable costs of providing HRSN services. States or other entities considering HRSN-like initiatives should plan for substantial upfront and continued investment to support development of needed staffing and systems.
- **Reduce administrative complexity and add flexibility for eligible beneficiaries**. Offering social need services as a Medicaid benefit is a formidable undertaking, so avoiding unnecessary complexity is especially important. OHA has taken some steps to address unnecessary administrative complexity in HRSN, such as allowing utility payments to be non-consecutive or taking steps to adopt the Unite Us CIE platform for closed-loop referrals for the FFS population. Streamlined administrative processes can also support role flexibility across CCOs and HRSN Service Providers, which has helped to address capacity constraints in the first few years of HRSN. From the beneficiary perspective, other desired flexibilities include allowing the rent benefit to transfer across addresses if the beneficiary has to move, allowing benefits to be used in non-consecutive months, or

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authorizing lesser amounts of rent support over a longer period of time. In cases where existing Medicaid rules and requirements make it difficult to be more responsive to member needs, careful design thinking and flexibility at federal and state levels may be necessary to find the right balance.

- **Provide clear and timely information to members about HRSN eligibility rules and application status**. To the extent that overly general explanations of HRSN eligibility contributed to the high volume of requests for Housing benefits, clearer public- and member-facing communications might have helped to reduce confusion and demand. The communication materials going out ahead of the summer 2026 launch of the remaining Nutrition benefits suggest that OHA is attempting to manage expectations about eligibility more strongly in this phase of implementation. Beyond eligibility, OHP members who faced long delays between authorization and receipt of benefits found the lack of communication about the status of their application to be a major source of frustration and stress. Creating member-facing communication tools or self-service portals as part of HRSN technology infrastructure could improve transparency and member experience.
- **Fully leverage the experience of social service providers**. There are limits to how closely Medicaid processes can follow what works for social service providers or their clients. However, incorporating the expertise of both front-line social service staff and leadership creates opportunities to better align HRSN eligibility criteria with community needs, reduce administrative complexity, and find compromises between Medicaid requirements and social service workflows. OHA engaged social service partners regularly during policy design and implementation planning but some key entities felt that there was additional opportunity to learn from experienced practitioners. Other states engaging in HRSN should ensure they are planning for this engagement.

YSHCN

- **Consider non-staggered roll out to decrease confusion.** A staggered rollout approach was used for YSHCN to help manage budget, but a non-staggered roll out may have made communication around eligibility easier. This was particularly challenging when explaining the timing of eligibility to community partners or to YSHCN OHP members who were older than the age cut-off.
- **Passive enrollment and screeners embedded in enrollment were seamless ways to assess eligibility.** Enrollment in YSHCN was relatively seamless for both passive and active enrollment routes. Establishing the passive enrollment processes and adding the screener to the ONE system required the most effort from the state, but both routes are now running smoothly. Both members and application assisters do not recall the YSHCN

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screener standing out in the OHP application, indicating it fit well in the existing form and language.

- **Strong communication plans are needed for partner awareness.** The low awareness of the YSHCN policy and its benefits among community partners and members indicates there are opportunities for OHA and CCOs to conduct more outreach at an individual and organizational level. Community partners interface with YSHCN OHP members both before and after OHP enrollment and have extensive networks to find eligible YSHCN and educate those enrolled on what services they can access (HRSN, expanded vision and dental). Similarly, improved post-enrollment outreach from CCOs could increase the awareness of the benefits the policy provides to YSHCN OHP members. Community partners suggested that OHA create flyers or similar resources that could be shared via listservs or handed to YSHCN OHP members and their families.
- **Reaching young adult members is difficult and may require additional effort and multiple modes of outreach.** Key entities reported that reaching individuals eligible for YSHCN was challenging for many reasons such as young adults are generally less responsive to traditional outreach methods (mail and phone), YSHCN OHP members potentially need additional assistance due to their complex health conditions, lack of medical literacy, and engagement of multiple caregivers. A YSHCN-specific communication strategy was not initially developed by the CCOs. However, several CCOs are working on additional ways to reach and communicate with YSHCN OHP members through digital methods such as text messaging, robocalling, social media posts and patient portals.
- **Endeavor to increase provider availability alongside improving duration of covered benefits.** While it is still too early to understand impacts of this policy on continuity of care, YSHCN OHP members are reporting some challenges in obtaining and maintaining care with providers who take Medicaid and can support their needs. This is particularly challenging in rural areas. Efforts should continue to expand the network of available providers alongside the increased duration of benefits for YSHCN**.**

