Policy Memorandum

To: Coordinated care organizations (CCOs)

From: Dave Inbody, CCO Operations director

Date: April 14, 2026

Subject: Anticipated Impacts of H.R.1 and other federal changes on Oregon's CCOs

Executive Summary

H.R.1 introduces significant changes to the Oregon Health Plan (also known as Medicaid) member eligibility, including more frequent renewals, work or activity rules, cost-sharing, and coverage for non-citizens, among others. For Oregon, these provisions will directly affect CCO operations, member outreach, billing reporting practices, and contractual obligations.

The law rewrites Medicaid eligibility, financing, and compliance rules over the next several years, and the State must implement federal directives. These changes cascade down to CCOs by affecting operations, member enrollment, and may increase administrative burden.

OHA will need to evaluate whether contract changes, operational guidance, or new oversight mechanisms are required to maintain program integrity and continuity of care.

Additionally, new CMS policy changes require Healthier Oregon members to shift from enrollment with a CCO to OHP Open Card (also known as fee-for-service) by January 2027.

1. Eligibility Changes and Work Requirements: Implications for CCO Operations

Overview of H.R.1 Provisions

H.R.1 includes:

- New work or other activity rules for certain adult Medicaid populations, including:
  - Medicaid expansion adults who are under 138% of the Federal Poverty Level (FPL), also known as MAGI Adult. More information available here.
  - Some OHP members with Young Adults with Special Health Care Needs (who do not qualify for OHP based on disability or pregnancy). This is also known as the YSHCN standalone (PERC code 5B).
  - Some people with Healthier Oregon benefits (who do not qualify for OHP based on disability or pregnancy). This will include Healthier Oregon Medicaid expansion adults (PERC codes HH, 3H, 3I and HI) and the Healthier Oregon YSHCN standalone (PERC 5A).
- More restrictive eligibility verification and more frequent renewal processes.
- Major structural changes to how Medicaid state-directed payments can be calculated and funded.
- H.R.1 includes direct restrictions on Medicaid funding for Planned Parenthood.
- Adults with certain immigration statuses, including refugees, asylees, some humanitarian parolees, and survivors of domestic violence/human trafficking will move to Healthier Oregon from other OHP Programs

Separate from HR1:

- In September 2025 the federal Centers for Medicare & Medicaid Services (CMS) updated their policy, which means that, under Oregon law, Oregon must change the structure of Healthier Oregon. All Healthier Oregon members must move from managed care – where members get health care through regional networks called coordinated care organizations (CCOs) - to what is called “Open Card,” or fee-for-service (FFS).

- States were also offered the option to move to non-risk payment arrangements, which allow for the plan to receive payments for care. However, if costs are more than those payments, the state must cover the difference. Oregon law does not allow non-risk payment arrangements.
- Oregon must make this change by January 1, 2027 so OHA can continue offering Medicaid coverage that meets federal requirements. Oregon law already allows Healthier Oregon to use a fee-for-service model.

Operational Impacts on CCOs

A. Continued Outreach Responsibilities

To best serve their members, CCOs currently conduct outreach to support renewals, continuity of care, and engagement. Under H.R.1, they may decide to:

- Coordinate with community partners to support employment, volunteer, and education documentation and reporting that falls within the scope of the CCO's contracts with the State.
- Consequently, CCOs may choose to develop new workflows to identify members at risk of losing coverage due to non-compliance, to improve their operational flow.

CCOs will have a role in supporting OHA with the following tasks that are within the scope of their existing contracts:

- Outreach and Education: for example, distribute information related to renewal and work or activity rule changes and encourage members to update or double check accuracy of their information. CCOs should also educate members about exemptions or help members connect with work, volunteer, or education opportunities and support documentation. OHA will provide links to resources; information is currently being posted to: OHP.Oregon.gov/HR1.
- Share Certain Information Already Held by the Plan: for example, distribute information regarding eligibility criteria for specific eligibility categories
- Promote Continuity of Coverage: for example, encourage members to report changes to address, phone number and other contact information so they receive renewals. Members should also report other changes; you can

encourage members to double check accuracy of eligibility data within ONE. Members can report changes and get answers online at benefits.oregon.gov, by calling 800-699-9075, or find a local office at ODHSoffices.oregon.gov

- Refer Members to Community Partners for help: In addition to the routes to report changes or get help above, CCOs can refer members to OHP-certified assisters for support. You can find assisters in your area at OregonHealthcare.gov/GetHelp.

B. Contractual Considerations

Current CCO contracts assume a relatively stable eligibility environment. H.R.1 may require:

- Adjustments to quality metrics tied to continuity of care or preventive service utilization
- Revisions to risk adjustment calculations to account for turnover-related instability

C. Changes to State-Directed Payments (SDP)

These changes significantly narrow state flexibility and will reshape many existing SDP arrangements.

- New, lower federal ceiling on SDP payment levels
- Transition Period for Existing or “Good-Faith” Submitted SDPs
- CCO network providers may provide fewer services or close operations if they depend on the SDPs at current levels. The lower SDP rates may adversely impact their business operations

H.R.1 includes $911 billion in federal Medicaid cuts over 10 years, which will indirectly intensify scrutiny of SDPs and supplemental payments. CCOs will need to support OHA in implementation efforts.

