ANALYSIS

Oregon Health Authority
Unwinding the Federal Public Health Emergency

Analyst: Steve Robbins

Request: Acknowledge receipt of the report on the unwinding of the public health emergency (PHE) by the Oregon Health Authority (OHA).

Analysis: OHA has submitted a report on managing through the end of the PHE for COVID-19 and next steps in redeterminations and continuing medical coverage for Oregonians as required by HB 4035 (2022), Section 2(5):

> *On or before March 1, 2023, the authority shall report to the interim committees of the Legislative Assembly related to health, the subcommittee of the Joint Interim Committee on Ways and Means related to human services, the President of the Senate, the Speaker of the House of Representatives and the Legislative Fiscal Officer: (a) Any waivers or other approvals granted by the Centers for Medicare and Medicaid Services pursuant to subsection (4) of this section; (b) How the redetermination process has been implemented; and (c) Any substantial changes to the timeline for the completion of the redetermination process.*

OHA submitted a report entitled, "Unwinding the Federal Public Health Emergency - HB 4035 Report," on March 1, 2023. The report covers the history of the PHE, an overview of the redetermination process, the deliverables from HB 4035 (2022), the planned phases for redetermination and continued coverage for Oregonians, communications and operations efforts, systems activities, and a risk assessment.

History of the PHE and redeterminations

The report first covers the initial federal legislation, the March 2020 Family First Coronavirus Recover Act (FFCRA), that provided both an enhanced federal medical assistance percentage (FMAP) of 6.2%, and the directive that states participating would not remove Medicaid members from coverage for the duration of the PHE for accepting the additional federal dollars.

Prior to the pandemic, Oregon Health Plan (OHP) members were annually assessed as to their continued eligibility to remain covered, a process called redetermination. With redeterminations paused for the extent of the PHE, the number of members covered in Oregon rose from 1 million to nearly 1.5 million over the past 3 years. When the PHE was to end, however, Oregon would be required to redetermine 100% of OHP members. While the caseloads for the OHP fall under OHA, those conducting and adjudicating redeterminations are employees of the Oregon Department of Human Services (DHS). With the significant increase in Oregonians covered under the PHE and the potential for them to lose coverage through the pending redetermination process, the Oregon Legislature passed HB 4035 (2022) in an effort to find alternatives for those facing disenrollment (see below).

The PHE was extended repeatedly throughout the pandemic, continuing the enhanced FMAP and growth in the OHP caseload. In December 2022, the federal government enacted the Consolidated Appropriations Act (CAA) of 2023, legislation the de-coupled the Medicaid program from the PHE and signaling the end of the enhance FMAP and redetermination restrictions. Instead of an immediate end to the 6.2% enhance match rate, the CAA phases out the match through the end of calendar year 2023.

	Medicaid Matching Rate Increase (Percentage Points)	CHIP Matching Rate Increase (Percentage Points)
January 1 - March 31, 2023	6.2	4.34
April 1 - June 30, 2023	5.0	3.5
July 1 – September 30, 2023	2.5	1.75
October 1 – December 31, 2023	1.5	1.05

HB 4035 (2022) Deliverables

Adopted during the 2022 session, HB 4035 (2022) directed agencies to explore and implement strategies for phasing the renewal dates of OHP members by population categories to preserve coverage for as long as possible, set forth requirements to initiate two external work groups and directed OHA to pursue waiver authorities with the Centers for Medicare and Medicaid Services (CMS) to preserve eligibility for some individuals who would potentially lose coverage once redeterminations began.

The Community and Partner Work Group (CPWG) was asked to recommend strategies to OHA and DHS on obtaining current information on OHP enrollees and methods for communication and outreach to the various stakeholders involved. The Bridge Program Task Force was asked to develop recommendation for a new health insurance program that will provide coverage to people earning up to 200 percent of the federal poverty level (FPL) and to recommend strategies to stabilize the insurance markets for individuals and small businesses as a phased approach is considered. The work of these group was predicated on the state's intention to preserve coverage for the estimated 300,000 individuals who could lose coverage as a result of redeterminations and who could no longer be eligible for OHP or an OHP-like health plan.

Planned phases for redeterminations and continued coverage for Oregonians

The Bridge Program Task Force supported a phased implementation to address redeterminations and the implications of disenrollment and alternatives to keep OHP members covered. Those phases are:

Phase 0: Requesting a Medicaid 1115 Waiver amendment to temporarily continue OHP coverage for enrollees with incomes between 138 and 200 percent of FPL who would otherwise lose this coverage after the PHE ends and are redetermined. This has also been referred to as the coverage extension phase. This temporary coverage will receive only the 60% federal match, leaving 40% of the cost covered by state funds.

Phase 1: Begins when Oregon receives federal approval through a 1331 Waiver to establish the Basic Health Plan (BHP). Those OHP members that have remained in the program through Phase 0 will transfer to the BHP as the first cohort covered. Phase 1 is anticipated to begin July 1, 2024.

Phase 2: Beginning January 1, 2025, the BHP will open to the conversion of members of the Marketplace and those not previously covered by OHP.

Communications and operations efforts

The report breaks down communications and operating plans into various categories, to include benefit recipients, partners and providers, and staff.

Benefit recipients need encouragement to update their contact, income, and household information; understand what is expected of them and how to prepare; and provide information to those that may experience benefit loss or reductions and what options are available.

Provider and non-provider community partners will play a critical role in reaching benefit recipients in their communities to help clarify the process and provide direction for assistance. These stakeholders will also need information and training to adapt to the end of the PHE for changes in their own organizational processes and services.

Training modules and engagement efforts have already started with eligibility staff, management, and customer-facing offices to develop an understanding across the entire staff of unwinding the PHE across medical and SNAP benefits, sharing the operational timeline, and providing connections to the supports available to staff.

	Pre-PHE Ending	PHE Ending Notice	Renewal Period
	March 2022 - Dec 2022	Dec 2022 – March 31, 2023	April 1, 2023 – June 2024
Objectives	**Encourage people to update their contact, income and household information.**	• **Let people know what to expect and how to prepare.** • **Reinforce importance and urgency of updating their information.**	• **Encourage people to read their notices and quickly submit information to continue benefits.** • **Let people who may experience benefit loss or reductions know about other resources.**
Bedrock Strategies	• Equip internal staff with scripts and supporting materials to use in every client interaction. • Share information and tools with community partners, providers and assisters so they can help those they serve navigate changes. • Reach people through broad and targeted awareness campaigns, preferred channels, and trusted senders to meet them where they are with the information they need when they need it .		• Coordinate with the Marketplace to ensure people who lose OHP are supported in their transition to a private plan. • Promote the Bridge Plan as an option for those who do not qualify for OHP and cannot access Marketplace plans.
	Solicit and use partner, benefit recipient and Community Partner Work Group (CPWG) feedback to identify and address equity issues and improve PHE -unwinding efforts.		

In addition to eligibility staff at DHS, OHA has contracted with Performance Health Technology (PH Tech) to provide supplemental customer service to help support the people of Oregon prior to the beginning of redeterminations and during the re-introduction of OHP renewals, assist with inquires on all self-sufficiency programs and continue supporting the stabilization of the ONE Customer Service Center. Finally, a separate contract has been established by the Marketplace with PH Tech for a call center dedicated to outreach, education, and enrollment assistance for individuals who are found ineligible for OHP that are likely eligible for Marketplace plan coverage.

Systems activities

The ONE system that holds eligibility data is also undergoing changes to accommodate volume and increase efficiency. Verified income information from other systems (such as the Supplemental Nutrition Assistance Program, or SNAP) will be automated into the medical renewal process without having to request additional information from a member. The use of federal and state data sources for income verification will be automated. The use of text messaging functionality, online resources, and a mobile application to integrate systems are additional strategies underway.

Risk Assessment

A number of risks associated with the redetermination process were included in the report, to include the historically low accuracy of member contact information, general confusion over the process (which communication strategies are aimed at alleviating), hard-to-reach communities with language barriers, increasing the workforce capacity to handle the high volume of renewals and eligibility tasks, call center wait times, and competing programmatic changes to the ONE system are all forefront in the agency's planning. In addition, the report calls out the lack of a state-based health insurance exchange for navigating to Marketplace health plans. Without a state system, Oregon utilizes the HealthCare.gov federal site and migration to the Marketplace is a manual process where Oregon no longer has real-time access to member progress.

Legislative Fiscal Office Recommendation: The Legislative Fiscal Office recommends that the Joint Committee on Ways and Means acknowledge receipt of the report.

Request: Report on the implementation of House Bill 4035 (2022), which changed the eligibility determination process in Oregon and authorized the creation of a new program to provide health insurance to Oregonians between 138 percent and 200 percent of the federal poverty level.

Recommendation: Acknowledge receipt of the report.

Discussion: House Bill 4035 (2022) made changes to the process for determining eligibility for the Oregon Health Plan (OHP) and authorized the creation of a new program to provide Medicaid-like coverage to Oregonians between 138 percent and 200 percent of the federal poverty level (FPL) in order to preserve the health insurance coverage gains achieved in Oregon as a result of federal eligibility changes made in response to the COVID-19 pandemic. While the bill defines legislative goals and a process for establishing the new program, significant program details were left to the Oregon Health Authority (OHA) and a work group to work through. Section 2 of the bill directs OHA to report to the legislature on certain details of the policy development process as follows:

> On or before March 1, 2023, the authority shall report to the interim committees of the Legislative Assembly related to health, the subcommittee of the Joint Interim Committee on Ways and Means related to human services, the President of the Senate, the Speaker of the House of Representatives and the Legislative Fiscal Officer: (a) Any waivers or other approvals granted by the Centers for Medicare and Medicaid Services pursuant to subsection (4) of this section; (b) How the redetermination process has been implemented; and (c) Any substantial changes to the timeline for the completion of the redetermination process.

OHA submitted its report on March 1, 2023 to address the information requested in the bill.

Background
House Bill 4035 was passed to help maintain health insurance coverage for low-income Oregonians after the COVID-19 public health emergency (PHE) ends and they are found no longer eligible for the OHP. The issue arises from federal changes to Medicaid eligibility intended to combat the pandemic: during the public health emergency declaration, OHP members were allowed to remain on the caseload except in case of death, a move out of state, or voluntary removal. Before the pandemic, approximately 20,000 OHP members per month would transition off the caseload after being determined no longer eligible or due to a lack of response to outreach efforts and a similar number would enroll or re-enroll. After the PHE declaration, OHA's medical assistance caseload grew steadily month after month and is expected to peak at 1.5 million individuals in July 2023, a trough-to-peak increase of approximately 400,000 individuals since the beginning of the pandemic. As a result of this change, Oregon's uninsured rate declined from 6.0 percent in 2019 to 4.6 percent in 2021. The largest coverage gains have been experienced by people with incomes between 138 and 200 percent of FPL, who often have changes in income, which affects their eligibility for Medicaid and interrupts their access to care.

House Bill 4035 Policy Planning Process
House Bill 4035 established a legislative task force to work with OHA to develop a program to cover Oregonians between 138 and 200 percent of the FPL. The task force met 14 times between April 2022 and December 2022 to develop a recommendation. After extensive consultation with OHA, the Centers for Medicare and Medicaid Services (CMS), and other state departments, the task force put forward the following recommendation.

Phase 1 of the plan would create a period of temporary eligibility for Oregonians found ineligible for OHP as a result of the end of the PHE. These individuals would maintain their current coverage and the federal government would match state expenditures at the standard federal match rate (currently anticipated to average 59.30 percent in 2023-25). Phase 2 would start on July 1, 2024 with the transfer of the estimated 55,000 individuals who had their eligibility temporarily extended in Phase 1. The individuals would be transferred to the Basic Health Program (BHP), which would provide an OHP-level of service with no cost sharing through Oregon's Coordinated Care Organizations (CCOs). Federal revenues to support the BHP come from federal estimates of what the federal government would have paid in Advance Premium Tax Credits to subsidize those individuals' coverage on the individual marketplace. Phase 3 would start on January 1, 2025, when the BHP would be open to anyone in Oregon who meets the eligibility requirements. This would require the transfer of an estimated 35,800 individuals currently served on Oregon's individual marketplace from their commercial plans to a CCO plan. OHA also estimates approximately 11,000 uninsured individuals could be enrolled in the BHP once it was opened to wider membership. A final, optional stage of the plan would allow CCOs to sell their plans on Oregon's individual marketplace. This would require amending Oregon's Section 1332 waiver with CMS. It would reintroduce the element of consumer choice for this population and would allow for more seamless coverage as people's incomes change.

Federal Approvals

OHA has requested a series of federal approvals to implement the desired redetermination process and BHP as planned. The table below outlines the changes requested from prior procedure, the date the request was submitted and the status of the request.

Policy	Description	Authority	Date Submitted	Status
Member Communications	Allow OHA to receive member address updates from managed care entities	Section 1902(e)(14)(A) Waiver	August 2022	Approved
Bridge Plan	Temporary coverage for Medicaid-ineligible individuals	1115 Waiver Amendment	November 2022	To be finalized by April 2023
Basic Health Program	Coverage for individuals between 138 and 200 of federal poverty	Section 1331 Blueprint	July 2023	In progress
Basic Health Program FFS Option	Provide tribal members with a fee for service option similar to the BHP	1115 Waiver Amendment	November 2022	In progress
Mitigate Marketplace Impacts	Offset potential impacts to Marketplace consumers due to BHP creation	Section 1332 Waiver Amendment	In progress	In progress

Redetermination Process

The CMS has provided extensive guidance on the timeline and process for redetermining OHA's Medicaid caseload. CMS will allow states 12 months to start and 14 months to complete the redetermination process. OHA estimates 70 percent of its caseload will be renewed passively, meaning that OHA has enough information from other sources to determine that person's eligibility. For those for whom there isn't enough information, OHA will send a request for information to attempt to verify that person's eligibility. House Bill 4035 increased the amount

of time to respond to requests for information prior to a notice of closure being issued from 60 to 90 days. After a notice of closure is issued, that person has 60 days to respond before they are removed from the caseload. OHA must also sequence its redeterminations over the course of 12 months in order to ensure workload is distributed relatively evenly over time. The bill directs OHA to sequence groups for redetermination, with passive renewals and individuals more likely to retain coverage redetermined first. This will allow vulnerable Oregonians to maintain coverage for longer and provide OHA with additional time to establish the BHP.

Substantial Changes to the Redetermination Timeline

The end of the COVID-19-related PHE and the beginning of the redetermination process were thought to be imminent when House Bill 4035 passed in March 2022, due to the widespread availability of vaccines and therapeutics to address the COVID-19 pandemic. Those facts notwithstanding, the PHE was extended multiple times afterward by the Secretary of Health and Human Services. The Consolidated Appropriations Act passed by Congress in December 2022, severed the end of the public health emergency from Medicaid continuous eligibility, ending the continuous eligibility policy and beginning redeterminations on April 1, 2023. OHA and the Department of Human Services (ODHS) have engaged in extensive preparations for the redetermination of the Medicaid caseload. Significant risks to the plan detailed above include federal and state approvals, difficulties in reaching members, the sufficiency and preparation of OHA's and ODHS' workforces, competing eligibility work at ODHS, and the use of the ONE system, which was rolled out during the pandemic and as a result, has not been used for large-scale redetermination work for this caseload before. OHA's scenario planning has indicated that contrary to direction from CMS, it could take 15 months or longer to complete the redetermination process but it is unclear at this time whether that will be the case.

Oregon Department of Human Services
Office of the Director
Oregon Health Authority

Tina Kotek, Governor

500 Summer Street NE
Salem, OR 97301

March 1, 2023

The Honorable Elizabeth Steiner, Co-Chair
The Honorable Tawna Sanchez, Co-Chair
Joint Ways and Means
900 Court St. NE
Salem, Oregon 97301

SUBJECT: Report on HB 4035 (2022)

Dear Co-Chairs and Members of the Committee:

Pursuant to HB 4035 (2022), please find attached a report on the Oregon Health Authority and Oregon Department of Human Services' planning and activities regarding benefit redeterminations as the public health emergency ends.