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Section J. Attachments

Attachment 1. References

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Attachment 2. Secondary Data Sources Used in This Report

CCO Financial Reporting (Exhibit L). OHA requires CCOs to report annual spending related to health-related services. This reporting requirement is a part of the CCO contracts with the OHA. Health-related services, as defined by both state and federal regulations, refers to both flexible services offered to individuals to supplement covered benefits and to Community Benefit initiatives that focus on improving population health and health care quality. Beginning in 2024, OHA required CCOs to report spending on HRSNs through the same mechanism. Expenditures are reported at both the individual member level for direct member level services and at the organization level for community benefit initiatives. Member identifiers within the health-related services and HRSN expenditure reports enable the data to be matched to Medicaid enrollment and claims data for reporting by demographics, chronic conditions, and health care utilization patterns. Data from Exhibit L included in this report cover March 2024 through September 2025.

Documents related to HRSN. A framework was developed for identifying documents related to HRSN implementation or the broader context of health-related social need service availability outside the waiver. The protocol included search steps and key terms, inclusion and exclusion criteria, and an initial list of search locations (e.g. news sources, government agency websites). An inventory was also created to track resources identified and document the authors, dates and content. Examples of the types of documents included are OHA, CCO, or other publicly-available agency reports, public testimony, meeting records, and news articles. Documents collected were created in 2024 or later.

Medicaid Management Information System (MMIS). MMIS is a comprehensive database that contains detailed, timely, year-over-year data about Medicaid enrollees and the health care services paid by Medicaid. MMIS also contains information on HRSN services expenditures (in addition to these expenditures being tracked and reported in the CCO Financial Reporting Exhibit L). The MMIS data are used for monitoring, reporting, and improving Oregon's Medicaid delivery system. The MMIS data are collected from two main sources: eligibility data and claims/encounter data. Data from MMIS used for this report cover the years 2018 through 2025.

ONE Eligibility System. The ONE Eligibility system is a platform that simplifies the application process for Oregon residents seeking medical, food, cash, and childcare benefits. The system offers multiple application options, including online, phone, or in-person, via a single application. The ONE Eligibility System aims to reduce the time and effort required to apply for benefits by streamlining the application process. This system provides a convenient way for users to apply for benefits, check application status, renew benefits, upload documents, report changes, and update information. Data from the ONE Eligibility System used for this report cover the years 2018 through 2025.

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REALD Data Repository. The REALD (race, ethnicity, language and disability) repository began development in 2022 in OHA's Equity & Inclusion (E&I) Division to maximize the use of REALD data, drawing from the ONE eligibility system as well as high-quality REALD data from other internal sources (Birth Certificate and Acute and Communicable Disease data (e.g., COVID)). Currently, over 90% of the records in the Repository include demographic data from OHP members. Data from the REALD repository used for this report cover the years 2018 through 2025.

Social Needs Service Coordination Report (SNSC). OHA requires CCOs to submit quarterly via the SNSC information on HRSN recipient member identification, closed loop referral information, and care coordination. Member identification includes Medicaid ID, date of birth, method of identifying the potential HRSN recipient, date of identification, HRSN category the recipient is potentially eligible for, and covered population (i.e. which HRSN-eligible population the recipient is a member of). Referral and care coordination information includes date of referral, provider or organization the potential recipient is referred to, referral status, the procedure and modifier code for each specific HRSN service, and service status (i.e. has the recipient received the service?). Data from the SNSC used in this report cover January through September 2025.

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Attachment 3. PERC Codes for YSHCN identification

The following Program Eligibility Resource Codes (PERC) are used to identify YSHCN with supplemental coverage:

- 23 - Aid to the Blind - YSHCN
- 33 - Aid to the Blind, Medical only - YSHCN
- 24 - Aid to the Disabled - YSHCN
- 34 - Aid to the Disabled, Medical only - YSHCN
- 3M - CHIP FCEP (From Conception through End of Pregnancy) / Healthier Oregon Pregnant, YSHCN
- 3W - CHIP FCEP (From Conception through End of Pregnancy) / Healthier Oregon Pregnant, Oregon Supplemental Income Program Medical (OSIPM), YSHCN
- 3Z - CHIP FCEP (From Conception through End of Pregnancy) / Healthier Oregon Pregnant, Oregon Supplemental Income Program Medical (OSIPM), YSHCN
- 3L - CHIP FCEP (From Conception through End of Pregnancy) / Healthier Oregon Pregnant, Parent or Other Caretaker/Relative, YSHCN
- 3A - CHIP FCEP (From Conception through End of Pregnancy) / Healthier Oregon Pregnant, Parent or Other Caretaker/Relative, YSHCN
- 3B - CHIP FCEP (From Conception through End of Pregnancy) / Healthier Oregon Pregnant, YSHCN
- 35 - CHIP to Medicaid, YSHCN
- 3H - Healthier Oregon Adult, with child/unborn, YSHCN
- 3I - Healthier Oregon Adult, without child/unborn, YSHCN
- 3S - Healthier Oregon Blind, YSHCN
- 3K - Healthier Oregon Breast and Cervical Cancer, YSHCN
- 3G - Healthier Oregon Child, YSHCN
- 5J - Healthier Oregon CHIP, YSHCN
- 5K - Healthier Oregon CHIP Postpartum 0-60 days, YSHCN
- 5L - Healthier Oregon CHIP Postpartum 61-365, YSHCN
- 5M - Healthier Oregon CHIP Pregnant, YSHCN
- 3U - Healthier Oregon OSIPM (Oregon Supplemental Income Program Medical), YSHCN
- 3V - Healthier Oregon OSIPM (Oregon Supplemental Income Program Medical), YSHCN
- 3E - Healthier Oregon Parent or Other Caretaker/Relative, YSHCN
- 3J - Healthier Oregon Parent or Other Caretaker/Relative, YSHCN
- 3O - Healthier Oregon Postpartum 0-60 days, YSHCN
- 36 - Healthier Oregon Postpartum 0-60 days, Oregon Supplemental Income Program Medical (OSIPM), YSHCN

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- 3X - Healthier Oregon Postpartum 0-60 days, Oregon Supplemental Income Program Medical (OSIPM), YSHCN
- 3N - Healthier Oregon Postpartum 0-60 days, Parent or Other Caretaker/Relative, YSHCN
- 3C - Healthier Oregon Postpartum 0-60 days, YSHCN
- 3Q - Healthier Oregon Postpartum 61-365 days, YSHCN
- 39 - Healthier Oregon Postpartum 61-365 days, >139% FPL, YSHCN
- 37 - Healthier Oregon Postpartum 61-365 days, Oregon Supplemental Income Program Medical (OSIPM), YSHCN
- 3Y - Healthier Oregon Postpartum 61-365 days, Oregon Supplemental Income Program Medical (OSIPM), YSHCN
- 3P - Healthier Oregon Postpartum 61-365 days, Parent or Other Caretaker/Relative, YSHCN
- 3D - Healthier Oregon Postpartum 61-365 days, YSHCN
- 45 - MAGI Adult, with child/unborn, YSHCN
- 41 - MAGI Adult, with child/unborn, 0-133% FPL, YSHCN
- 42 - MAGI Adult, with child/unborn, 0-75% FPL, disabled, YSHCN
- 46 - MAGI Adult, without child/unborn, YSHCN
- 43 - MAGI Adult, without child/unborn, 0-133% FPL, YSHCN
- 44 - MAGI Adult, without child/unborn, 0-75% FPL, disabled, YSHCN
- 6A - MAGI Parent or Other Caretaker/Relative, 0-50% FPL, YSHCN
- 2C - MAGI Pregnant, no due date requirement, continuous eligibility, YSHCN
- 2D - MAGI Pregnant, protected pregnant eligibility, YSHCN
- 2B - MAGI Pregnant, with due date, >=133% FPL, YSHCN
- 2A - MAGI Pregnant, with due date, 0-133% FPL, YSHCN
- 25 - SCF Children (Foster/Adoptive Care), MAGI Substitute Care, Former Foster Care, YSHCN
- 5C - SCHIP to MCHIP, Age 6-21, 133-200% FPL, YSHCN
- 5F - SCHIP to MCHIP, Age 6-21, 201-250% FPL, YSHCN
- 5I - SCHIP to MCHIP, Age 6-21, 251-300% FPL, YSHCN

The following PERC codes were used to identify YSHCN with Standalone coverage:

- 5A - HOP YSHCN Stand Alone
- 5B - YSHCN Stand Alone

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Attachment 4. Administrative Cost Categories and Definitions

1) Staff

Payroll and Benefits - Salary and benefit costs for staff supporting demonstration implementation and operations. Benefits include but are not limited to: Employment Retention Bonus assessment; Public Employees' Retirement System; pension bond contribution; Social Security tax; unemployment assessment; Paid Family Medical Leave Insurance; workers' compensation assessment; and flexible benefits.

