Other formats and languages
You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact 1115 OHP Waiver Renewal at 1115Waiver.Renewal@odhsoha.oregon.gov or 503-580-0295 (voice/text). We accept all relay calls.

Public Notice

From: Jessi Wilson, 1115 Waiver Strategic Operations director and Ruben Soliz, Medicaid Federal Policy director

Date: Nov. 9, 2026

Subject: Oregon's draft application for renewal of the Oregon Health Plan (OHP) 1115 Waiver is available for public comment

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Oregon Health Authority (OHA) announces its intent to submit an application to extend the 1115 OHP Waiver Demonstration to the Centers for Medicare & Medicaid Services (CMS) for the period Oct. 1, 2027, through Sept. 30, 2032.

The draft 2027-2032 OHP 1115 Waiver Renewal Application is now available for public comment. OHA will accept written and verbal comments on the draft application for 30 days, through Dec. 9, 2026.

- The full draft application and this notice are available online on the 2027-2032 OHP 1115 Waiver Application page.
- To request a paper copy of the application, please contact us at 1115Waiver.Renewal@odhsoha.oregon.gov or 503-580-0295.

In accordance with the government-to-government relationship, OHA will also conduct Tribal Consultation with the Nine Federally Recognized Tribes of Oregon and the Urban Indian Health Program on the entire application.

OHA will use comments received to inform the final application that OHA will submit to CMS.

Other formats and languages

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2027-2032 1115 OHP Demonstration Waiver Renewal Public Notice (11/9/26)

The Oregon Health Authority (OHA) is requesting a five-year extension of the existing Section 1115(a) Medicaid Waiver demonstration, which is set to expire on Sep. 30, 2027.

The following sections summarize the proposed draft 2027-2032 1115 Oregon Health Plan (OHP) Demonstration Waiver Renewal application content posted for public comment for a 30-day period beginning Nov. 9, 2026, and ending Dec. 9, 2026. Application content is subject to change prior to final submission to the Centers for Medicare & Medicaid Services (CMS) upon completion of public comment and Tribal Consultation activities.

Please visit our website for the full draft application and up-to-date information including how to provide public comment.

How to Comment

OHA welcomes public review and input on Oregon's draft 1115 OHP Waiver Renewal application. Please see the opportunities for providing public comments below.

Written comment

Written comments can be sent by email or mail. All written comments should be postmarked or emailed by Dec. 9, 2026.

Email comments to: 1115Waiver.Renewal@odhsoha.oregon.gov

Mail comments to:

Attention: 1115 OHP Waiver Renewal
500 Summer Street NE, E35
Salem OR 97301

Public meetings

Members of the public may provide verbal comments at any of the following public hearings:

Medicaid Advisory Committee

- Meeting date and time: Dec. 2, 2026, 9:05 - 11:55 a.m. Pacific Time
- Meeting location: Register for the Zoom meeting
- If you require an accommodation to fully participate in this meeting, please contact MAC.Info@odhsoha.oregon.gov or 971-304-9642. OHA accepts all relay calls.

1115 Waiver All Come Webinar

- Meeting date and time: Dec. 4, 2026, 9:05 - 11:55 a.m. Pacific Time
- Meeting location:
    - In-person option: Portland State Office Building, Room 177, 800 NE Oregon Street, Portland OR 97232
    - Virtual option: Register for the Zoom meeting
- If you require an accommodation to fully participate in this meeting, please contact 1115waiver.renewal@odhsoha.oregon.gov or 503-580-0295. OHA accepts all relay calls.

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Program Description, Goals, and Objectives

For more than three decades, Oregon's 1115 OHP Demonstration Waiver has been a central tool for transforming Oregon's health care system, improving, care, and lowering costs. Working with Coordinated Care Organizations (CCOs), Tribal partners, providers, community-based organizations, and members, OHA has used the 1115 OHP Waiver to strengthen the CCO model, evidence-based coverage design, and Tribal partnerships. It has also allowed the state to try new approaches to coverage and care, such as providing continuous OHP eligibility for children and adults, health-related social needs (HRSN) supports for housing and nutrition, expanded benefits for young adults with special health care needs, and addressing the needs of Tribes and the Urban Indian Health Program (UIHP).

Key accomplishments of the current Demonstration include (as of mid-2026):

- More than 15,000 OHP members received HRSN rent and utility assistance, and the HRSN housing provider network grew to 121 providers.
- More than 28,000 members received HRSN Outreach and Engagement services, and over 80,000 medically tailored meals were provided.
- Over 49,000 young adults with special health care needs enrolled in YSHCN coverage (as of September 2026).
- Over 700,000 children maintained OHP coverage due to continuous eligibility (as of July 2026).
- Six of the Nine Federally Recognized Tribes of Oregon and the UIHP are delivering and billing Medicaid for Traditional Health Care Practices (as of October 2026).