The full report can be found at https://www.oregon.gov/oha/PHE/Documents/HB-4035-Legislative-Report.pdf.

Sincerely,

James M. Schroeder
Interim Director
Oregon Health Authority

Fariborz Pakseresht
Director
Oregon Department of Human Services

Unwinding the Federal Public Health Emergency

HB 4035 Report

March 1, 2023

Oregon Department of Human Services

Oregon Health Authority

This publication was prepared by the Oregon Health Authority and Oregon Department of Human Services.

This report and other information about the medical assistance redeterminations process is available at https://oregon.gov/oha/phe

For questions about this report, please contact:

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Executive Summary

When the state begins processing the eligibility redeterminations of all 1.5 million[1] Oregon Health Plan members starting in April 2023, hundreds of thousands of Oregonians will be at risk of losing access to health care. A disproportionate number of these people have already experienced health inequities, including higher rates of mortality during the pandemic, and are at a higher risk of experiencing lasting harms from COVID-19.

At the start of the pandemic, the federal Family First Coronavirus Recovery Act provided states an enhanced federal Medicaid match rate of 6.2% and directed that states that accepted the enhanced match rate would not terminate Medicaid members' coverage for the duration of the federal public health emergency (PHE). Oregon participated and, largely as a result, enrollment in Oregon's Medicaid system – the Oregon Health Plan (OHP) – has risen considerably from about 1 million to about 1.5 million. Oregon's overall uninsured rate fell from 6.0% to 4.6%, with the largest improvements among priority populations. The enhanced federal match was expected to continue until the expiration of the PHE, at which point states would be required to initiate the regular redetermination process.

During the pandemic, Oregon has continued to perform annual redeterminations, to keep member contact information and income data as current as possible, but no actions were taken to terminate enrollment in most cases. When regular redetermination processes start, members will be disenrolled if they are no longer eligible or fail to respond, per federal requirements.

In December, Congress passed the Omnibus Consolidated Appropriations Act of 2022 (CAA, 2023) and directed all states to begin their redeterminations no later than April 1, 2023, effectively decoupling the work that was previously tied to the expiration of the federal state of emergency. While the start of redeterminations is no longer dependent on the expiration of the PHE, the state has also been operating under additional flexibilities afforded through the emergency declaration, many of which will be rescinded when the PHE is scheduled to expire on May 11, 2023. As a result, the state will be begin processing the largest volume of OHP renewals it has ever performed, revising temporary program changes in dozens of policy areas, and transitioning potentially hundreds of thousands of people in Oregon to a different form of medical coverage in order to preserve the gains in coverage rates experienced during the pandemic, all at once.

Starting in April, all states will be required to redetermine whether every individual enrolled in Medicaid is eligible. With that, much of the increase in coverage Oregon achieved could be lost. Current estimates are that anywhere from 90,000 to 300,000 members will become ineligible. Through the redetermination process, Oregon's goal is to ensure as many people as possible retain OHP coverage, and other needed benefits and services, or are transitioned to other affordable health coverage with the least disruption possible.

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[1] *This estimate has been revised from previous reports of 1.4 million using updated enrollment data*

The numbers and potential complications of redeterminations are substantial. Known risks to successful implementation include:

- Historically low accuracy of member contact information, creating delays in the delivery of time-sensitive content;
- Confusion for members and service providers about what to do to preserve coverage when redeterminations begin;
- Populations that are historically hard-to-reach, due to cultural and linguistic factors and housing insecurity, who are at risk of being disenrolled due to non-response;
- Limited agency workforce capacity to perform high volume of renewals in a condensed timeframe;
- High volume of eligibility tasks to serve current members with an increasing workload due to concurrent program changes;
- Lengthy call center wait time for members seeking assistance;
- Eligibility staff who lack familiarity with the redeterminations process outside of PHE conditions;
- Competing agencies' priorities for programmatic changes to the ONE System and legacy systems;
- Unique challenges facing seniors whose eligibility changed during the pandemic; and
- Lack of a state-based health insurance exchange for navigating to Marketplace health plans for those no longer eligible for OHP.

The timeline for the redetermination process is organized into four periods, which are applied across policy, operations, communications, external engagement, and coordination with the Community and Partner Work Group. Those periods are:

- **Phase 1** – Prepare for redeterminations while the PHE is in effect: March 2022 to December 20, 2022
- **Phase 2** – Notice received for start date of renewals, begin readiness assessment: December 20, 2022 – March 31, 2023
- **Phase 3** – Start of 14-month unwinding period: April 1, 2023
- **Phase 4** – Post-redetermination: July 1, 2024

During the 2022 short session, the Legislature passed House Bill 4035 and appropriated to OHA a total of $120 million to support both OHP redeterminations and a Bridge Program. Of

the total, $94.4 million is for direct services to support the additional caseload. The remaining $25.6 million will support administration of the program.

Background on the COVID-19 Public Health Emergency

Declaration of a state of emergency and federal protections

In March 2020, at the beginning of the COVID-19 pandemic, Congress passed the Family First Coronavirus Recovery Act (FFCRA). The act provided states an enhanced federal Medicaid match rate of 6.2% and directed that states that accepted the enhanced match rate would not terminate Medicaid members' coverage for the duration of the PHE.

FFRCA also removed various administrative barriers to enrollment, allowing applicants to attest to most eligibility criteria without providing proof of the reported information and expanding presumptive eligibility; that is, an individual would be presumed eligible for medical assistance if they applied, rather than needing to prove their eligibility. Normally members would be disenrolled if an annual redetermination found that their income exceeded the current eligibility threshold (in expansion states, like Oregon, 138% of the Federal Poverty Level) or if they did not respond to requests for information.

In Oregon, Medicaid members receive coverage through the Oregon Health Plan (OHP). During the PHE, in accordance with FFCRA, Oregon has not terminated coverage of members (except in very narrow circumstances identified in FFCRA, such as death, an out-of-state move, or voluntary coverage termination). Oregon has continued to perform annual renewals solely to keep member contact information and income data as current as possible, not to end or reduce eligibility. The effect is that OHP enrollment has risen considerably, from about 1 million members before the pandemic to about 1.5 million members today (900,000 cases or family groups).

As a positive unexpected consequence of the pandemic and the PHE's continuous coverage requirements, Oregon has made great strides in expanding access to health care coverage. While group insurance coverage decreased by 2.1 percentage points, and enrollment in the Oregon Health Insurance Marketplace remained consistent, enrollment in OHP increased by 4.0 percentage points from 2019 to 2021. Oregon's overall uninsured rate fell from 6.0% to 4.6%, with the largest improvements among priority populations. More people in Oregon report having health insurance today than ever before in the state's history.

When the state begins processing the eligibility redeterminations of all 1.5 million OHP members starting in April, hundreds of thousands of Oregonians will be at risk of losing access to health care. A disproportionate number of these people have already experienced health inequities.

The state has been actively planning for the start of redeterminations since early 2022 and reflects a joint effort between OHA and ODHS. OHA, as the single state Medicaid agency, is responsible for the administration of the Oregon Health Plan, contracts with managed care entities known as Coordinated Care Organizations (CCOs) to administer OHP benefits and is

the agency accountable to the Centers for Medicare and Medicaid Services (CMS) during the unwinding. ODHS administers the ONE System, the integrated eligibility platform responsible for processing all applications and benefit renewals for several programs including OHP, the supplemental nutrition assistance program (SNAP), employment related day care (ERDC) and Temporary Assistance for Needy Families (TANF), or cash assistance. All of these benefits, with the exception of ERDC, have been expanded during the pandemic, meaning families in Oregon who depend on these services for survival are likely to experience extreme hardship as their benefits are suddenly reduced.

An interagency project team has been working closely with the Community and Partner Work group (CPWG) to develop and implement operational changes, draft and launch a robust communications and engagement plan, and organize teams to mitigate known risks to the success of the work. OHA and ODHS have developed strategies for each known risk – and in many cases, are already implementing those strategies.

The Medical Assistance Redetermination Process

The redeterminations conducted during the unwinding of the PHE will be the largest Medicaid redetermination project in the state's history. Eligibility for OHP for most populations requires that the member have a reported income of 138% of the federal poverty level (FPL) or less, which for a 1-person household is $17,774 per year. Current estimates are that most OHP members will continue to be eligible for benefits, but anywhere from 90,000 to 300,000 of the current 1.5 million OHP members will become ineligible. Some of the latter may be eligible to enroll in other health plans on the Oregon Health Insurance Marketplace. Some will become eligible for Medicare coverage, which generally covers fewer services than OHP. However, many will have no affordable options for health care coverage.

Before the Pandemic

Prior to the COVID-19 pandemic, Oregon was federally required to redetermine eligibility of OHP members every 12 months after their date of enrollment. This process would validate that they remain eligible for OHP based on income and other non-financial factors. There were two administrative pathways for redetermination, known as "passive renewal" and "active renewal."

The process began with an attempt at *passive renewal*. Ninety days prior to a member's annual redetermination date, the ONE System would seek to confirm the member's information on file against other databases. If some necessary information was still missing, the system would automatically contact the member, using the contact information in the system; the member could then provide the information by logging into an applicant portal. If eligibility was confirmed, no further action (or potentially no action at all, if no information was missing) would be required on the part of the member to renew their enrollment. If the member was requested to provide information demonstrating eligibility and did not respond, they were disenrolled.

If passive renewal was not successful, the system would attempt an *active renewal*, which requires a member to sign and return a renewal letter. This could happen because of a

technical error while trying to process the passive renewal, such as being unable to use electronic sources to verify information in a timely manner, a case being "in progress," or the individual having an active medical Special Circumstance in the ONE System. In active renewal, a renewal packet was sent to the member 60 days prior to the member's renewal date. The Eligibility Worker would follow up, and usually an oral interview would be required. If the member provided the information needed to confirm eligibility, their enrollment would be renewed. Again, if the member was requested to provide information demonstrating eligibility and did not respond, they were disenrolled.

During the Pandemic

During the PHE, OHP enrollment was continuous (except in very narrow circumstances identified in FFCRA, such as death, an out-of-state move, or voluntary coverage termination) without the need to re-confirm eligibility. Oregon has continued to perform annual renewals while ensuring the OHP members remain continuously eligible for coverage, but there have not been reductions or closures in benefits due to non-response.

After the Pandemic

The newly enacted Consolidated Appropriations Act of 2023 (CAA, 2023) addresses the end of the temporary FMAP increase in alignment with the resumption of redeterminations. The FFCRA's temporary FMAP increase will be gradually reduced and phased down beginning April 1, 2023, and will end on December 31, 2023.

Table 1. Timing of Increased FMAP Phase Out

2023 Calendar Overview	**Temporary FMAP Increase Available**
Q1: January 1-March 31, 2023	6.2 percentage points
Q2: April 1-June 30, 2023	5.0 percentage points
Q3: July 1-September 30, 2023	2.5 percentage points
Q4: October 1-December 31, 2023	1.5 percentage points

When redeterminations begin, states will again be required to determine whether each member – all 1.5 million in Oregon – is currently eligible, and to end coverage for those whose eligibility cannot be confirmed. It provides a window of 14 months to complete eligibility redeterminations on all currently enrolled Medicaid members.

OHA and ODHS will aim for as many members as possible to have their eligibility redetermined through passive renewal. This will depend on the ONE System having all the information needed to establish eligibility for programs or having a valid way to contact members to collect any missing information.

In turn, this will require system updates to ensure that information previously verified for other OHA or ODHS programs does not have to be requested again. One of the goals is to minimize the number of coverage terminations for members who remain eligible but merely have not responded to requests for information.

Preserving Oregon's gains in the insured rate

As previously mentioned, an unexpected positive consequence of the pandemic and the PHE's continuous coverage requirements was that Oregon made great strides in expanding access to health care coverage. More people in Oregon report having health care coverage today than ever before in the state's history. House Bill 4035 set out clear objectives to preserve the gains in coverage seen during the pandemic, and identified strategies to reduce the risk of disenrollment, expand coverage options for populations likely to become ineligible, and develop operations, outreach and communications plans in collaboration with external partners.

Planning to date has been focused on preserving coverage for as many people as possible, through several lines of effort: a robust communications and outreach strategy that is designed to keep members and recipients informed and support external partners and providers, a series of operational changes intended to improve the functionality of the ONE system and make it easier for members and recipients to access, and an engagement strategy to prepare eligibility staff for upcoming changes, and connect with community partners and external entities to provide operational details about what will happen and how to elevate issues to the state.

Planning and laying the foundation

One of the most challenging factors throughout the planning has been the shifting timeline for the ending of the PHE; the emergency declaration was renewed in 90-day increments by the Secretary of Health and Human Services since it was originally issued in January 2020, with a commitment from the federal government that states would receive a 60-day notice if the declaration would be allowed to expire, to provide enough time to ramp up operations. When early plans were in development in May of 2022, the state was still operating under the assumption that expiration of the PHE was no more than 90 days away, and many proposed mitigation strategies had to be quickly deployable (in under 60 days) to be considered feasible.

This meant the agencies had to balance the impact of short-term solutions that could support the work and be deployed quickly but were unlikely to fully mitigate the underlying issues they were intending to resolve. With the direction from Congress to begin redeterminations in April, this concrete date provided a clear timeline for assessing operational readiness and beginning the work.

House Bill 4035 (2022)

The Oregon Legislative Assembly passed House Bill 4035 (HB 4035)[2] in early 2022 to prepare for the PHE unwinding and maintain coverage gains achieved during the pandemic. As guided by the Legislature, the Oregon Health Authority, Oregon Department of Human Services and Department of Consumer and Business Services are working to maximize health care coverage as the PHE ends, including maintaining as many eligible individuals as possible in OHP and assisting those who lose eligibility to find other coverage options.

Adopted during the 2022 short session, the legislation directed the agencies to explore and implement strategies for phasing the renewal dates of OHP members by population categories to preserve coverage for as long as possible, set forth a requirement to stand up two external work groups, the Community and Partner Work Group and the Bridge Program Task Force, directed OHA to pursue waiver authorities to preserve eligibility for some individuals who would potentially lose coverage once redeterminations began, and provided flexibilities related to data sharing and collaboration with external partners.

Reporting on progress

Among other things, HB 4035 directs OHA to report as follows:

> SECTION 2. (3) No later than **May 31, 2022**, the authority shall submit a report to the interim committees of the Legislative Assembly related to health, the subcommittee of the Joint Interim Committee on Ways and Means related

[2] *https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureDocument/HB4035*

to human services, the President of the Senate, the Speaker of the House of Representatives and the Legislative Fiscal Officer describing:

(a) The medical assistance program redetermination process;

(b) The operational timelines for processing the medical assistance program redeterminations;

(c) The risks to successfully implementing the medical assistance program redetermination process; and

(d) How the authority will use the authority's appropriations from the Legislative Assembly to complete the redeterminations.

The first report to the legislature was submitted on May 31, 2022[3]. The legislation also requires a follow up report as described below:

(5) On or before **March 1, 2023**, the authority shall report to the interim committees of the Legislative Assembly related to health, the subcommittee of the Joint Interim Committee on Ways and Means related to human services, the President of the Senate, the Speaker of the House of Representatives and the Legislative Fiscal Officer:

(a) Any waivers or other approvals granted by the Centers for Medicare and Medicaid Services pursuant to subsection (4) of this section;

(b) How the redetermination process has been implemented; and

(c) Any substantial changes to the timeline for the completion of the redetermination process.

This report is intended to provide an update on the planning and implementation of the redetermination process, an assessment of the remaining risks to the project, and a detailed timeline of activities once renewals begin on April 1, 2023.