Employee Services and Supports - Costs that directly support staff but do not appear on employee paychecks, including in-state and out-of-state travel; office expenses; telecommunications and technology services and supplies; recruitment, training, and professional development; dues and subscriptions; and personal IT.

OHA Indirect Costs - Costs associated with staff who allocate a portion of their time to 1115 Waiver activities but are not fully dedicated to the demonstration. These costs reflect shared administrative and operational functions across OHA.

2) Consulting and Contracting

Consulting and contracting costs include funds disbursed to external organizations in support of demonstration implementation and operations. Reported expenditures in this category reflect amounts booked to federal fiscal years 2023 and 2024. Consulting and contracting costs are mutually exclusive from information technology project costs.

3) Information Technology Projects

Information technology project costs include administrative expenditures related to systems development and modification necessary to support demonstration implementation. OHA noted that IT costs may be underrepresented during early phases if work occurred prior to CMS approval of an Advance Planning Document (APD), as costs are fully captured in the state accounting system only after APD approval. OHA-funded costs related to ONE Eligibility System waiver updates during the interim period were limited to printing and mailing communications to members and are captured under Outreach and Operations.

4) Outreach and Operations

Outreach and Operations costs include administrative expenditures related to communication, legal, and operational support activities not captured in other categories. Legal fees reported in this category reflect costs incurred through the Oregon Department of Justice for legal interpretation and guidance related to policy implementation and are distinct from externally contracted legal services.

5) Grants

Grant-related administrative costs capture expenditures associated with administering waiver-specific grants. During 2024, OHA reported CCBF awards supporting the development of HRSN service delivery infrastructure, workforce capacity, and provider network development. These investments were intended to support organizations' ability to participate in the Medicaid delivery system and deliver HRSN services.

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Attachment 5. Additional Tables

Appendix Table 1. Characteristics of 19,495* OHP members receiving HRSN services by HRSN category type, March 2024 through September 2025.

	Housing (excluding home changes for health) N = 7,865		Housing (home changes for health) N = 6,347		Nutrition N=136		Outreach & Engagement N=10,590	
	N	%	N	%	N	%	N	%
Age at Receipt of First Service								
Under 18	492	6.3%	625	9.8%	<12†	--	571	5.4%
18-34	2,437	31.0%	1,102	17.4%	20	14.7%	3,375	31.9%
35-64	4,574	58.2%	2,972	46.8%	93	68.4%	6,130	57.9%
65 and over	327	4.2%	1,589	25.0%	<20‡	--	466	4.4%
Unknown	35	0.4%	59	0.9%	0	0.0%	48	0.5%
Sex								
Female	5,409	68.8%	4,276	67.3%	89	65.4%	7,109	67.1%
Male	2,456	31.2%	2,066	32.6%	47	34.6%	3,478	32.8%
Unknown	0	0.0%	5	<0.1%	0	0.0%	3	<0.1%
Race/Ethnicity								
American Indian/Alaska Native	491	6.2%	286	4.5%	23	16.9%	510	4.8%
Asian	191	2.4%	268	4.2%	0	0.0%	291	2.7%
Black/African American	922	11.7%	407	6.4%	<12†	--	1,537	14.5%
Latino/a/x/e	1,242	15.8%	847	13.3%	25	18.4%	1,811	17.1%
Native Hawaiian & Pacific Islander	129	1.6%	82	1.3%	<12†	--	194	1.8%
Middle Eastern/North African	104	1.3%	28	0.4%	<12†	--	150	1.4%
White	4,261	54.2%	3,869	61.0%	76	55.9%	5,346	50.5%
Multiple/Other	52	0.7%	52	0.8%	0	0.0%	74	0.7%
Unknown	473	6.0%	508	8.0%	6	4.4%	677	6.4%
Language Used at Home								
Chinese (Cantonese or Mandarin)	<12†	--	58	0.9%	0	0.0%	<12†	--
English	7,151	90.9%	5,614	88.5%	<130‡	--	9,388	88.6%

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Appendix Table 1. Characteristics of 19,495* OHP members receiving HRSN services by HRSN category type, March 2024 through September 2025.