As OHA developed its 2027–2032 1115 OHP Waiver renewal application, the federal policy landscape changed significantly. For example:

- CMS issued a new budget neutrality framework, which will impact whether CMS will approve and pay for certain 1115 waiver initiatives (June 2026)
- CMS released updated guidance rescinding HRSN guidance outlined by the prior administration (March 2025)
- CMS stated it will not approve or extend continuous eligibility authority (July 2026) nor Designated State Health Program (DSHP) funding (April 2025)
- New federal legislation, "H.R. 1" created new 6-month Medicaid redetermination requirements and is projected to significantly cut available Medicaid funding for Oregon

Given changing federal requirements and state budget limits, OHA is submitting a more focused 1115 OHP Waiver renewal application. OHA proposes to:

- Continue authorities that are working
- Adjust authorities to fit with available funding and implementation experience
- Discontinue authorities that no longer align with federal guidance

OHA’s commitment stays the same: keep as much of the progress made under the current demonstration as possible, and focus resources where they help members most.

2027-2032 1115 OHP Waiver Goals and Objectives

The extension is an opportunity to consolidate the gains under the current Demonstration and to concentrate the next five years on the coverage, services, and delivery system features proven to be most effective. Oregon proposes the following goals:

- 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.

To meet these goals and objectives, Oregon proposes to renew certain authorities without modification, modify others based on implementation experience, and discontinue authorities no longer aligning with federal guidance. All requests related to Tribal priorities are subject to further refinement through Tribal Consultation.

Proposed Health Care Delivery System and Eligibility Requirements, Benefit Coverage and Cost sharing

Delivery System

Oregon will continue to deliver most services through CCOs, community-based managed care organizations operating under risk contracts. CCOs provide integrated physical, behavioral, and dental services. American Indian/Alaska Native (AI/AN) members may choose CCO enrollment or Fee-for-Service (FFS); dually eligible individuals are passively enrolled in CCOs with the option to opt out; long-

term services and supports remain carved out and delivered through FFS. No changes to the delivery system are proposed.

Eligibility

No changes are proposed to OHP eligibility categories other than (1) discontinuing continuous eligibility and (2) reducing YSHCN income eligibility to up to 138% FPL. The Expanded Adult Program for individuals ages 19–64 with household income above 133% up to and including 200% FPL who are exempt from mandatory managed care continues without change. Changes to eligibility for specific initiatives (e.g., HRSN) are enumerated above.

Benefits

The application does not propose any changes to the OHP benefit package, except as described above.

Cost Sharing

The application does not propose any new premiums, co-payments, or deductibles.

Waiver Initiatives Requested to Continue with No Changes

Oregon requests to continue the following 1115 OHP Waiver initiatives with no changes:

Waiver Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System	Reasoning
HRSN Nutrition (Medically Tailored Meals, Nutrition Education, Pantry Stocking, Fruit & Vegetable)	No change 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.	Oregon requests to continue existing waiver and expenditure authorities to allow for more time to provide and evaluate newly implemented HRSN Nutrition benefits. Oregon will continue to discuss with Tribal partners through Tribal Consultation process prior to application submission.

Traditional Health Care Practices	No change	Oregon requests to continue existing authority and will continue to discuss with Tribal partners through Tribal Consultation process prior to application submission.
Chemical Dependency	No change	Oregon requests to continue existing authority for chemical dependency treatment 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.
Expanded Adult Program for Individual Exempt from Managed Care	No change	Oregon requests to continue existing authority for OHP Bridge – Basic Medicaid. This authority ensures that American Indian / Alaska Native (AI/AN) members otherwise eligible for OHP Bridge – BHP (133-200% FPL) continue to be exempt from mandatory CCO enrollment.
Care Coordination Organization (CCO) Delivery System	No change	Oregon requests to continue longstanding waiver and expenditure authority to administer OHP via the Managed Care CCO model.

Waiver Initiatives Requested to Continue with Amendments

Oregon requests to continue the following 1115 OHP Waiver initiatives with changes as outlined in each row:

Waiver Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System	Reasoning
HRSN Housing: Rent, Utilities, and Tenancy Services	*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. The state will continue to work with the Nine Federally	Oregon is facing $833 million in funding cuts projected in 27-29 due to HR 1. CMS' policy decision indicated in guidance issued April 2025 to not extend Designated State Health Program (DSHP) funding authority inhibits the ability of the state to offer a robust housing benefit through the Medicaid program.