The Community and Partner Work Group

The scope of the Community and Partner Workgroup (CPWG) as defined in HB 4035 included recommending strategies to OHA and ODHS and instructed the group to recommend:

(a) Strategies for obtaining and updating contact information for enrollees in the medical assistance program;

(b) Strategies for outreach and communication with enrollees in the medical assistance program, health care providers, community partners and other organizations;

[3] https://www.oregon.gov/oha/Documents/HB-4035-Legislative-Report.pdf

(c) Strategies to maximize awareness of and utilization of navigational assistance for enrollees in the medical assistance program who will need to transition to other forms of coverage;

(d) Other strategies for conducting medical assistance program redeterminations to minimize the loss of enrollees' medical assistance program coverage; and

(e) Strategies to maximize the use of community-based organizations and other organizations that contract with the authority to provide navigational assistance to medical assistance program enrollees.

(4) The authority shall consult with and seek recommendations from the work group for additional changes to the medical assistance program redetermination process that may be done within the authority's legislatively approved budget, such as:

(a) Conducting ex parte, automatic or active eligibility renewals;

(b) Changes to streamline the process for requesting additional information from medical assistance program enrollees;

(c) Changes to the post-eligibility verification process to allow continuous enrollment while eligibility is verified;

(d) Extending deadlines of up to 90 days for medical assistance program enrollees to respond to requests from the authority to verify eligibility factors;

(e) Increasing the use of application assisters; and

(f) Phasing in renewals by population.

Details on the work of the CPWG and the integration of CPWG recommendations into operational plans can be found later in this report.

Bridge Program Task Force

One of the strategies outlined in HB 4035 for managing the PHE unwinding and maintaining coverage gains achieved during the pandemic was the creation of the Bridge Program Task Force. The measure established a task force to: 1) develop recommendations for a new health insurance program, the Bridge Program, that will provide coverage to people earning up to 200 percent of the federal poverty level (FPL), and 2) recommend strategies to stabilize the insurance markets for individuals and small businesses when the Bridge Program is created.

HB 4035 required the Task Force to develop recommendations on designing the Bridge Program with consideration for specific program design elements, including:

- the federal pathway and timeline to create the program;
- guidelines for how the state and CCOs should administer the program; and
- the benefits to be offered by the program.

Updates on the current status of task force recommendations and waiver submission can be found later in this report.

Planning progress to date (March 2022 – present)

Phase 1 – Prepare for redeterminations while the PHE is in effect: March 2022 to December 20, 2022

The work to prepare for the eventual resumption of redeterminations is based on several assumptions and known risks. First, that the state intends to preserve some form of coverage for the estimated 300,000 individuals who could no longer be eligible for OHP or an OHP-like health plan. Second, that the state has a role in supporting the transition to other forms of coverage through direct outreach, or to facilitate outreach through informational tools and data sharing with partners.

In the May 2022 report to the legislature, the state identified several known risks to the redeterminations work and has taken steps, detailed below, to mitigate the impact wherever possible. It also outlined some possible strategies for supporting the successful preservation of coverage and access to services. This section details the progress to date in implementing those changes.

Joint interagency project team

To maintain close coordination between all impacted agencies, the state set up a joint agency project structure that included leaders from both OHA and ODHS to direct this work. Interagency workstreams focused on planning and executing changes to IT systems and staff operations, maintaining regular progress and risk reporting to executive leadership and supporting executive decision making through project governance, and developing an engagement and communications plan for all phases of the work. The state also implemented an adjusted and phased renewal timeline, expanded the ability to share data and collect contact information from external partners and recipients, and worked to improve public transparency and partner coordination by planning for and creating a dashboard which will report on progress once renewals begin.

Community and Partner Work Group

The state also launched the Community and Partner Work Group (CPWG) which provided guidance and suggestions to the State to support the development of a community-informed communications and outreach campaign in partnership with the Engagement and Communications teams. The CPWG also worked with the state to provide suggestions on which populations should fall where in the new phased renewal timeline, specifically whether identified populations should be front-loaded, spread throughout, or backloaded during the renewals process.

The CPWG advised OHA, ODHS, and DCBS on the development of outreach and enrollment assistance and communications strategies to communicate and assist medical assistance

program members in navigating the redetermination process and any transitions to coverage through the health insurance exchange. This work had the dual goals of:

- Maintaining health care coverage for the most individuals possible so that benefits are not lost, and
- Ensuring additional protective measures for identified vulnerable populations, priority populations, and populations and individuals facing health inequities during this transition and process.

The CPWG brought together representatives from impacted health systems, community partners, organized labor, individuals enrolled in medical assistance programs, and members of Oregon's Medicaid Advisory and Health Insurance Exchange Advisory committees. The CPWG was a 16-member workgroup with members representing from the following sectors:

- 4 community partners
- 4 current OHP members or individuals who have been enrolled in OHP in the last year and have transitioned to the Marketplace, private insurance, Medicare, or who have lost health insurance coverage
- 4 representatives of impacted health systems with a focus on representation from across the state (CCOs, hospital systems, clinics)
- 1 representative of organized labor
- 1 tribal representative (appointed)
- 1 representative from the Medicaid Advisory Committee (appointed)
- 1 representative from the Health Insurance exchange Advisory Committee (appointed)

Members were selected based on their availability and willingness to attend CPWG sessions, lived experience and subject matter expertise, and in a manner to ensure diversity of perspective and representation of the state. Members representing intersecting identities and Oregon's priority populations were given preference.

Areas of focus for the CPWG recommendations include:

- Developing and deploying an effective communications plan
- Designing and running efficient operations
- Conducting outreach to communities that are hard-to-reach and at-risk
- Transparent reporting through the external dashboard
- Leveraging and disseminating resources for partners and providers
- Conducting staff readiness activities
- Sequencing of populations for renewals to preserve coverage

The CPWG has met regularly since late May on a variety of topics. The full record of meeting materials can be found online[4].

Table 2. Schedule of CPWG meeting topics

Month	Topics
May 2022	Introduction to redetermination process and background on scope and goals of CPWG
June	Overview of Marketplace, review of existing community input; discussion of renewals and eligibility pathways
July	Review proposed communications plan; Overview of populations for redetermination sequencing
August	Overview of sub-populations and redetermination sequencing timeline
September	Continued discussion of redetermination sequencing conversation; Finalize redeterminations sequencing recommendations
October	Discuss strategies for reaching unhoused populations; discuss individuals with Limited English Proficiency: other populations as identified by CPWG to prioritize for outreach planning
November	Metropolitan Group introduction; Discuss non-MAGI populations: strategies to support people with disabilities
December	Overview of Marketplace assistors
January 2023	Overview of application assistors (non-Marketplace); Review recommendation survey results; discuss online dashboard and language lines
February	Review the Metropolitan Group campaign plan; Review the final CPWG draft report
March	Feedback team presentation; adjourn

The extension of the federal PHE to May 11, 2023, allowed for much more in-depth and substantive conversations with the Community and Partner Work Group on how best to conduct the process, prior to beginning implementation, than would have been possible if the PHE expired in July 2022. Recommendations from the work group have been incorporated into operational planning and noted throughout this report.

Bridge Program and Basic Health Program

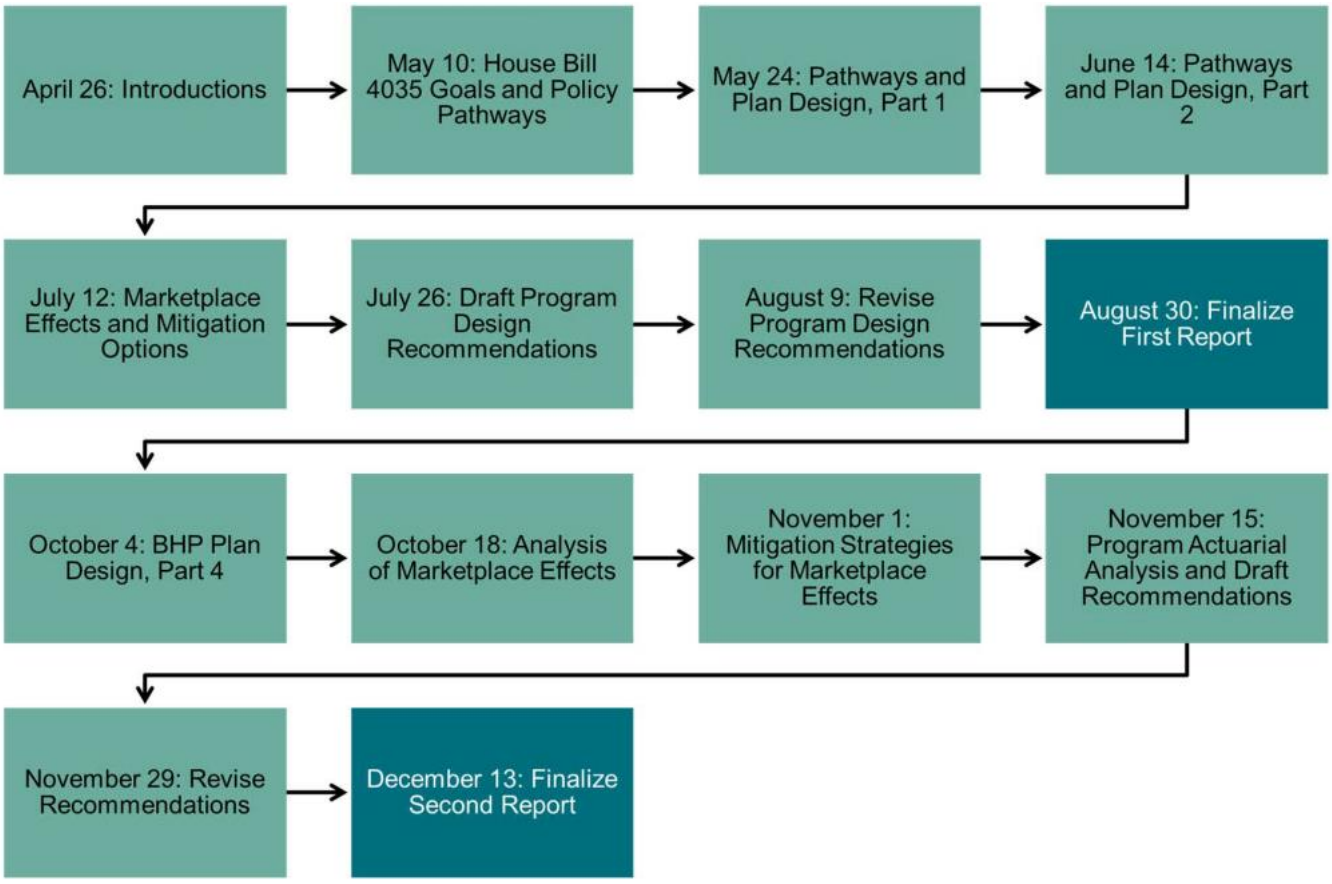
In addition to launching the project structure, the teams initiated activities to launch the Bridge Program, which will provide a form of coverage for people who earn between 138-200% of the

[4] *https://www.oregon.gov/oha/PHE/Pages/phe-maintain-coverage.aspx*

federal poverty level. The Bridge Program will be implemented in stages, beginning with *Temporary Medicaid Expansion* and transitioning to a *Basic Health Program*.

HB 4035 (2022) created the Legislative Joint Task Force on the Bridge Health Care Program, which convened fourteen times between April and December 2022 to offer OHA recommendations on a permanent coverage solution for people who churn on and off OHP due to frequent fluctuations in income. Membership included representation from several CCOs and marketplace insurers in addition to individuals with expertise in health equity and the needs of lower-income workers.

Visual 1. Task Force meeting journey



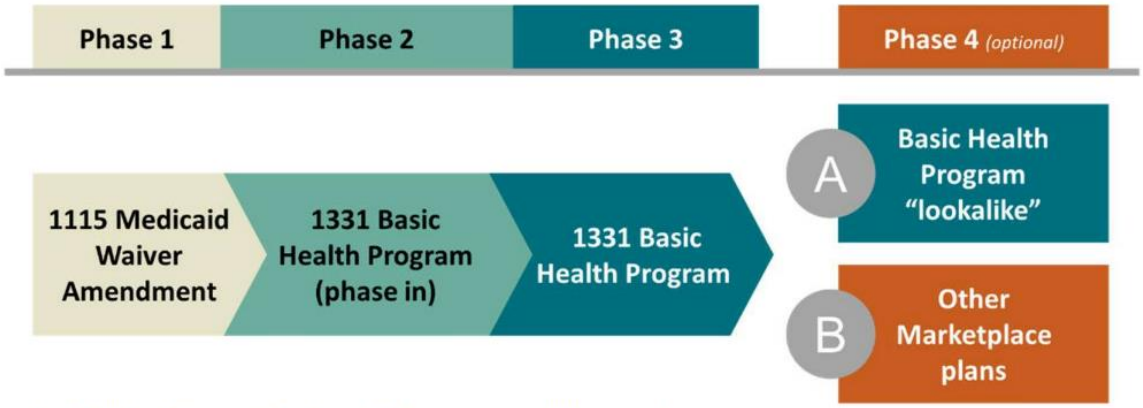
Source: Legislative Policy and Research Office

On December 13, 2022, the Task Force unanimously recommended Oregon request approval from the Centers for Medicare and Medicaid Services (CMS) to implement a Basic Health Program (BHP) to cover adults 138-200% federal poverty level (FPL), an option offered under Section 1331 of the Affordable Care Act (ACA). By implementing a BHP, Oregon will become the third state to take advantage of Section 1331, which offers states federal funding to implement the program. The Task Force recommended that the BHP be administered by CCOs and cover the CCO-delivered OHP service package at no cost to the enrollee. See the

Joint Task Force on the Bridge Health Care Program Final Report[6] to learn more about their recommendations.

The Task Force supported a phased implementation of the program, in which Oregon will temporarily expand Medicaid up to 200% FPL during redeterminations, transition BHP-eligible Medicaid members to the BHP in 2024 and make the BHP available to all BHP-eligible adults in the state in 2025(*see Phased implementation timeline, below)*.

Visual 2. Phased Implementation Timeline Recommended by BPTF



Source: Adapted from Oregon Department of Consumer and Business Services

This timeline would begin with a Medicaid 1115 waiver amendment in **Phase 0** to temporarily continue OHP coverage for enrollees with incomes between 138 and 200 percent of FPL who would otherwise lose this coverage after the PHE ends. **Phase 1** would begin when Oregon receives federal approval to establish the Basic Health Program. During this phase, people who remained eligible for OHP under the temporary 1115 waiver authority in Phase 1 would transition to the BHP. In **Phase 3**, the program would open to all other eligible consumers.

To implement the Task Force recommendations, Oregon applied for an amendment to the state's 1115 Medicaid demonstration in November 2022 to temporarily expand OHP up to 200% during the redetermination process. This application is pending CMS final approval, though CMS has assured Oregon the authority will be finalized in time for redetermination to begin in April 2023. OHA is currently drafting a Section 1331 Blueprint to apply for BHP federal funding. This Blueprint will be submitted in July of 2023 to prepare for implementation in 2024.

Actuarial analysis conducted in the fall of 2022 found that the individual market would remain relatively stable following implementation of the BHP, which will cover an estimated 102,100 people, including 35,800 coming from the Marketplace. Overall enrollment in the Marketplace is anticipated to remain constant because the continuation of American Rescue Plan Act (ARPA) subsidies results in a majority of enrollees facing lower net premiums now than before ARPA subsidies were implemented in 2021. The exit of the BHP-eligible population from the market could lead to a modest reduction in average premium subsidies for remaining consumers. Despite these net premium changes for some subsidized consumers, the actuarial

[6] https://olis.oregonlegislature.gov/liz/2021I1/Downloads/CommitteeMeetingDocument/258397

analysis found that few enrollees leave the market, though some will instead transition to lower-cost plans.