	Housing (excluding home changes for health) N = 7,865		Housing (home changes for health) N = 6,347		Nutrition N=136		Outreach & Engagement N=10,590	
	N	%	N	%	N	%	N	%
Russian/Ukrainian	17	0.2%	46	0.7%	0	0.0%	18	0.2%
Spanish	488	6.2%	440	6.9%	<12†	--	851	8.0%
Vietnamese	<12†	--	64	1.0%	0	0.0%	<12†	--
Other language	204	2.6%	108	1.7%	0	0.0%	318	3.0%
Unknown	<12†	--	17	0.3%	0	0.0%	7	0.1%
Geography								
Frontier	199	2.5%	174	2.7%	<12†	--	237	2.2%
Rural	2,620	33.3%	2,285	36.0%	71	52.2%	2,183	20.6%
Urban	4,970	63.2%	3,816	60.1%	55	40.4%	8,050	76.0%
Unknown	76	1.0%	72	1.2%	<12†	--	120	1.1%
Disability								
Non-disabled	3,773	48.0%	1,764	27.8%	27	19.9%	5,112	48.3%
Independent living/self-care disability	2,534	32.2%	3,263	51.4%	79	58.1%	3,418	32.3%
1 Limitation	814	10.3%	621	9.8%	<12†	--	1,067	10.1%
2+ Limitations	627	8.0%	510	8.0%	<12†	--	801	7.6%
Unknown	117	1.5%	189	3.0%	1	0.7%	192	1.8%

*Members can receive multiple categories of HRSN services; these members are represented in each relevant column.

†Value suppressed to protect confidentiality.

‡Value suppressed to prevent backward calculation of other suppressed values.

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Appendix Table 2. Characteristics of 33,385* YSHCN enrolled in Medicaid during calendar year 2025 by enrollment route.

	Passive enrollment via BH/PMCA N = 29,010		Passive enrollment via ODDS N = 682		Active via Screener N=4,056	
	N	%	N	%	N	%
Age at YSHCN Enrollment						
18	<12†	--	0	0.0%	<12†	--
19	19,700	67.9%	423	62.0%	2,517	62.1%
20	9,298	32.1%	259	38.0%	1,536	37.9%
21	<12†	--	0	0.0%	<12†	--
Sex						
Female	17,412	60.0%	218	32.0%	2,520	62.1%
Male	11,598	40.0%	464	68.0%	1,536	37.9%
Race/Ethnicity						
American Indian/Alaska Native	1,523	5.2%	37	5.4%	216	5.3%
Asian	989	3.4%	51	7.5%	183	4.5%
Black/African American	1,537	5.3%	35	5.1%	246	6.1%
Latino/a/x/e	7,771	26.8%	112	16.4%	759	18.7%
Native Hawaiian & Pacific Islander	306	1.1%	<12†	--	50	1.2%
Middle Eastern/North African	155	0.5%	<12†	--	29	0.7%
White	13,380	46.1%	322	47.2%	2,255	55.6%
Multiple/Other	287	1.0%	13	1.9%	41	1.0%
Unknown	3,062	10.6%	100	14.7%	277	6.8%
Language Used at Home						
Chinese (Cantonese or Mandarin)	<60‡	--	0	0.0%	<12†	--
English	23,888	82.3%	617	90.5%	3,670	90.5%
Russian/Ukrainian	118	0.4%	<12†	0.1%	<12†	--
Spanish	4,544	15.7%	55	8.1%	288	7.1%
Vietnamese	76	0.3%	<12†	--	<12†	--
Other language	327	1.1%	<12†	--	20	0.5%
Unknown	<12†	--	<12†	--	58	1.4%
Geography						
Frontier	772	2.7%	<12†	--	104	2.6%
Rural	10,790	37.2%	218	32.0%	1,334	32.9%
Urban	17,101	58.9%	455	66.7%	2,551	62.9%
Unknown	347	1.2%	<12†	--	67	1.7%
Disability						
Non-disabled	17,347	59.8%	84	12.3%	1,925	47.5%
Independent living/self-care disability	5,291	18.2%	502	73.6%	1,116	27.5%
1 Limitation	2,232	7.7%	36	5.3%	440	10.8%
2+ Limitations	1,284	4.4%	42	6.2%	350	8.6%

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Appendix Table 2. Characteristics of 33,385* YSHCN enrolled in Medicaid during calendar year 2025 by enrollment route.