D. Restrictions on Reproductive-Health Providers, like Planned Parenthood

H.R.1 defunds Planned Parenthood by prohibiting Medicaid payments to reproductive-health providers classified as “prohibited entities.”

2. Copayment and Cost-Sharing Changes: Implications for CCO Billing and Reporting

Overview of H.R.1 Provisions

H.R.1 expands state authority to impose Medicaid copayments and allows higher cost-sharing for certain services. This will begin in October 2028.

Potential Impacts on CCO Behavior

A. Encounter Copayment Billing Reporting

If copayments become more common or higher:

- Providers may need to increase the number of encounters reported as “copay applicable”.
- CCOs may need to adjust claims adjudication systems to track care copayment billing data and report to OHA.

B. Risk of Under-Reporting or Misclassification

Higher copayments can create incentives for:

- Providers to waive copays informally, leading to discrepancies in encounter data.
- CCOs to reclassify services to avoid member cost-sharing burdens that could reduce utilization.

OHA may need to:

- Issue guidance on copay enforcement expectations
- Strengthen encounter data reporting
- Update financial reporting requirements to ensure transparency

C. Contractual Considerations

CCO contracts may require updates to:

- Billing and encounter data reporting requirements and standards

- Member rights and protections sections, ensuring compliance with federal limits on cost-sharing for vulnerable populations
- New workflow for CCO, which may include a major increase in member calls to customer service
- H.R.1 may also result in some provider systems no longer seeing members with outstanding balances, which creates a network issue if members can't access a provider due to non-payment of copay.

3. Non-Citizen Coverage Changes: Implications for CCO Contract Requirements

Overview of H.R.1 and other federal Provisions

H.R.1 restricts which lawfully residing non-citizens can receive federally funded Medicaid/CHIP and Marketplace subsidies. In Oregon, this will mean some OHP members move to Healthier Oregon in October 2026, including refugees, asylees, and domestic violence/human trafficking survivors. This will affect about 7,000 people.

CMS will also require separation of Healthier Oregon billing for emergency services from Coordinated Care Organizations. As a result, Oregon will need to move all Healthier Oregon members who are in CCOs to OHP Open Card on January 1, 2027. This will affect over 100,000 members, roughly doubling the OHP Open Card population.

Detailed information is available here.

Implications for Oregon's CCO Model

A. Current CCO Contract Impact

CCOs will see the following:

- Reduction in number of enrolled members

B. Operational and Financial Impacts

OHA may need to:

- Develop and communicate new capitation calculation for CCO services without Healthier Oregon population consideration

The non-citizen transition from OHP to Healthier Oregon will require the following:

- OHA Guidance on transition processes, member notifications, and continuity-of-care protections.
- Coordination between CCOs, Medicaid Division, and OHP Open Card care coordination (Acentra)

C. Contractual Considerations

OHA will need to revise:

- Duties under Eligibility and Enrollment sections
- CCO member outreach obligations
- Data reporting related to CCO billing for member assigned costs
- Healthier Oregon coverage

4. Recommendations for OHA and CCO Operations

A. Immediate Actions

- Conduct a contract gap analysis to identify sections affected by H.R.1.

B. Medium-Term Actions

- Develop interim guidance for CCOs on outreach expectations related to work requirements.
- Communicate CCO responsibilities regarding implementation of cost-sharing duties.
- Communicate Healthier Oregon population transition to OHP Open Card.
- Field questions and comments from CCOs and capture input in engagement tracking tool.
- Cross-sector collaboration: OHA is working closely with the Governor's Office, community partners, providers, coordinated care organizations, and legislators

to review the entire system, identify the greatest risks, and develop strategies to preserve coverage wherever state authority allows.

- Cross-sector collaboration: OHA is working closely with the Governor's Office, community partners, providers, coordinated care organizations, and legislators to review the entire system, identify the greatest risks, and develop strategies to preserve coverage wherever state authority allows. OHA is planning several efforts with members and partners to understand how best to prepare people for upcoming changes and ensure we can reach and support eligible individuals so they remain covered.
- Open Card provider network expansion: OHA is reviewing the current Open Card provider network to understand provider locations, service use, and gaps in access. OHA will conduct ongoing statewide provider engagement to increase the Open Card network through enrollment, claims technical assistance, trainings, and identifying program reform methods to incentivize provider participation.
- Language access: OHA is planning to customize Open Card communications, systems, and language access resources to support a linguistically diverse population.

C. Long-Term Considerations

- Monitor impacts on health equity

Conclusion

H.R.1 represents a significant shift in federal Medicaid policy with direct operational and contractual implications for Oregon's CCOs. The most immediate challenges will arise from new administrative duties and compliance burdens, expanded responsibilities related to cost-sharing implementation, and a significant transition for the Healthier Oregon population.

Proactive planning, particularly around contract changes, operational guidance, and data sharing systems, will be essential to maintaining continuity of care and safeguarding Oregon's coordinated care model.