The Task Force recommended that OHA and DCBS pursue strategies to mitigate any effect on Marketplace consumers, including studying and, if appropriate, requesting federal approval for an amendment to Oregon's Section 1332 waiver to capture federal dollars and apply them to offset premium changes for consumers. OHA and DCBS remain in discussion with CMS on the best way to accomplish this goal. Because Oregon remains on the federally-facilitated marketplace, opportunities for creative 1332 solutions are limited.

Partnership with the Nine Federally Recognized Tribes of Oregon

In March of 2022, our Tribal partners reached out to OHA to request that coverage strategies for American Indian/Alaska Native OHP members be prioritized in the planning for the redeterminations process. Over the past six months, OHA has worked closely with CMS and the OHA Tribal Affairs team to craft a solution for ongoing coverage for American Indian/Alaska Native (AI/AN) individuals earning between 138-200% FPL. Under federal law, Oregon is prohibited from auto-enrolling AI/AN OHP members in CCOs. Accordingly, 40 percent of AI/AN adult OHP members receive their coverage through fee-for-service. Because Section 1331 of the Affordable Care Act does not allow for fee-for-service Basic Health Program coverage, the only OHP population with income less than 200 percent FPL that will not have continuous coverage following implementation of the BHP are AI/AN members who are currently enrolled in fee-for-service OHP. Oregon has therefore proposed to CMS that populations exempt from autoenrollment in CCOs (including AI/AN individuals) be exempt from the CCO-administered BHP, and instead receive OHP coverage through an 1115 demonstration. This provision, along with the rest of the SUD 1115 amendment to temporarily expand OHP up to 200%FPL, is currently undergoing negotiations with CMS.

Addressing Tribal requests related to PHE Unwinding

The Oregon Health Authority is working with the federally recognized Tribes of Oregon to develop a range of solutions to challenges brought on by the Public Health Emergency Unwinding, the restart of redeterminations and the development of a Basic Health Program. Key concerns brought to OHA by the federally recognized Tribes include facilitating data access for Tribal Health partners, supporting communications and outreach to AI/AN OHP members, and maintaining ongoing coverage choice for AI/AN individuals from 138-200% FPL following the launch of the Basic Health Program.

Our Tribal partners have requested a monthly data set of AI/AN OHP members at risk of losing coverage during redeterminations. The PHE Unwinding data team, the OHA Tribal Affairs team, Health Systems Division and the Office of Health Analytics established a monthly cadence for delivering this information to Tribal partners. This data will help Tribal health clinics and health departments assist their members in navigating OHP and Marketplace coverage during redeterminations and provide important advanced notice to members who may not know they are at risk of losing health care coverage. In addition to this reoccurring dataset, Tribal representation on the Community and Partner Workgroup contributed significantly to

informing OHA's communication and outreach strategy around the PHE Unwinding. This work includes a range of physical and digital material to assist providers, CCOs, community partners contracted fee-for-service care coordination entities, and health clinics in explaining the PHE Unwinding, redeterminations and the Basic Health Program to their members and patients.

Communications efforts

The communications and engagement goal of this project is to deliver timely, person-centric, actionable information to help people in Oregon keep or receive the health coverage and human services benefits they qualify for and to support those who may be ineligible by connecting them to additional resources. The agencies have been working in lockstep to prepare people, including members and recipients, partners and providers, as well as internal staff, for the upcoming changes with audience-specific messaging, tactics, and tools.

During this phase of the project, planning focused on establishing and disseminating the appropriate level of information to members and recipients, developing tools and platforms for partners and providers, launching training plans for internal staff, and standing up focus groups to develop culturally and linguistically appropriate materials for priority populations, as defined by the Community and Partner Work Group. Detailed plans are included below.

Below in Figure 4 are the core objectives of each phase of the communications plan, including calls to action for benefit recipients and general approaches, or ownable, tangible plans to achieve that goal and objectives for preparing for the end of the PHE by phase. This approach was intentional to help balance the timing of information to when people could act on it, avoid creating panic, and not overwhelm people with complex information.

Visual 3. Communications Objectives Timeline

	Pre-PHE Ending March 2022 - Dec 2022	PHE Ending Notice Dec 2022 – March 31, 2023	Renewal Period April 1, 2023 – June 2024
Objectives	**Encourage people to update their contact, income and household information.**	• **Let people know what to expect and how to prepare.** • **Reinforce importance and urgency of updating their information.**	• **Encourage people to read their notices and quickly submit information to continue benefits.** • **Let people who may experience benefit loss or reductions know about other resources.**
Bedrock Strategies	• Equip internal staff with scripts and supporting materials to use in every client interaction. • Share information and tools with community partners, providers and assisters so they can help those they serve navigate changes. • Reach people through broad and targeted awareness campaigns, preferred channels, and trusted senders to meet them where they are with the information they need when they need it .		• Coordinate with the Marketplace to ensure people who lose OHP are supported in their transition to a private plan. • Promote the Bridge Plan as an option for those who do not qualify for OHP and cannot access Marketplace plans.
	Solicit and use partner, benefit recipient and Community Partner Work Group (CPWG) feedback to identify and address equity issues and improve PHE -unwinding efforts.		

Communicating with Partners and Providers

Provider and non-provider community partners are preferred and trusted messengers for people receiving benefits that strengthen ODHS and OHA's reach into the community. Through preparing and supporting this group to reach people where they are and in ways they prefer, both agencies can amplify and extend their own efforts, especially for communities that are hard-to-reach. Planning in this phase has primarily focused on developing tools that can support individuals in the community who are likely to be the first sources of information for members and benefit recipients.

Partners provide access to and promote awareness of benefits to people in Oregon and include contracted OHA-certified community partner organizations, non-certified Community-Based Organizations (CBOs), SNAP partners, Marketplace community partners, certified insurance brokers, and more. Providers manage or deliver benefits to eligible people in Oregon and include CCOs, CareOregon Tribal Care Coordination, Fee for Service (FFS) providers, FFS Care Coordination entities, Local Public Health Authorities (LPHA), Federally Qualified Health Clinics (FQHC), school-based health centers, Oregon Home Care Commission (OHCC), health care providers and clinics, state-paid and unpaid caregivers, insurers, and pharmacies.

Provider and non-provider community partners alike are well-positioned to interact with, educate, and support people in Oregon with healthcare-related information. The state's goal is to empower our partners with phase-specific resources and training to support the people they serve. Additionally, networks, providers, and insurers will need information and training to adapt to PHE unwinding-related changes to their own organizational processes and services. The state has produced tailored materials, including:

- Phase 1 and 2 partner toolkits
- Change journeys and tools
- External websites
- Virtual webinars
- General and partner FAQ
- Information on households they service and how the state will sequence renewals when continuous eligibility requirements end —to support providers in implementing changes.

Partner toolkit

Informational toolkits have been created for each phase of the unwinding and can be utilized by partners to share updated information with their staff and the people they serve. Partner toolkits can be found in 13 languages on the PHE Unwinding website to increase accessibility in dissemination of information[8].

PHE Unwinding Website

The external PHE Unwinding website has been live since summer 2022 and will continue to serve as a one-stop-shop for critical, phase-specific information, calls to action, and resources for various external audiences, including partners, providers, and people receiving benefits.

- Landing page: oregon.gov/covidphe
- Partner page: oregon.gov/covid-phe-partners
- Member/benefit recipient page: oregon.gov/OR-benefit-changes

Partner webinars

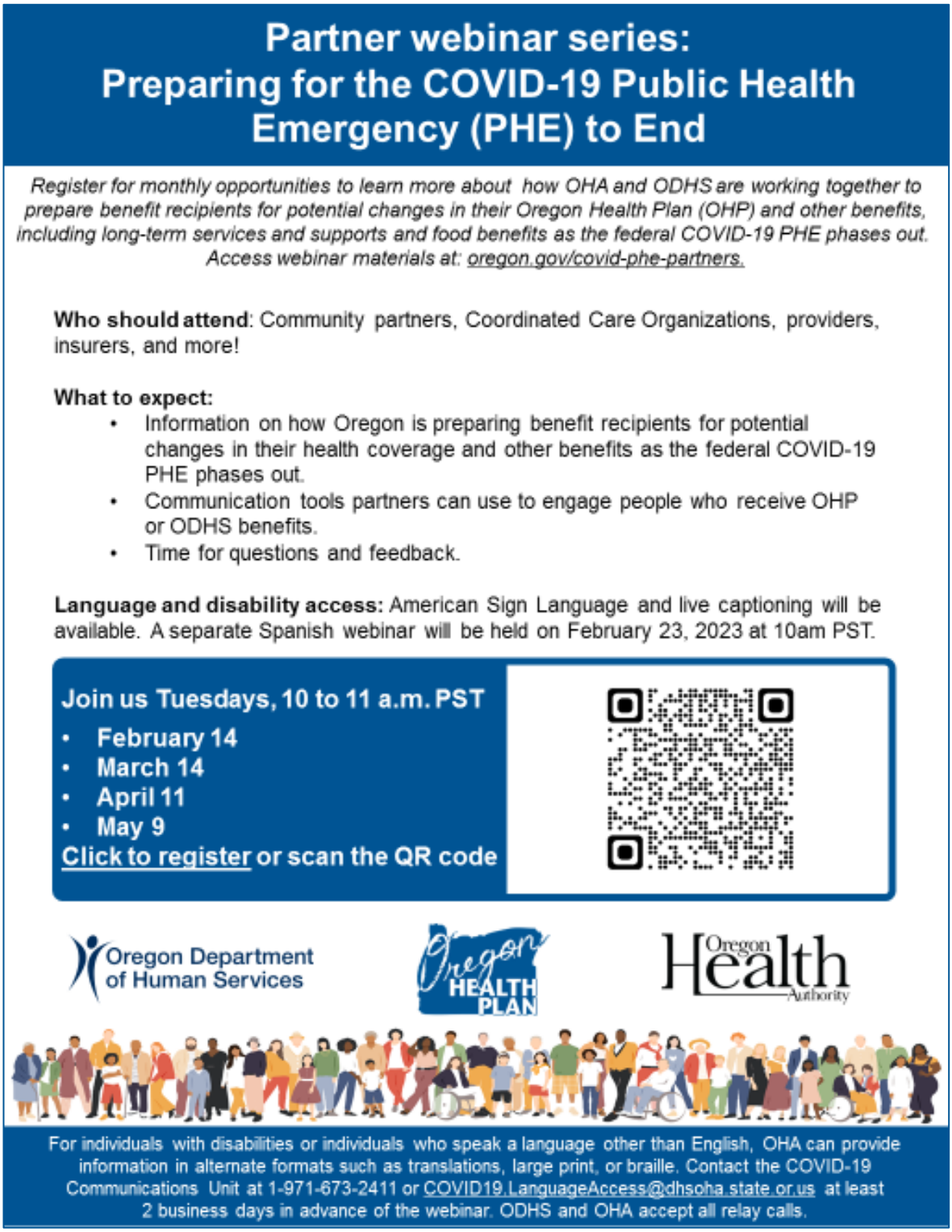
Since September 2022, OHA and ODHS have hosted a monthly partner webinar series for partners and providers to learn more about how the state is preparing for these upcoming changes with the goal of preserving benefits for individuals and families. Five English webinars and one Spanish webinar have been held to date reaching over 1000 partners in total.

Webinars are held in both English and Spanish. Following each webinar, meeting materials and a recording are posted on the PHE Unwinding website's partner page. Question and Answer documents are also posted following each webinar and can be found on the PHE Unwinding website.

More information can be found at oregon.gov/covid-phe-partners.

[8] *https://www.oregon.gov/oha/PHE/Pages/partners.aspx*

Visual 4. Partner Webinar Flyer



Early communications to members and benefit recipients

Courtesy Notice mailing – September 2022

In the fall of 2022, the state sent a courtesy notice to every active medical case in the ONE System, approximately 860,000 ('cases' often reflect households with multiple OHP members, which accounts for the difference between the 1.5 million OHP members enrolled, and 860,000 letters mailed). The purpose of this notice was to inform individuals that the PHE protections currently in place were expected to end sometime in 2023, and to encourage households to keep contact information up to date to ensure they don't miss any important information from the state.

A secondary objective of this mailing was to gain a better understanding of how many cases in the system might have out of date address information. As part of the courtesy notice effort, the state launched a pilot project for automating the returned mail process. The state contracted with a vendor who was able to process the returned mail at a much faster rate than current processes allowed. Once returned mail was processed, the data was matched against enrollment records and this matched data was disseminated to FFS care coordination entities and CCOs to perform outreach. As of February 23, 2023, 81,392 returned letters have been received from this effort, and FFS care coordination entities and CCOs have submitted approximately 17,000 address changes[9].

This allowed CCOs and other contracted providers to focus outreach efforts on individuals with known errors in mailing address, provided an opportunity to launch and test an online tool to collect updated contact info from CCOs directly, and more accurately assess the prevalence of inaccurate addresses in the ONE System. This submission tool will be in place when redeterminations begin and will be used to intake updated contact information stemming from the distribution of 30-day and 60-day non-response data to CCOs and other agency partners. More information on this process can be found in the section titled The Unwinding Timeline.

As a result of this pilot project, the state has prioritized a system and process change to how returned mail is handled going forward.

Beginning in April of 2023, the agency is streamlining its returned mail process. With this new process, a QR code is printed on the first page of every notice sent out by the ONE system. When mail is returned, agency staff will only need to scan in the first page of the returned mail. The ONE system then uses optical reader technology to scan the QR code and applies a "returned mail" indicator to the case which generates an automated 'outreach' task. Once this is added, individuals will receive an automated notification based on the communication preferences they have selected for their case (text message, email, automated phone call/voicemail). If for some reason the automated outreach fails, the system will create a manual task for staff to follow-up with the individual. If the individual updates their address shortly after the returned mail is received, all priority notices will be resent, ensuring access to them. Implementing this new process will allow the agency to keep up with returned mail

[9] *This process will remain operational during the unwinding period*

processing and make it much easier to pull data relating to returned mail rates for future outreach efforts.

Training and support to eligibility staff and store front offices

As part of preparing eligibility staff for the upcoming work, the state has been developing and deploying training modules and regular updates about operational timelines and what to expect, a venue to share topics related to PHE Unwinding, and centralized support to answer questions. The state has held and will continue to hold forums for managers at local offices, launched training related to upcoming changes to the system and the work required during renewals, and has also provided a PHE Unwinding resource guide for all, with new and updated versions being released monthly.

Ongoing engagement started in December with District Managers, Program Managers, Office Managers, and Supervisors within Aging and People with Disabilities (APD) and Area Agencies on Aging (AAA), Type B store front offices, Self-Sufficiency (SSP) store front offices and Virtual Eligibility Centers (VEC) on a monthly basis, which increased to twice a month for February and March. The focus has been to develop an understanding across the entire staff of unwinding the public health emergency across medical and SNAP benefits, sharing the operational timeline and providing connections to the supports available to staff.

Resource Guide

The COVID-19 Public Health Emergency (PHE) Unwinding Resource Guide Version 2 is now available and is intended to complement other training activities. This Resource Guide is a tool for eligibility workers and support staff to prepare for temporary pandemic programs and regulatory flexibilities to end as the federal government phases out the COVID-19 PHE. Oregon Health Plan, long-term services and supports, and food benefit programs will be affected as the unwinding began with the end of SNAP Emergency Allotments on March 1 and will continue through mid-2024.