	Passive enrollment via BH/PMCA N = 29,010		Passive enrollment via ODDS N = 682		Active via Screener N=4,056	
	N	%	N	%	N	%
Unknown	2,856	9.8%	18	2.6%	225	5.5%

*There are 300 YSHCN missing enrollment route information; they are excluded from this table.

†Value suppressed to protect confidentiality.
‡Value suppressed to prevent backward calculation of other suppressed values.

Appendix Table 3. Characteristics of 33, 855* YSHCN enrolled in Medicaid during calendar year 2025 by coverage type.

	Supplemental N = 33,382		Standalone N = 2,297	
	N	%	N	%
Age at Enrollment in Specific Coverage Type				
19	22,573	67.7%	863	37.6%
20	10,760	32.2%	1,129	49.2%
21	49	0.1%	305	13.2%
Sex				
Female	19,904	59.6%	1,437	62.6%
Male	13,478	40.4%	860	37.4%
Race/Ethnicity				
American Indian/Alaska Native	1,758	5.3%	102	4.4%
Asian	1,202	3.6%	93	4.0%
Black/African American	1,809	5.4%	92	4.0%
Latino/a/x/e	8,533	25.6%	660	28.7%
Native Hawaiian & Pacific Islander	363	1.1%	21	0.9%
Middle Eastern/North African	185	0.6%	13	0.6%
White	15,778	47.3%	1,083	47.1%
Multiple/Other	339	1.0%	22	1.0%
Unknown	3,415	10.2%	211	9.2%
Language Used at Home				
Chinese (Cantonese or Mandarin)	51	0.2%	<12†	--
English	27,876	83.5%	1,840	80.1%
Russian/Ukrainian	129	0.4%	<12	--
Spanish	4,826	14.5%	395	17.2%
Vietnamese	84	0.3%	<12†	--
Other language	350	1.0%	<12†	--
Unknown	66	0.2%	<12†	--
Geography				
Frontier	874	2.6%	49	2.1%
Rural	12,208	36.6%	808	35.2%

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Appendix Table 3. Characteristics of 33, 855* YSHCN enrolled in Medicaid during calendar year 2025 by coverage type.

	Supplemental N = 33,382		Standalone N = 2,297	
	N	**%**	**N**	**%**
Urban	19,885	59.6%	1,423	62.0%
Unknown	415	1.2%	17	0.7%
Disability				
Non-disabled	19,113	57.3%	1,532	66.7%
Independent living/self-care disability	6,878	20.6%	240	10.4%
1 Limitation	2,671	8.0%	182	7.9%
2+ Limitations	1,655	5.0%	92	4.0%
Unknown	3,065	9.2%	251	10.9%

*YSHCN can be enrolled in both coverage types during the calendar year; these YSHCN are represented in both columns.

†Value suppressed to protect confidentiality.

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Appendix Table 4. Characteristics of all Oregon Health Plan members by age-based eligibility group (2024).

Characteristic	<6 (N)	<6 (%)	6+ (N)	6+ (%)
Total	153,501	100%	1,562,949	100%
Sex				
Female	75,090	48.9%	818,407	52.4%
Male	78,411	51.1%	744,542	47.6%
Race/Ethnicity				
American Indian/Alaska Native	6,271	4.1%	63,144	4.0%
Asian	5,733	3.7%	76,377	4.9%
Black/African American	10,160	6.6%	73,606	4.7%
Latino/a/x/e	42,917	28.0%	337,625	21.6%
Middle Eastern/North African	1,164	0.8%	11,136	0.7%
Native Hawaiian & Pacific Islander	3,390	2.2%	21,433	1.4%
White	58,848	38.3%	794,321	50.8%
Multiple/other	3,210	2.1%	14,867	1.0%
Unknown	21,808	14.2%	170,440	10.9%
Language Used at Home				
Chinese (Cantonese or Mandarin)	288	0.2%	8,229	0.5%
English	130,738	85.2%	1,299,612	83.2%
Russian/Ukrainian	1,163	0.8%	12,459	0.8%
Spanish	17,580	11.5%	201,511	12.9%
Vietnamese	301	0.2%	8,323	0.5%
Other language	2,287	1.5%	25,745	1.6%
Unknown	1,144	0.7%	7,070	0.5%
Disability				
Non-disabled	127,625	83.1%	922,172	59.0%
1 Limitation	1,424	0.9%	97,396	6.2%
2+ Limitations	715	0.5%	55,190	3.5%
Independent living/self-care disability	3,607	2.3%	298,327	19.1%
Unknown	20,130	13.1%	189,864	12.1%
Geography				
Frontier	5,055	3.3%	43,963	2.8%
Rural	57,791	37.6%	558,236	35.7%
Urban	89,881	58.6%	956,252	61.2%
Outside of Oregon	772	0.5%	4,480	0.3%
Unknown	<12*	--	18	<0.1%