	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.	A limited benefit focused on this high-risk population during a critical life transition and period of development is proposed. Oregon will continue to discuss with Tribal partners through Tribal Consultation process prior to application submission.
HRSN Outreach and Engagement (O&E)	*Changes to eligibility:* Modify eligibility to align with eligible populations for HRSN nutrition and HRSN housing renewal 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.	Oregon requests to modify to align with eligibility for available HRSN services. Oregon will continue to discuss with Tribal partners through Tribal Consultation process prior to application submission.
Young Adult with Special Health Care Needs (YSHCN)	*Changes to eligibility:* Reduce financial eligibility criteria to up to 138% FPL.	In alignment with CMS' guidance issued April 2025 Oregon requests to modify eligibility expecting a decrease in available funds for YSHCN services without continued DSHP Funds. Oregon requests these changes so the YSHCN program can remain sustainable given the removal of a key funding source.
Reentry Demonstration	*Changes to Benefit:* Reduce benefit duration from up to 90-days pre-release to up to 60 days pre-release.	Oregon requests reduced benefit duration to align with CMS guidance issued September 2026 and state budget constraints.
Traditional Health Care Practices Implementation Funds	The state will continue to work with the Nine Federally Recognized Tribes of Oregon and the UIHP through Tribal Consultation to further refine a	Oregon will continue to discuss with Tribal partners through Tribal Consultation process prior to submission.

	request for ongoing Traditional Health Care Practice Implementation Funds that meets Tribal partners' needs and ensures culturally appropriate service delivery.	
Primary Care Services for Tribes (formerly called "Tribal Uncompensated Care Program" or "UCCP")	The state will continue to work with the Nine Federally Recognized Tribes of Oregon and 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 UIHP, which may include discussing with CMS expanding the covered services to best meet Tribal partner's needs.	Oregon will continue to discuss with Tribal partners through Tribal Consultation process prior to application submission.
Special Diabetes Program for Indians (SDPI)	The State requests to continue conversations with CMS regarding waiver and expenditure authority to establish the SDPI services as a Medicaid benefit. 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 SDPI.	Oregon will continue to discuss with Tribal partners through Tribal Consultation process prior to application submission.

Waiver Initiatives Discontinuing

Oregon requests to discontinue the following 1115 OHP Waiver initiatives where federal demonstration authority is no longer needed or aligned with current CMS policy. 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.

Waiver Initiative	Changes to Eligibility, Benefits, Cost Sharing, or Delivery System	Reasoning
HRSN One-time transition and moving costs (not currently implemented)	Discontinuing initiative	Initiative was not implemented during 2022-2027 demonstration. In alignment with CMS' guidance issued April 2025 Oregon plans to discontinue expecting removal of a key funding source (DSHP) and state budget constraints.
HRSN Home Changes for Health (formerly Climate)	Discontinuing initiative	In alignment with CMS' guidance issued April 2025 Oregon plans to discontinue expecting removal of a key funding source (DSHP) and state budget constraints.
HRSN Housing: Storage fees, hotel/motel stays, home modifications, and remediations	Discontinuing initiative	In alignment with CMS' guidance issued April 2025 Oregon plans to discontinue expecting removal of a key funding source (DSHP), low uptake of benefits during this demonstration, and state budget constraints.
HRSN Infrastructure Funding	Discontinuing initiative: Access to time-limited funds ends 9/30/27	In alignment with CMS' guidance issued April 2025 Oregon plans to discontinue the DSHP HRSN Infrastructure expenditure authority. CMS approved this funding through the end of our current 22-27 Waiver and will no longer be available after September 30, 2027.
Continuous Eligibility (CE) up to Age 6	Discontinuing initiative	CMS indicated in July 2026 guidance they will not approve requests for CE going forward. H.R.1 created 6-month redetermination requirements.
Continuous Eligibility (CE) for 2 years beyond age 6	Discontinuing initiative	CMS indicated in July 2026 guidance they will not approve requests for CE going forward. H.R.1 created 6-month redetermination requirements.
Designated State Health Programs (DSHP)	Discontinuing initiative	In alignment with CMS' guidance issued April 2025 Oregon plans to discontinue DSHP expenditure authority.

Reentry Demonstration Infrastructure Funding	Discontinuing initiative	In alignment with CMS' guidance issued April 2025 and September 2026 Oregon plans to discontinue the DSHP Reentry Implementation expenditure authority. 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.

Enrollment and Fiscal Projections

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.

The State anticipates a total caseload across the extension proposal to consist of an average monthly enrollment of 524,806 members for DY 26, with projected aggregate waiver expenditures of approximately $6.3 billion. These numbers are subject to change depending on the demonstration year used. These projections reflect baseline utilization trends.