The Resource Guide has program-specific information to support us through the unwinding period. Version 2 contains:

- Updated information about the COVID-19 PHE Unwinding
- Common questions by program that eligibility workers and support staff may receive
- Information about how to connect an individual to Family Coaches and Case Managers
- Asset Verification System (AVS) Process
- Income Eligibility and Verification Systems (IEVS) Table
- General Do’s and Don’ts of processing an application
- Other helpful resources and information

The Resource Guide will continue to be updated and resources will be added as information becomes available. If you haven’t already, please bookmark this document for your quick reference.

Although the Resource Guide is designed for eligibility workers and support staff, it has valuable information for all staff that are interested in learning more about COVID-19 PHE Unwinding. It complements other resources and TT4T related trainings.

In addition, the Oregon Eligibility Partnerships (OEP) Learning and Engagement Team has created specific trainings for staff, and hosted weekly question and answer sessions:

- Recorded training sessions for eligibility workers and support staff on PHE changes and unwinding topics – A four-part training series comprised of PHE Overview, Medical Income Verification, Presumptive Medical Referral and Asset Verification System policies, and MAGI Expanded Adult is available now via Workday for all staff to complete
- Open question and answer forums – available for all staff after completing the four-part recorded training sessions. The Q&A forums are recurring sessions held twice per week each Tuesday and Thursday from February 28, 2023, through March 30, 2023

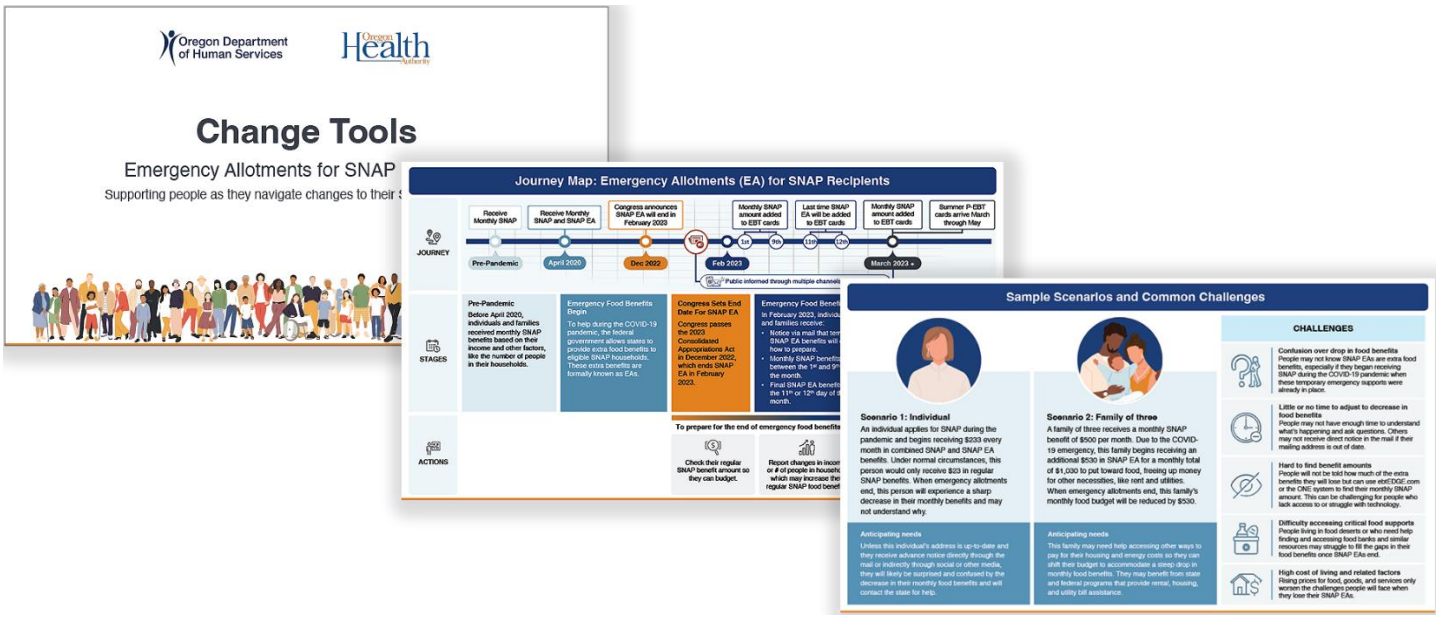
Supporting AAAs, CDDPs, SHIBA

Ongoing engagement is occurring with staff throughout OHA and ODHS who administer programs that are impacted by a person's eligibility for medical programs. This includes some Older Americans Act benefits that are provided by Area Agencies on Aging (AAA), supportive services through Community Developmental Disability Programs and Brokerages (CDDP), and the Senior Health Insurance Benefits Assistance program's Medicare benefit navigation support (SHIBA). The goals are to understand the specific needs of the programs as it pertains to medical redeterminations, and where the project team can provide support. As a result, these groups will be receiving regular distributions of requested data and reports that will assist these agencies in purposeful outreach to recipients of their benefits.

Change Tools

PHE Unwinding Change Guides are collections of tools that staff can use to educate people receiving medical and non-medical benefits about their renewals and changes to their benefits, including OHP, Long Term Services and Supports, and SNAP. Each guide provides journey maps and scenarios that illustrate what people can expect to experience during the renewal process as well as actions they can take and resources they can use along the way.

Visual 5. Change Guide Sample



Operations and policy efforts

During this phase, operational planning was focused on ways to alleviate workload from the ONE Customer Service Center, ways to create efficiencies for members and recipients to use the Applicant Portal, obtaining waivers from CMS that allowed eligibility data from other programs (such as SNAP) to be used during renewals, establishing the phasing schedule of renewals by population with the Community and Partner Work Group and implementing the required system changes in time for renewals to begin.

Waivers allowing the ability to receive member and recipient contact information from partners

On August 9, 2022, CMS approved Oregon's request for a waiver under section 1902(e)(14)(A) of the Social Security Act, allowing the state to collect updated contact information from managed care entities, including FFS care coordination entities and CCOs, for the first time. This waiver was a critical first step in the Courtesy Notice mailing described above, which has resulted in the receipt of 17,000 updates to member addresses since October 2022. This waiver will be in place for the duration of the redeterminations work, with the possibility of requesting ongoing waiver authority to continue this method beyond the unwinding period.

Supplemental call center support

OHA and ODHS have contracted with Performance Health Technology (PH Tech) to provide supplemental customer service to help support the people of Oregon prior to the beginning of redeterminations and during the re-introduction of Oregon Health Plan renewals into ODHS operations, assist with inquiries on all ONE System programs (self-sufficiency programs including SNAP, TANF, APD, ERDC) and continue supporting the stabilization of the ONE Customer Service Center. As redeterminations begin, one goal is to find more ways to direct

calls to PH Tech to triage to the appropriate staff member. There are opportunities to have the PH Tech staff inserted into business processes to continue to free up staff with higher levels of expertise and experience to be available for the most complex work ahead.

Support activities include:

- Provide an initial level of call triage by responding to basic questions, providing access to resources, and helping members and recipients get access to local support, as needed. The call center triages calls to eligibility staff as needed so the most complex calls get to the eligibility staff with the best experience to assist those callers.
- Updating contact information submitted by FFS care coordination entities and CCOs, with the goal of updating as many addresses and demographic details to smooth the process once renewals begin.
- Assisting with the notice translation process to ensure that Oregonians receive documents written in the requested languages that are outside of our automated language options.

To date, PH Tech has onboarded approximately 150 full time staff and is answering approximately 2000 calls a day. Early indicators show that this workforce is supporting the reduction in call wait time for support staff and applicant portal assistance calls[10].

ONE System changes for operational efficiency

To help reduce and manage the increased workload, the state has implemented, or is in the process of implementing, several strategies:

- Increasing automated medical renewals as much as possible by using verified income information from other programs (such as SNAP) to verify income for medical eligibility, without having to request anything additional from the member;
- Distributing the upcoming redeterminations workload using the population phasing schedule recommended by the CPWG, and accounting for a variety of operational factors including future workload projections;
- Improving the income verification process by automating the use of federal and state data sources instead of requiring verification from the member;
- Improving text messaging functionality to encourage timely response to renewals and requests for information, as well sending appointment reminders;
- Improving the Member and Community Partner Applicant Portal dashboard so that contact and demographic information can be updated more quickly and easily;
- Implementing an Applicant Portal mobile app to make it easier for Oregonians to check status of benefits and upload information;
- Increasing accessibility by enabling seven languages in the system;
- Redesigning the medical eligibility and renewal notices, and the request for verification notice, using a member focused “human centered design” process

[10] *In a six-week span (Jan 9, 2023 to Feb 23, 2023), average call wait time for support staff at the ONE Customer Service Center went from 25 minutes to 1 minute; for callers seeking help with the Applicant Portal, average wait time went from 7 minutes to 1 minute.*

- Leveraging community partners, FFS care coordination entities and CCOs for outreach by providing 30- and 60-day non-response reports to facilitate outreach to members who have not responded to requests for information

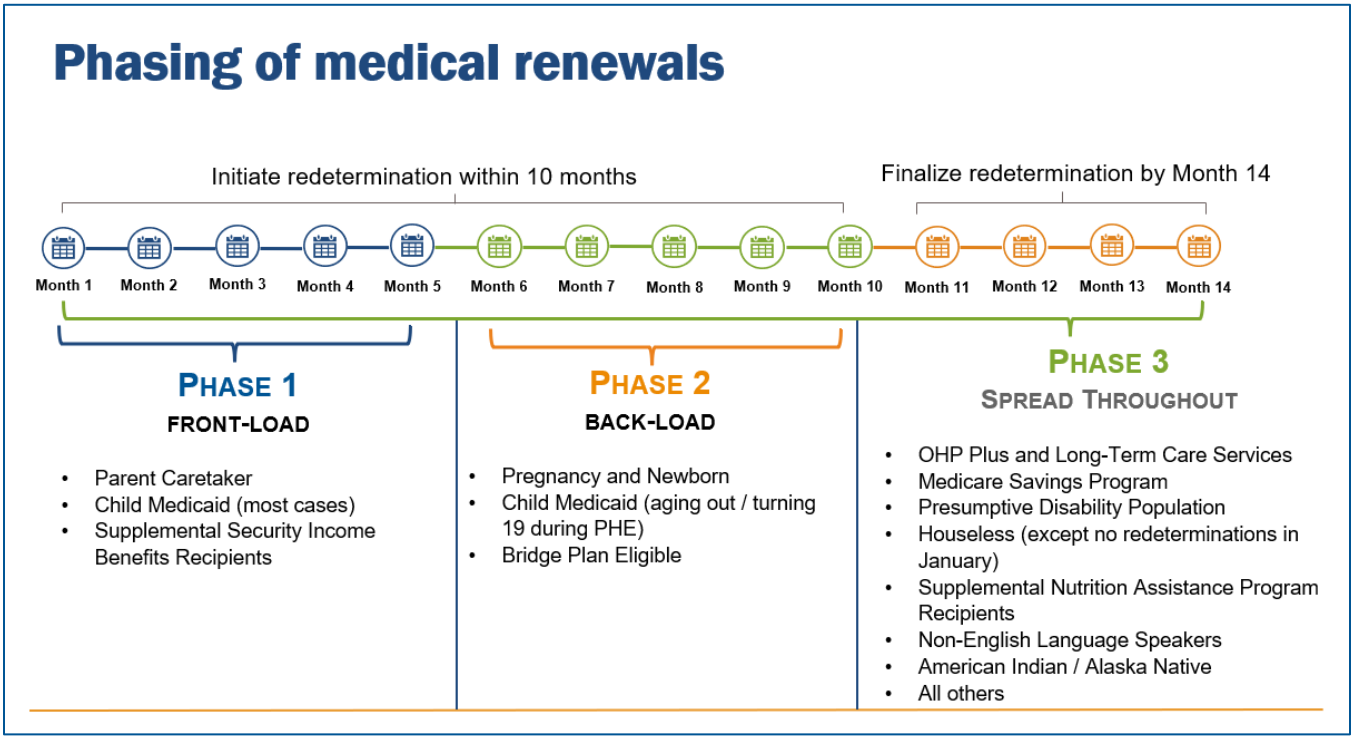
Phased renewals by population

HB 4035 directed the state to explore opportunities to phase in the schedule of renewals by population, and in partnership with the CPWG, a recommended schedule was established and is in the process of being implemented. Typically, a renewal would be scheduled annually based on the date of enrollment of the individual receiving benefits. The approach to scheduling by population group will attempt to front-load the cases that are most likely to go through the renewal process successfully, creating more time for outreach and communication for communities that are hard-to-reach.

When establishing the schedule for renewals, the approach was as follows: those populations who are more likely to retain their health coverage should be redetermined early in the unwind, while those more at risk of losing coverage or who are at the highest risk if they lose coverage should be redetermined at the end of the unwinding period. Phasing redeterminations by population is intended to minimize the risk of disruptions in coverage or care.

While this schedule is intended to phase populations according to known risk factors, it is important to note that it is not a precise indicator of when an individual will be scheduled for renewal due to several factors, including the grouping of ‘cases’ (designed to create efficiencies within a household for renewals by scheduling them all at once, based on the information on file for the head of household). The visual below shows the estimated schedule for when renewals will be scheduled in the ONE System, based on the attributes of the member:

Visual 6. Phasing of medical renewals



The order for how different groups will go through the renewals process is based on CPWG recommendations.

- **Front-load redeterminations** (Months 1-5): Groups likely to remain eligible and need fewer interventions and verifications to maintain eligibility, including parent caretaker, child Medicaid (most cases), Supplemental Income Security Benefits Recipients.
- **Back-load redeterminations** (Months 6-10): Groups that we want to provide maximum protections after the Public Health Emergency ends and people likely eligible for the new Temporary Medicaid Expansion, including pregnancy and newborn, child Medicaid (aging out/turning 19 during PHE), Bridge Plan eligible. American Indian / Alaska Native members will also be backloaded, which was a sequencing decision made by Tribes.
- **Spread throughout the redetermination process** (Months 11-14): Groups that may need more support, either to remain enrolled in OHP or move to a different type of coverage, including OHP Plus and Long-Term Care Services 1 and 2, Medicare Savings Program, Presumptive Disability Population, Houseless (except no redeterminations in January), Supplemental Nutrition Assistance Program recipients, non-English language speakers, and others.

Between July 28 and October 13, 2022, the Community and Partner Workgroup convened to consider the proposed sequencing of groups for eligibility redetermination and made the recommendations listed above. During the process of developing these recommendations the workgroup sought to understand the agency's initial suggested approaches and discussed

these approaches in detail and by population in five 3-hour meetings from July to October. The CPWG considered risk factors, the likelihood of remaining eligible for Medicaid, and potential barriers to transitioning to other coverage. The CPWG members remarked that thoughtful work had already been done by the state and did not seek to make different recommendations if the workgroup members were in general agreement with the state's rationale for the proposed schedule.

Marketplace transition

For those individuals who are no longer eligible for OHP and may be eligible to enroll in a plan on the Health Insurance Marketplace, early planning activities have focused on operationalizing a call center to support the navigation to a Marketplace plan, developing protocols for data exchange to support outreach to members and the identification of a comparable benefits package, and testing of a matching algorithm to help identify plans with an individual's existing provider to smooth the risk of disruption during transition.

Call center onboarding

A separate contract has been established by the Marketplace with PH Tech for a call center dedicated to outreach, education, and enrollment assistance for individuals who are found ineligible for OHP that are likely eligible for Marketplace plan coverage. Assistance will be available in multiple languages. Operationalizing the call center has included recruitment and onboarding of call center staff, finalizing Marketplace training, setting up the mailroom, implementing the CRM (customer relationship management software) database, finalizing the process for individualized outreach letters, and publishing the dedicated toll-free number and email address for the transition program concurrent with the start of the first notices to go out.

Closure notice data transfer for Marketplace outreach

Once a member is found ineligible for OHP, they will be included in what is known as a "closure report". This report will be distributed to the Marketplace team to be used for individualized outreach. This data is still being tested; however, the baseline test appears to be successful and may be used to inform additional processes.