*Value suppressed to protect confidentiality.

Appendix Table 5. Characteristics of continuous eligibility enrollment by age-based eligibility group (2024).

Characteristic	Continuity* <6 (N)	Continuity <6 (%)	Churn† <6 (N)	Churn <6 (%)	Continuity 6+ (N)	Continuity 6+ (%)	Churn 6+ (N)	Churn 6+ (%)
Sex								
Female	52,237	48.9%	641	48.4%	628,820	53.4%	10,215	40.1%
Male	54,597	51.1%	683	51.6%	549,279	46.6%	15,237	59.9%
Race/Ethnicity								
American Indian/Alaska Native	4,550	4.3%	50	3.8%	48,283	4.1%	1,576	6.2%
Asian	3,875	3.6%	32	2.4%	54,668	4.6%	784	3.1%
Black/African American	7,132	6.7%	68	5.1%	54,632	4.6%	1,553	6.1%
Latino/a/x/e	30,124	28.2%	415	31.3%	252,850	21.5%	5,178	20.3%
Middle Eastern/North African	744	0.7%	<12‡	--	7,795	0.7%	130	0.5%
Native Hawaiian & Pacific Islander	2,303	2.2%	31	2.3%	14,796	1.3%	389	1.5%
White	42,518	39.8%	498	37.6%	601,367	51.0%	13,949	54.8%
Multiple/other	2,212	2.1%	40	3.0%	10,902	0.9%	182	0.7%
Unknown	13,376	12.5%	<190§	--	132,806	11.3%	1,711	6.7%
Language Used at Home								
Chinese (Cantonese or Mandarin)	199	0.2%	<12‡	--	6,593	0.6%	39	0.2%
English	92,424	86.5%	1,086	82.0%	982,302	83.4%	22,327	87.7%
Russian/Ukrainian	749	0.7%	<12‡	--	9,338	0.8%	126	0.5%
Spanish	11,452	10.7%	204	15.4%	150,691	12.8%	2,607	10.2%
Vietnamese	213	0.2%	<12‡	--	6,419	0.5%	55	0.2%
Other language	1,360	1.3%	17	1.3%	18,958	1.6%	293	1.2%
Unknown	437	0.4%	<12‡	--	3,798	0.3%	<12‡	--
Disability								
Non-disabled	90,743	84.9%	1,157	87.4%	680,170	57.7%	15,706	61.7%
1 Limitation	1,169	1.1%	<12‡	--	73,379	6.2%	2,481	9.7%
2+ Limitations	635	0.6%	<12‡	--	42,023	3.6%	1,633	6.4%

Independent living/self-care disability	2,975	2.8%	16	1.2%	244,362	20.7%	4,868	19.1%
Unknown	11,312	10.6%	140	10.6%	138,165	11.7%	764	3.0%
Geography								
Frontier	3,457	3.2%	46	3.5%	33,890	2.9%	638	2.5%
Rural	41,133	38.5%	526	39.7%	433,282	36.8%	9,269	36.4%
Urban	62,149	58.2%	745	56.3%	710,223	60.3%	15,472	60.8%
Outside of Oregon	94	0.1%	<12‡	--	697	0.1%	73	0.3%
Unknown	<12	--	<10§	--	<12	--	0	0.0%

* "Continuity" refers to members who are continuously enrolled January 1 – December 31, 2024.
† "Churn" refers to members who have at least one gap in enrollment that lasts fewer than 3 months, prior to reenrollment.
‡ Value suppressed to protect confidentiality.
§ Value suppressed to prevent backward calculation of other suppressed value(s).

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