The State's enrollment and fiscal projections are documented in the tables below. These projections reflect baseline utilization trends based on available data for currently approved initiatives. All projections are subject to change.

Historical Caseloads and Cost

Demonstration Year (DY)	DY 21	DY 22	DY 23	DY 24	DY 25
Historical enrollment (Member Months)	6,892,411	6,881,497	6,526,593	6,332,336	6,322,536
Historical Caseload (Monthly Average)	574,368	573,458	543,883	527,695	526,878
Historical expenditures ($)	4,718,746,707	4,944,897,573	5,362,660,849	5,156,749,741	5,904,328,284

Projected Caseloads and Cost*

Demonstration Year (DY)	DY 26	DY 27	DY 28	DY 29	DY 30
Projected enrollment (Member Months)	6,297,677	6,241,890	6,241,890	6,241,890	6,241,890
Projected Caseload (Monthly Average)	524,806	520,158	520,158	520,158	520,158
Projected expenditures ($)	6,350,009,029	6,650,374,465	7,014,048,894	7,400,211,583	7,807,680,837

*Inflated 5.5% annually

Proposed Demonstration Extension Evaluation and Hypothesis

The goals and objectives of this demonstration extension 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. The proposed evaluation questions, hypotheses, measures and data sources are subject to change based on feedback during the approval process.

Proposed Evaluation Metrics by Authority Under Extension

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	**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	Data Sources: • Oregon Medicaid claims • CCO financial reporting • CCO contract reporting • HRSN nutrition beneficiary survey

Objectives	Proposed Hypothesis	Potential Approaches
number of chronic conditions,[1] and is a risk factor for depression, stress, and anxiety.[2] Food instability can also contribute to poor medication adherence and postponed medical care.[3,4,5] Related initiatives addressing food insecurity, such as the Supplemental Nutrition Assistance Program (SNAP) and food prescription services, have been shown to reduce food insecurity and affect health outcomes.[6,7,8,9] Pending completion of Tribal Consultation to determine best approach for ensuring the Tribes' members' HRSNs are supported.	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 improve physical and behavioral health outcomes among beneficiaries overall and among subpopulations who experience inequities in physical and mental health outcomes.	• 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
Traditional Healthcare Practices		
Since 2003 representatives from the Tribes in Oregon and dedicated	**Research Hypothesis 1.** The development of technical systems	• MMIS Claims Data

[1] 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.

[2] 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.

[3] 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.

[4] 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.

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

[6] 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.

[7] 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.

[8] 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.

[9] 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
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 state to implement that longstanding goal.	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.	• 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)
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	**HRSN research hypothesis 1.** The demonstration will meet HRSN for	• Eligibility and enrollment data

Objectives	Proposed Hypothesis	Potential Approaches
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 and are less than 12 months postpartum. Pending completion of Tribal Consultation to determine best approach for ensuring the Tribes' members' HRSNs are supported.	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 experience inequities in physical and mental health outcomes	• 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
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	**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	• 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

Objectives	Proposed Hypothesis	Potential Approaches
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 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.[10,11] Navigation programs can also decrease family social needs and improve health outcomes.[12] 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;[13,14] studies have shown that being connected with a CHW can improve patient experiences	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.	dual-eligible Medicaid members) REALD and SOGI Data Repository

[10] 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.

[11] 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.

[12] 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.

[13] 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.

[14] 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.[15,16] 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) • READL and SOGI Data Repository
Reentry Services		
The demonstration's policies for individuals transitioning out of participating carceral facilities are designed to	**Reentry Research Hypothesis 1.** The Reentry policy will expand Medicaid enrollment and improve continuity of	• Eligibility and enrollment data

[15] 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.

[16] 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
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.	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.	• Oregon Medicaid claims • READL/SOGI Data Repository • Oregon Death Data/Vital Statistics Program

Proposed Waiver and Expenditure Authorities

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

Summary of Authorities Requested and Status Under Extension

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

#	Title	Summarized Description	Status under Extension
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
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	Continue

#	Title	Summarized Description	Status under Extension
		Organization-enrollable Oregon Health Plan eligibility. (Applies to all Medicaid state plan and CHIP populations included in the mandatory and optional Medicaid eligibility groups).	
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
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

#	Title	Summarized Description	Status under Extension
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 amounts as set forth in the Approved 2022-2027 1115 Waiver STCs.	Discontinue

#	Title	Summarized Description	Status under Extension
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.	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.	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.	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,	Discontinue

#	Title	Summarized Description	Status under Extension
		except as noted in Approved 2022-2027 1115 Waiver STC 4.5.c.	
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 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**	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	Continue

#	Title	Summarized Description	Status under Extension
	Section 1902(a)(23) Section 1902(a)(10)(B)	are 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.	

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