Data matching to provider networks – pending

The Marketplace is currently testing the application of an algorithm to the closure data with the goal of identifying the primary or most frequently used medical providers of the individuals referred to the Marketplace. If the approach is successful, it would result in the ability to individualize the outreach letters to provide potential plan options based on their estimated income, geographic area, and medical provider(s) that would be in network. Testing of the application of this algorithm is still ongoing, with the goal to have a successful implementation for the first April 2023 notices.

External dashboard

HB 4035 also requires the state to produce an external-facing dashboard that depicts the progress in completing redeterminations. One goal of this work is to pilot the use of the REALD Data Repository, to enable the state to monitor the impacts of the redetermination process by race, ethnicity, age, language and disability, as well as SOGIE (sexual orientation, gender identity and expression). There are known challenges in the consistent collection and validation of this data across the impacted systems. The dashboard will be launched prior to the start of renewals in April, with a working prototype that is currently being validated and evaluated for visual accessibility.

The components of the dashboard have been defined with three primary questions in mind, specific communication objectives, and a description of what the dashboard will depict:

1: Who is impacted by the resumption of redeterminations?

Communication objective: People across Oregon will be impacted by the PHE Unwinding. Over the next 14 months, we will process a large number of renewals and you will be able to see the progress through this dashboard.

In this section, you will see detailed information about who receives benefits in Oregon, how many medical renewals remain, how many are in progress, and how many have been completed. You will also see information about which communities and populations are impacted.

2: Who is maintaining medical coverage, who is being disenrolled and why?

Communication objective: Renewal activities, from our outreach and communications efforts to the ability of recipients to reach us and provide the right information, will not impact all people equitably. We want to understand what the impact of renewal activities is having on communities of color, persons with lower incomes and other populations that face inequities.

In this section, you will see how many renewals are started, pended, completed, and their outcomes. You will also see information about which communities and populations are impacted.

3: How well are we keeping up with the work, and where is it being supported?

Communication objective: We are attempting to process a large volume of renewals on an expedited timeline in addition to the existing workload and ongoing eligibility activities. This will put a strain on our current staffing and will create delays and barriers for people looking to renew. We are putting strategies into place to help alleviate this impact, but there will still be unavoidable capacity constraints.

In this section, you will see how many applications, renewals, and changes are received, pending, processed, and past-due for Medical, SNAP, CASH, and ERDC benefits, and current call center wait time metrics.

Once the dashboard has been launched, it will be available on the PHE Unwinding website.

Phase 2 – Notice received for start date of renewals, begin readiness assessment: December 20, 2022 – March 31, 2023

With the start date of renewals confirmed, the state's planning efforts for the ending of the PHE and resumption of redeterminations have shifted: the project is now focused on the implementation of tools that will support the completion of medical redeterminations and the unwinding of other emergency benefits, assessing operational readiness to perform the activities across impacted systems, including collecting and reporting on data, deploying planned communications, validating engagement plans with external partners, and engaging in tabletop exercises to identify new risks to the work. These exercises have resulted in several high-quality visual products to help communicate the upcoming work and milestones to internal and external audiences.

As previously mentioned, the CAA identified the start of medical renewals and the phase down of enhanced FMAP. The bill also ended SNAP Emergency Allotment at the end of February 2023. In January, notices were sent to impacted Oregonians and eligibility staff to prepare them for the ending of the SNAP EA benefits.

People Readiness – Assessing Partner Engagement

Keep Covered: A Campaign to Support OHP Members Through Redetermination

While Phase 1 communications planning was focused on broad messaging, Phase 2 readiness is focused on finalizing materials that were created with the help of community-driven focus groups designed to co-create culturally and linguistically appropriate materials for a list of priority audiences, established by the CPWG. This work was conducted by the Metropolitan Group, a firm brought on to support a focused communications campaign.

The information below provides an early view of the results of focus group research, proposed core messaging and proposed products that are anticipated to launch in April, contingent on approvals and available budget:

The State of Oregon anticipates an historic number of people living in Oregon will be affected by changes coming to OHP this year. Because many people may not be reached through typical OHP communication channels alone (e.g., direct mail, social media accounts, the news media), the Oregon Health Authority (OHA) is launching Keep Covered, a campaign to advance health equity by ensuring as many individuals and families as possible keep their benefits or get connected to alternative supports.

Priority Populations, Identified and Engaged in Collaboration with Communities

OHA and ODHS worked with community-based organizations and the Community and Partner Work Group to co-identify 19 priority populations for outreach. OHA worked with community-based organizations and the Community Partner Workgroup (CPWG) to co-identify 19 priority populations for outreach. Each of the 19 populations will 1) be highly impacted by changes to

OHP benefits and 2) need tailored, culturally-informed communication to help ensure they keep covered. They include:

- COFA islanders
- Farm workers
- Indigenous people who are not served by Indian Health Services (IHS)
- People who identify as Asian
- People who identify as Black and/or African American
- People who identify as Latina, Latino, or Latinx
- People experiencing intellectual or developmental disabilities
- People experiencing physical disabilities
- People with low or no literacy
- People aged 65+
- People living in rural or remote areas
- People experiencing serious mental health conditions or illness
- People leaving private hospitals
- People leaving custody of the judicial system
- Recent immigrants
- People experiencing substance use disorders
- People who are undocumented
- People who are unhoused or housing insecure
- Youth aging out of foster care, emancipated youth

To understand more about the strengths and needs of these populations, OHA, along with the Oregon Department of Human Services (ODHS) and communication partners, conducted **community listening** via focus groups with OHP members, interview sessions with equity-focused community leaders who serve the priority populations, and a quantitative OHP member survey shared via state, professional and community networks.

In addition, a group of **Campaign Advisors**—community organizations representing each priority audience group listed above—helped analyze insights from the community listening and provided input into communication strategies for their represented audience in the resulting campaign plan. These Advisors will also review and provide input on core campaign content to ensure it is responsive to the needs and context of their represented audience, and will share campaign messages, content and materials through their channels and networks. As trusted sources of information and relationships within their communities they are vital partners in this work and are compensated for their time and expertise.

Keep Covered Campaign Overview (in final reviews)

The Keep Covered campaign strategy, which was reviewed by the CPWG and Campaign Advisors, is guided by communities and incorporates feedback loops for continuous learning

and iteration to meet emerging needs. It includes the following actions which will begin launching in April 2022:

- **Materials:** Serve OHP members with clear, focused information.
    - Provide print and digital written materials available in 14 languages.
    - Provide audio and video materials available in multiple languages.
    - Be open and transparent, use plain language and culturally- and linguistically-relevant information, and combine urgency with care and support.
    - Timing:
        - March: initial materials
        - Late April: Initial set of core member-facing materials (fact sheet, FAQ, poster, flyer, table tent, social posts, web banners) in English
        - Mid-May: core materials (listed above) in all other languages
        - June-December: other materials roll out as needed/developed
- **Distribution:** Equip the network of messengers.
    - Work with Campaign Advisors and others
    - Provide toolkit and website for community partners and assisters
        - Timing:
            - Ongoing: engagement and support
            - April: toolkit and website
- **Advertising:** Say it multiple times and ways, where OHP members are
    - Place advertisements in places that reach OHP members to build broad awareness, and to spark conversation, information-sharing and action.
        - Timing:
            - TBD; aiming to launch flight in April
- **Iteration:** Adapt and respond.
    - Monitor feedback and redetermination data to see and respond to emerging needs (e.g. increasing resources where enrollments are lower).
    - Through a Technical Assistance Bank, work with community organizations to create additional materials or actions to reach people who have not taken action.
        - Timing: TA Bank available immediately and ongoing

How You Can Support the Keep Covered Campaign

- Share the messages below.
- Refer OHP members, community organizations, clinics and other resources in your communities to the OHA information page (https://www.oregon.gov/oha/PHE). Here they can learn more and update their contact information to be sure they receive ongoing communication and instructions.
- Sign up for email updates to access campaign materials as soon as they are released: https://www.oregon.gov/pers/Pages/How-to-Sign-Up-for-GovDelivery.aspx.

- Use OHA's feedback app to share input, flag concerns or make suggestions about what is needed to support OHP redetermination. Email feedback@odhsoha.oregon.gov.

Effective Messages for OHP Members

Change is coming to OHP. Renewals are starting soon. Take action to keep covered.

Step 1: Update your address so we can reach you with important information. You can do that – or get free help – online, by phone, or in-person.

- Go to www.benefits.oregon.gov, or
- Call the ONE Customer Service Center: 800-699-9075 (TTY 711). Help is available in many languages, or
- Stop by a local ODHS office or Area Agency on Aging Office, or

Visit a community partner. To find one near you visit bit.ly/ohplocalhelp

Step 2: Watch your mail for a letter from OHP. Sign up for a text or email alert to let you know when the letter is coming. When it comes, do what it asks right away.

Core Materials and Proposed Campaign Items

The campaign is expected to launch with a set of core items intended for all 19 prioritized populations. These will be offered both for use as-is, and in a customizable version that allows intermediary organizations to insert their logo and brief content (e.g. times/locations of assistance resources.)

Table 3. MG Core Campaign

Core campaign items to develop for launch (ready April 1) *(in all 14 written languages noted above)*	
CAMPAIGN ITEM	**DESCRIPTION**
Fact sheet	A fact sheet (8.5x11" one page, double-sided) about the redetermination process and key actions OHP members need to take to keep their coverage or find new coverage via OHIM. *Option to request printed waterproof copies for outdoor outreach workers.*
Poster + Flyer	An 11" x 17" poster (with less text than the fact sheet) that has the main calls to action for OHP members. This poster will also be adapted into a smaller size that can be distributed as a 5.5" x 8.5" flyer, handed-out at events or shared through digital properties (websites, emails, social media, etc.)

Social media posts (content + graphics)	Up to 6 social media posts (content + accompanying graphic) that alert OHP members to the redetermination process, provide instructions on actions they must take, and point to resources and more information.
2-page FAQ	Two-page "Frequently Asked Questions" document

Each of these items will be available in the 14 following written languages:

- English
- Arabic
- Chuukese
- Hmong
- Marshallese
- Spanish
- Russian
- Korean
- Somali
- Simplified Chinese (written)
- Traditional Chinese (written)
- Vietnamese
- Tagalog
- Ukrainian

Table 4. MG Initial Phase of Campaign

Campaign items to develop and roll-out over the first three months *(each in up to 10 languages as campaign advisors recommend)*	
CAMPAIGN ITEM	**DESCRIPTION**
Video 1: Announcing the OHP redetermination process *(~30 seconds)*	Videos in recommended languages – as well as Mam and Mixteco, which are oral-only languages. Includes text and images with voiceovers from community leaders.
Video 2: Instructions on what to do when you get a letter *(~ 3-5 minutes)*	Videos in recommended languages – as well as Mam and Mixteco – with clear steps and where to go for help. Includes text and images with voiceovers from community leaders.
Audio recording on the OHP redetermination process	Audio (adapted from videos) in recommended languages – as well as Mam and Mixteco – to be used as a radio PSA, posted online, and/or played at community events.
One-pager: "Understanding your OHP notice letter"	Explanations of the sections of the notification letter and what to do depending on what it says. Based on OHA video content.

Population-specific FAQs, approximately 2 pages each	Developed with paid campaign advisors, as desired/needed, in cases where details, actions, etc. differ from the general information.

The list below is still tentative, subject to available budget, and should not be considered final.

Table 5. MG Potential Media

Potential Paid Media	
Potential Channel	**Type of Creative Needed**
Out-of-home: Billboards or posters (small billboards) (English and Spanish)	Still ads/creative
Out-of-home: Location-based advertising	Paid placements in grocery stores and mercados, pharmacies, laundromats or other places OHP members frequent
Social media (Instagram, Facebook, YouTube, WhatsApp (English & Spanish)	Video content + still ads/creative + copy for body of post.
Digital ads: search and/or geofencing	TBD: Search reaches people who are searching for OHP and related info. Geofencing reaches people in certain areas, e.g., near specific FQHCs or community locations.
Print ads in culturally specific newspapers/community papers, e.g.: - Street Roots - Language/community papers	Still ads/creative that includes copy translated into specific language of newspaper. We will also negotiate for value-added content (e.g., articles, fact sheet inserts) and online presence/features.
Radio ads, likely including stations with programming in the following languages: - Spanish - Mam - Mixteco - Tongan - Russian - English	Audio recording, including in Strategy A. We will also negotiate for value-added content (e.g., interviews) and online presence/features.

Sponsored TV news segments	Announcer-read content, news stories and other sponsored content that shares the situation, the urgency and what people can do. (This can be a more cost-effective way for broad visibility without TV ad production and placement—and can galvanize CBOs and stakeholders to help reach OHP members.)**

Draft Timeline (contingent on budget and approval)

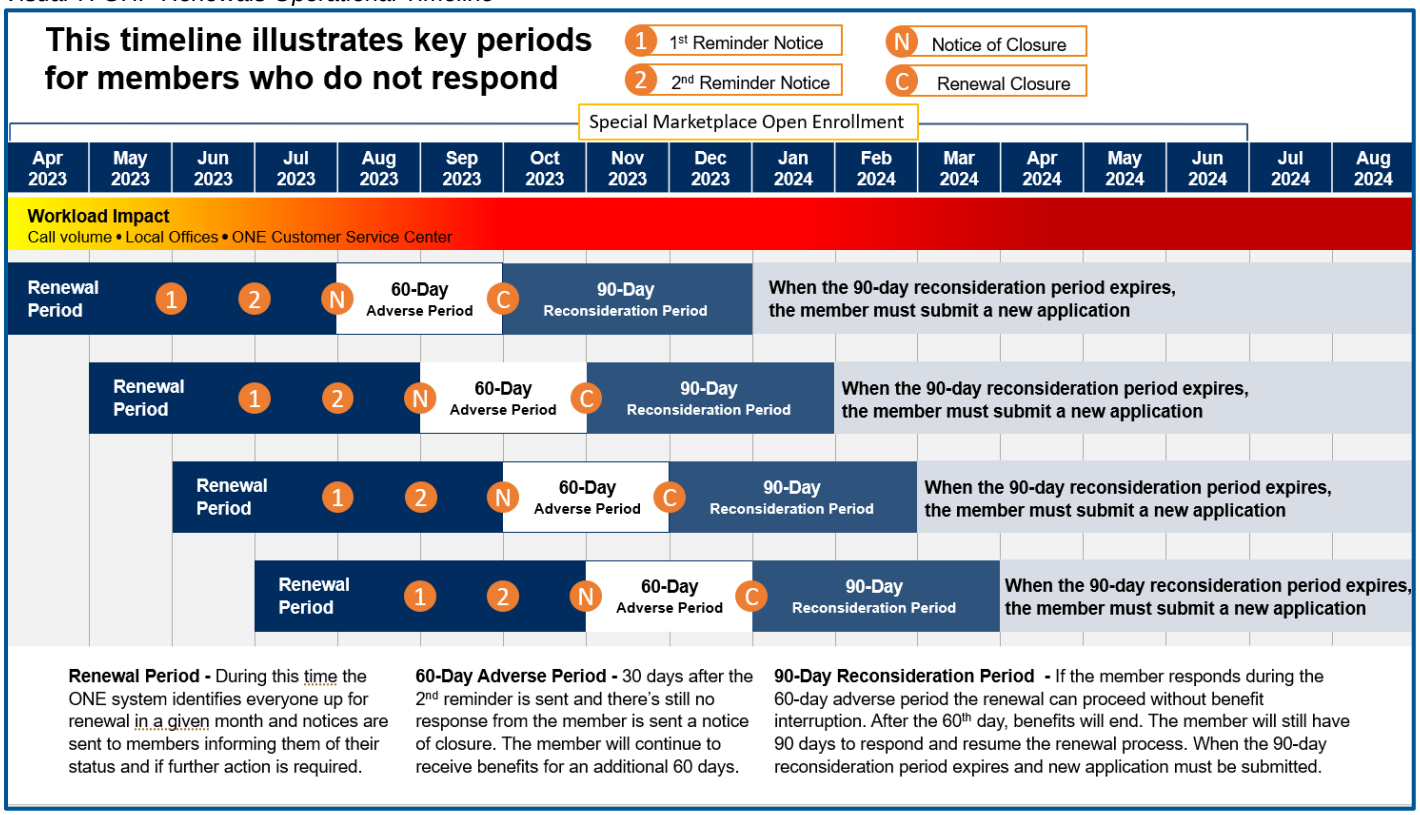
- Early March: Core messages and creative approved, along with full campaign strategy
- Late March: Paid media plan submitted and approved
- Mid-April: Core materials drafted in English, approved, designed, released
- Late April: Aiming to launch first paid media flight (may be phased in)
- May: Core materials translated in 19 languages, reviewed, approved, designed, released
- May through July: Campaign continues, additional materials created, translated, designed, approved, released
- July: Assess, adapt, decrease or increase activities as needed
- July-January 2024: Continue campaign
- February 2024: Campaign ends
- February 2024: Campaign evaluation report

This campaign is still in final approval stage, and updates on planned activities will be posted on the PHE Unwinding website.

The Unwinding Timeline – Overview

The Phase 1 and Phase 2 preparation for the resumption of PHE redeterminations will begin in April 2023, and will initiate a recurring process of system activities, notifications and mailings to members, data transfer to partners, outreach activities, and responses that will result in increased workload for ONE eligibility staff, the customer service call center, community partners, FFS care coordination entities, CCOs, providers, store front offices, health insurance navigators, and anyone else affiliated or associated with the health system. The timeline below shows the high-level overview of the entire 14-month unwinding period, activities that are anticipated, and the expected impact of those activities on partners and providers across the health care system.

Visual 7. OHP Renewals Operational Timeline



This interactive timeline tool will be available on the PHE Unwinding website beginning March 3, 2023

Overview of major activities – April 2022 – June 2024

Phase 3 – Start of 14-month unwinding period: April 1, 2023 – June 30, 2024

The redeterminations process will begin in April and will initiate a recurring process with activities that fall into three main categories. Each month a new renewal cycle begins with the group of members who have been scheduled based on their population category. The entire cycle from initiation of a renewal to the eventual closure of a case can vary, depending on whether a response is received, the type of renewal that individual is eligible for (passive or active), and a variety of other factors. This report attempts to depict the simplest path for an

individual to take, or the longest duration the activities could last before their enrollment is terminated. While some ad hoc actions are captured, most of the timeline is recurring once the process has begun.

Table 6. Major Renewal Activities

[11]**April 2023**	
ONE System activities	2nd – using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for April renewal
Communication to members	2nd – SMS nudges begin, reminding individuals to respond to notices and requests for information 16th – renewal packets will begin mailing to members in the April renewal 16th – Ineligibility notices will begin mailing to members in the April renewal First SNAP ABAWD[12] work requirement notices begin mailing
Outreach activities	9th – first daily report of members referred to the Marketplace is generated to support navigation assistance
Other activities	2nd – Oregon Health Insurance Marketplace (OHIM) Special Enrollment period opens
May 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for May renewal
Communication to members	2nd – OHIM packets being mailing 2nd – OHIM direct outreach begins 16th – renewal packets will begin mailing to members in the May renewal 16th – Ineligibility notices will begin mailing to members in the May renewal 16th – 30-day reminders will begin mailing to members in the April renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners* to facilitate outreach *(recurring monthly)*
Other activities	11th – COVID-19 PHE expires
**Partners include CCOs, Kepro, CareOregon, Tribes, CDDPs, and SHIBA*	
June 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for June renewal
Communication to members	2nd – Federal Health Insurance Marketplace packets begin mailing 16th – renewal packets will begin mailing to members in the June renewal

[11] *All dates are current estimates and subject to change, please consult the PHE Unwinding webpage for the most up to date information https://www.oregon.gov/oha/PHE*

[12] *State agencies are required to resume Able-bodied Adults Without Dependents(ABAWD) work requirements on July 1st, 2023, in areas not eligible for a waiver.*

	16th – Ineligibility notices will begin mailing to members in the June renewal 16th – 30-day reminders will begin mailing to members in the May renewal 16th – 60-day reminders will begin mailing to members in the April renewal Second SNAP ABAWD work requirement notices begin mailing SNAP student exemption ending notices begin mailing
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
July 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for July renewal
Communication to members	16th – renewal packets will begin mailing to members in the July renewal 16th – Ineligibility notices will begin mailing to members in the July renewal 16th – 30-day reminders will begin mailing to members in the June renewal 16th – 60-day reminders will begin mailing to members in the May renewal 16th – Closure notices for non-response being mailing to members in the April renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
Other activities	State agencies must resume ABAWD work requirements in areas not eligible for a waiver
August 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for August renewal
Communication to members	16th – renewal packets will begin mailing to members in the August renewal 16th – Ineligibility notices will begin mailing to members in the August renewal 16th – 30-day reminders will begin mailing to members in the July renewal 16th – 60-day reminders will begin mailing to members in the June renewal 16th – Closure notices for non-response being mailing to members in the May renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
September 2023	

ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for September renewal
Communication to members	16th – renewal packets will begin mailing to members in the September renewal 16th – Ineligibility notices will begin mailing to members in the September renewal 16th – 30-day reminders will begin mailing to members in the August renewal 16th – 60-day reminders will begin mailing to members in the July renewal 16th – Closure notices for non-response being mailing to members in the June renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
October 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for October renewal
Communication to members	16th – renewal packets will begin mailing to members in the October renewal 16th – Ineligibility notices will begin mailing to members in the October renewal 16th – 30-day reminders will begin mailing to members in the September renewal 16th – 60-day reminders will begin mailing to members in the August renewal 16th – Closure notices for non-response being mailing to members in the July renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
November 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for November renewal
Communication to members	16th – renewal packets will begin mailing to members in the November renewal 16th – Ineligibility notices will begin mailing to members in the November renewal 16th – 30-day reminders will begin mailing to members in the October renewal 16th – 60-day reminders will begin mailing to members in the September renewal 16th – Closure notices for non-response being mailing to members in the August renewal

Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
December 2023	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for December renewal
Communication to members	16th – renewal packets will begin mailing to members in the December renewal 16th – Ineligibility notices will begin mailing to members in the December renewal 16th – 30-day reminders will begin mailing to members in the November renewal 16th – 60-day reminders will begin mailing to members in the October renewal 16th – Closure notices for non-response being mailing to members in the September renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
January 2024	
ONE System activities	1st - using the population phasing logic, the ONE System will begin identifying individuals and cases scheduled for January renewal (final PHE Unwinding group)
Communication to members	16th – renewal packets will begin mailing to members in the January renewal 16th – Ineligibility notices will begin mailing to members in the January renewal 16th – 30-day reminders will begin mailing to members in the December renewal 16th – 60-day reminders will begin mailing to members in the November renewal 16th – Closure notices for non-response being mailing to members in the October renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
February 2024	
ONE System activities	Processing responses to RFIs and new benefit applications
Communication to members	16th – 30-day reminders will begin mailing to members in the January renewal 16th – 60-day reminders will begin mailing to members in the December renewal 16th – Closure notices for non-response being mailing to members in the November renewal

Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
March 2024	
ONE System activities	Processing responses to medical renewal RFIs Continue responding to inquiries related to medical Unwinding renewals Continue processing new applications, reported changes, and all other program renewals
Communication to members	16th – 60-day reminders will begin mailing to members in the January renewal 16th – Closure notices for non-response being mailing to members in the December renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
April 2024	
ONE System activities	Processing responses to medical renewal RFIs Continue responding to inquiries related to medical Unwinding renewals Continue processing new applications, reported changes, and all other program renewals
Communication to members	16th – Closure notices for non-response being mailing to members in the January renewal
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
May 2024	
ONE System activities	Processing responses to medical renewal RFIs Continue responding to inquiries related to medical Unwinding renewals Continue processing new applications, reported changes, and all other program renewals
Communication to members	Regularly scheduled program communications
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*
June 2024	
ONE System activities	Processing responses to medical renewal RFIs Continue responding to inquiries related to medical Unwinding renewals Continue processing new applications, reported changes, and all other program renewals
Communication to members	Regularly scheduled program communications
Outreach activities	16th – non-response data for members who have not responded to a request for information is generated and provided to partners to facilitate outreach *(recurring monthly)*

Impact to workload and call center time

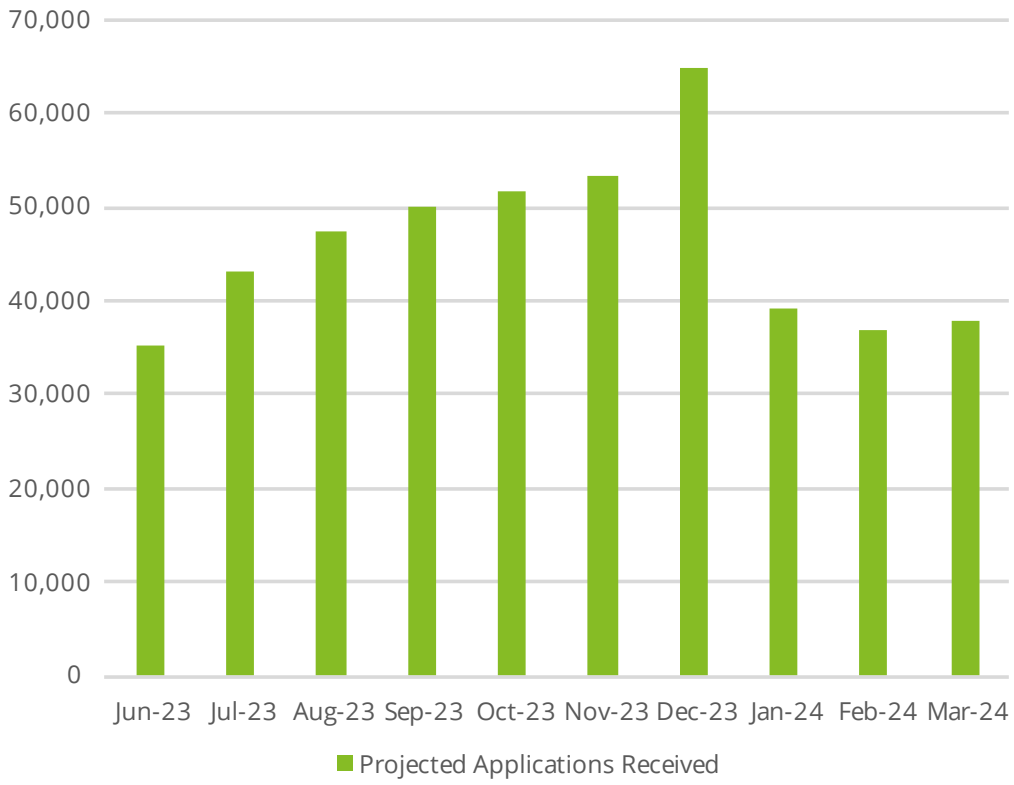
Visual 8. Projected Workload

one Oregon Eligibility Partnership

Unwinding Period Workload Projections– Applications and Renewals

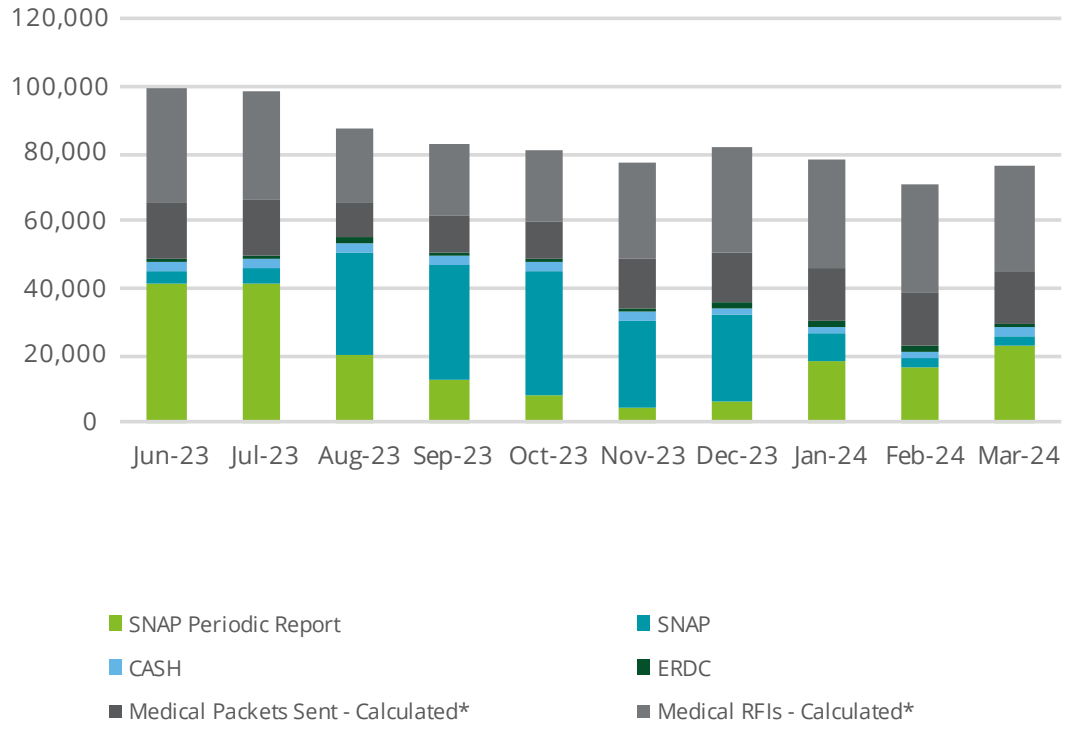
There is currently a **higher number of applications received vs processed at a monthly average**, which is contributing to ongoing backlog as volumes of applications and renewals increase. There are additional factors outside of overall application and renewal volumes, such as ABAWD requirements, that may further increase workload and backlog.

Visual 8.1. Projected Applications Received



NOTE: Average historical applications and renewals received and completed are calculated based on the average applications and renewals received and completed in the past 6 months (June 2022 – Jan 2023).

Visual 8.2. Projected Mailings



** Medical packets sent and RFIs are calculated based on assumptions for passive renewal and RFI generation rates. June 23– March 24assumes passive renewal rate of 83% and RFI generation rate of 32%.*

Phase 4 – Post-redetermination: July 1, 2024

The unwinding period per CMS requirements is expected to last 14 months in total. Once the PHE redeterminations are complete, the state anticipates the continuous eligibility provision of the 1115 Oregon Health Plan Demonstration Waiver (approved in October 2022) will be in effect, extending the renewal timeframe from 12-months (current) to 24-months for most adults, and 5-year continuous eligibility for children up to their 6th birthday. As a result, the schedule of renewals will need to be adjusted once more to spread the total volume of renewals across a 24-month period, rather than the 10-month schedule applied during the PHE Unwinding.

Update – Planning for Risks to the Redetermination Process

Incorporating recommended strategies from the Community and Partner Work Group

As described earlier, one of the most challenging factors throughout the planning has been the shifting timeline for the ending of the PHE; the emergency declaration has been renewed in 90-day increments by the Secretary of Health and Human Services since it was originally issued in January 2020, with a commitment from the federal government that states would receive a 60-day notice if the declaration would be allowed to expire, to provide enough time to ramp up operations. As a result, many proposed mitigation strategies had to be quickly deployable (in under 60 days) to be feasible. With the direction from Congress to begin redeterminations in April, this concrete date provided a clear timeline for assessing operational readiness and beginning the work that did not exist throughout most of the planning period.

In the May 2022 report, the state identified several known risks to the redeterminations work and has taken steps to mitigate the impact wherever possible. The experience brought by the members of the Community and Partner Work Group to this planning has been exceptionally valuable to this planning.

Unknown and Shifting Timeline for PHE Expiration

Initial risk: *The PHE extension timeline is unknown, creating timing, budget and communications challenges. The PHE has now been extended seven times and could well be extended again. In addition, CMS recently indicated that timelines for coverage termination could be extended for some Medicaid members by allowing longer response periods for those whose eligibility requires verification.*

Current status: In December 2022, Congress passed the Omnibus Consolidated Appropriations Act, which directed states to begin the renewal process on or before April 1, 2023. This effectively decoupled the initiation of redeterminations from the expiration date of the public health emergency, allowing the state to solidify the timeline of activities.

Historically Low Accuracy of Member Contact Information

Initial risk: *During the pandemic, OHA and ODHS have noted high rates of returned mail and incorrect contact information relating to OHP members. Inaccurate contact information could lead to members losing coverage even though they remain eligible based on income or other factors. Anticipating the monumental challenge states face in contacting all current Medicaid members, CMS has adjusted its rules to allow for more than one contact attempt within a 12-*

month period. However, the sensitive nature of **updating** *contact information necessitates time and resource-intensive processes and procedures to protect member privacy. Furthermore, people may have different addresses across the Medicaid system; for example, CCOs and providers may have different addresses than the state has for the same person.*

Current status: Several efforts have been made to address inaccurate contact information. The Courtesy Notice mailing and data sharing with FFS care coordination entities and CCOs have expanded the avenues through which the state can receive updates, system changes are now in place to enable members and recipients to more easily provide contact information, and notifications will soon be pushed out through multiple modalities to remind members and recipients that they need to respond to a request.

Confusion for Members and Service Providers

Initial risk: *Communicating the impact of the unwinding of the PHE in a clear and culturally appropriate manner is a foundational aspect of the communications strategy. There will likely be significant confusion among members, with multiple redeterminations for different assistance programs happening at once and on an uncertain timeline. OHA and ODHS have already received feedback that letters regarding OHP are confusing and overwhelming. Communicating too early with members about what they need to do could cause undue stress and lead to people providing information before the state can use it, while waiting too long could challenge the ability to get timely information from members when needed. Direct member communications that do not provide enough actionable and detailed information could increase confusion, raising the risk that people unnecessarily lose OHP coverage.*

Current status: A variety of communications strategies have been deployed to address this risk. Partner toolkits have been translated into 13 languages and offer sample languages, emails, posters, social media content, and key information to enable individuals in all areas of the health system to support members and recipients. Partner webinars offer additional opportunities for providers and community-based organizations to connect with the state to ask questions and request information and support.

Communities That are Hard-to-Reach, Due to Cultural and Linguistic Factors and Housing Insecurity

Initial risk: *Some OHP members are especially hard to reach, for a variety of reasons including cultural and linguistic factors and housing insecurity. It may require a variety of different outreach measures to contact them, including working with community organizations that best know people in their area.*

Current status: The work of the Metropolitan Group is intended to provide resources and tools to community-based organizations to support outreach to communities that are hard-to-reach and will utilize the experience and expertise of local ambassadors to expand the reach of this information. Additional details about specific products for priority populations will be available on the PHE Unwinding website.

Limited Agency Workforce Capacity to Perform High Volume of Renewals

Initial risk: *When member contact information is out-of-date, it increases the level of effort required by state workers to establish eligibility. The scale of culturally and linguistically appropriate outreach needed is unprecedented, creating substantial state workforce needs within an already strained labor market. Hiring and staffing across all government agencies is a significant challenge at this time. Existing staffing shortages exacerbate the challenges associated with increased communication and outreach.*

Current status: Hiring and staffing remains a challenge. The work to date to provide translated materials, work with focus groups and recruit community-based ambassadors to spread the word, and efforts to proactively connect with members to minimize the number of tasks required during the unwinding period are all designed to reduce the reliance on eligibility staff to complete this volume of work.

High Volume of Eligibility Tasks to Serve Current Members

Initial risk: *OHP has seen significant growth since the start of the pandemic, adding 321,000 members. There has been limited related staffing increase to serve those members' existing needs (separate from the staffing needs for the redetermination efforts). The growth in other programs in the ONE System also has been high.*

There is an expectation of major impacts on workload and timeliness as Oregon incorporates new programs into the ONE System and begins unwinding the PHE. Projections show the current total pending workload metrics (applications, renewals and changes) and operational metrics (same day/next day service, call wait times, etc.) are expected to decrease dramatically over the next few months due to the volume of upcoming workload.

There will be a further increase in reapplication as renewals dramatically scale up – as part of the PHE unwinding and SNAP changes – and processing is not done in a timely manner. This will be accompanied by an increase in questions/inquiries from people in Oregon (e.g., benefit closures, max allotment changes).

Current status: The risks associated with multiple changes in the ONE System and concurrent programmatic changes have not been fully mitigated. There will be impacts on

workload and timeliness as redeterminations begin. Efforts have been focused on proactive outreach to increase the number of passive renewals, and providing as much information as possible to support eligibility staff during this time.

Existing Call Center Wait Time is a barrier

Initial risk: *CCOs and members rely on the OHP Call Center, which historically has had 2-3 hour wait times. Members struggle to navigate a system that is struggling.*

Current status: The work of PH Tech to support the ONE Customer Service Center by triaging incoming calls, updating contact information, answering general questions, supporting the returned mail data process, and assisting in application submission have had a noticeable impact on call wait times. The tools for partners and providers, as well as improvements in the Applicant Portal, are intended to reduce the need to contact the call center for support, however, the state still anticipates that call wait times will increase as renewals begin.

Eligibility Staff who Lack Familiarity with the Work Outside of PHE Conditions

Initial risk: *As of May 2022, 32% of the current ODHS workforce that conducts eligibility renewals for OHP were hired (or technically, have continuous service dates) after May 2020. This means they have never determined medical eligibility outside the context of the PHE. They will require additional training to accurately serve people in Oregon.*

This figure does not include additional Eligibility Workers who began their State of Oregon employment in a different position and moved to ODHS Eligibility Worker in May 2020 or later. Therefore, it is likely the percentage of workers who lack this familiarity is actually much higher.

Current status: Training has been launched to provide more opportunities to familiarize staff with the processes and changes they can anticipate once redeterminations begin. There is also work underway to create forums, quick reference guides, clear escalation pathways to receive support, and other strategies to ensure staff have as much assistance as possible.

Competing Programmatic Changes to the ONE System

Initial risk: *All planning for the unwinding of the PHE will require changes to the MMIS and ONE information technology systems. In the face of other high priority programmatic system changes planned or underway, the uncertain timeline again creates significant challenges. System changes to ONE and/or MMIS are slated for:*

The launch of Healthier Oregon in July 2022 (complete);

The postpartum eligibility extension that increases the duration of enrollment from two months to twelve months postpartum;

To launch a redesigned eligibility notice; and

To redesign income verification processes.

Other assistance programs that determine eligibility through ONE also have competing priorities for system changes. The timing for system changes related to the PHE is uncertain, which significantly complicates efforts to stage these changes alongside the important changes planned over the coming six months.

Current status: Competing programmatic changes are still a risk to this work. The extended timeline for PHE expiration provided additional buffer for this planning to occur, but the implementation of initiatives such as the Basic Health Program and the 1115 Waiver are still factors that will impact the ability of the ONE System to perform efficiently.

Unique Challenges Facing Seniors

Initial risk: *Transitioning to Medicare coverage will add complexity and costs for older OHP members. Some people who have turned 65 (or otherwise gained Medicare eligibility) after March 2020 have remained covered by OHP due to the PHE. After the PHE ends, eligibility for OHP will narrow for this group. While those at lower income levels will still be eligible for Medicaid and thus become "dually-eligible" for both Medicaid and Medicare, others will lose some benefits and will need to access a patchwork of complicated programs designed to help seniors with the significant coverage gaps and out of pockets costs in Medicare. Navigational assistance will be key for this group, particularly given the relatively large numbers who will face these challenges all at once.*

Current status: Plans are in place to provide data on members who will be scheduled for renewal to SHIBA and AAA offices who serve Medicare members, along with tools to support eligibility staff working with Medicare Savings Plan members. An escalation path for identifying issues for this population will be established prior to the beginning of redeterminations.

Lack of a State-Based Health Insurance Exchange for Navigating to Marketplace Health Plans

Initial risk: *The state's ability to facilitate migration of people no longer eligible for OHP to the Marketplace is hindered by Oregon's continued use of the federally facilitated exchange. Because Oregon does not have a state-based marketplace eligibility and enrollment technology, it relies on HealthCare.gov, which presents significant limitations and forces migration to the Marketplace to be a manual process. Once a member's information is sent to*

HealthCare.gov, state agencies no longer have real-time access to the member's progress. The Marketplace will be required to wait for any data lists from HealthCare.gov to be able to assist in any communication, enrollment assistance, and outreach to help the member.

Current status: This remains a barrier. OHA has proposed a legislative concept during this legislative session that would provide the basis for a State-Based Health Insurance Exchange. This would not occur for several years, but would facilitate the streamlined enrollment and transition of members between different sources of coverage without the heavily manual workload associated with reliance on the federal health insurance exchange.

Community and Partner Work Group Recommendations to OHA and ODHS: Broader overall values to guide OHA and ODHS planning

Prioritize actions that support long-term improvements, beyond the PHE Unwinding, in the One Eligibility System and overall redetermination process to enable greater numbers of ex-parte renewals; alternative and accessible avenues of support so that individuals are supported through ways that reduce need to contact agency directly (community partners, systems enhancements, etc.); and increased accessibility (time, hours, staffing, etc.) for when individuals do need to access the ONE Call Center.

The Workgroup has created broad values based off the specific recommendations below:

- ONE System Improvements
- Communication Strategies and Priorities
- Navigating Insurance Transitions
- Community Partners
- Data and Dashboard Reporting
- Accessibility and Disability Access
- Language Access/ Language Justice
- Unhoused Populations
- Migrant and Seasonal Farmworkers

You will find these values below and specific recommendations under each value.

Table 7. CPWG Recommendations

The CPWG recommends that OHA and ODHS focus system enhancement and communication resources on **ONE System Improvements** to make notification paperwork simple and clear, to improve OHP member experience, reduce confusion and recognize the trauma of multiple and confusing message. While improvements have been made, more work is needed to ensure those receiving benefits notification paperwork understand what the paperwork is and what actions they need to take. (**8 recommendations total)**	
Not adopted	**ONE System Improvements** Add a “button” on the EBT app and phone line that allows people to certify that they still qualify for OHP and use that for auto-renewal. ***State activity: not implementing at this time, self-attestation of eligibility will end on March 31, 2023.***

Awaiting further legislative guidance	**ONE System Improvements/ Justice Involved** Add to the data available to OHA from jail/ prisons to support re-determination and resuming coverage without needing a new application. ***State activity: the state anticipates requirements pertaining to this issue will be debated during this legislative session, the state will evaluate any new legislative requirements this summer.***
Not adopted	**ONE System Improvements** Flag people who are up for redeterminations in MMIS and provide talking points for providers and staff checking eligibility to see, so they can provide additional support to their clients. ***State activity: MMIS changes could not be designed and completed in time for this recommendation to be implemented during the PHE Unwinding.***
Partially adopted	**ONE System Improvements** Streamline and simplify the redetermination processes and related communications. Seek to minimize stress and burden for consumers in this process. Gain a better understanding of how/when ONE system letters are beneficial in communicating information to enrollees of medical assistance programs. • OHA and ODHS should identify strategies to ensure that letters are being distributed efficiently to minimize the quantity and redundancy. • Re-evaluate the process of sending notifications and letters to medical assistance program recipients with the goals of reducing redundancy, unnecessary information, conflicting messages, and errors. • Understand specific areas where eligibility and renewal letters are confusing and revise letters to make the information clearer and more concise. ***State activity:***

Adopted	**ONE System Improvements** Prioritize cell phone accessibility for the ONE System to make mobile friendly. ***State activity: the ONE Mobile App is in production and expected to be available in 2023.***
Not adopted	**ONE System Improvements** Add redeterminations notifications to the EBT app, website and phone line. This will remind individuals when they check their SNAP balances that they need to also do redeterminations. ***State activity: this change would not be deployed in time for PHE Unwinding.***
Partially adopted	**ONE System Improvements** State should prioritize incorporating and analyzing additional digital sources of information used in the ex-parte eligibility verification process as additional data sources, if needed, to increase the number of people likely to be renewed through the ex-parte renewal process. Specifically, prioritize OHA adding additional sources of information that have the potential to allow or increase ex-parte redeterminations for non-MAGI individuals. Specific potential sources to prioritize may include IRS, DMV, State Asset Verification System. ***State activity: the ONE System already accesses DMV and AVS, additional data sources would require a major ONE System modification and there are significant data security barriers to incorporating additional sources that would not be feasible during the PHE Unwinding.***
Will explore further	**ONE System Improvements** State should prioritize system and policy changes to allow use of “express-lane” eligibility for Medicaid to use other applications. ***State activity: the state is interested in exploring waivers and State Plan Amendments for this recommendation, however they will not be implemented within the PHE Unwinding.***

Adopted	**ONE System Improvements** The state should work on resolving the ONE system's technical and operational issues to: a. Minimize barriers to access and reduce loss of coverage for eligible clients, and b. Streamline the process of requesting and gathering additional information from OHP members. ***State activity: Multiple technological efficiencies and customer service improvements have been added or are planned. This includes continual notice redesign, the ONE mobile app, call back options for the ONE Customer Service Center, text and email notifications, and more.***
Adopted	**ONE System Improvements** To the maximum extent possible allowable by CMS, ensure continuous enrollment while eligibility is verified. This will allow individuals struggling to navigate the renewal process or unable to reach the ONE eligibility system customer service phone line time to resolve concerns. ***State activity: if the member or recipient has responded to the notice or request for information, they will not be disenrolled while they await a determination from the state.***
The CPWG Recommends that OHA and ODHS utilize **Communication Strategies and Priorities** that engage OHP members, providers, contractors, community partners agency staff and others; engage those with lived experience to outreach to high priority populations and are clear, simplified and accessible across multiple languages and accommodation needs. In addition, the CPWG makes specific communication strategies and priorities recommendations related to language access, unhoused individuals, disability access and one system communications. **(11 recommendations total)**	
Adopted	**Communication Strategies and Priorities** Closely collaborate with community-based organizations, Coordinated Care Organizations, providers, and community partners when preparing and distributing communications and navigation resources to enrollees.

	State activity: as part of the contract with the Metropolitan Group, community-based organizations will be compensated to collaborate, co-create, and disseminate materials.
Adopted	**Communication Strategies and Priorities** Do not rely exclusively on phone calls as an outreach method. Problems with this method include low pickup rates, shared phones, frequent changes to phone numbers, use of another person's number, and suspicion of telephone-based scams ***State activity: All notices being sent to individuals through the ONE system are going through an iterative Human-Centered Design process that involves community voice and feedback. ODHS is also pursuing the ability to communicate with individuals via text and email and this should be implemented in 2023.***
Adopted	**Communication Strategies and Priorities** Ensure consistent messaging across all partners by providing advance notice of communications, talking points, and other resources needed to respond to inquiries. ***State activity: tools and resources developed for partners include talking points, examples of communications that will be received by members, and critical information to support responding to inquiries.***
Adopted	**Communication Strategies and Priorities** As appropriate, highlight key messages and information to recipients during the redetermination process, including: - Responding to notices - Making sure contact information is up to date ***State activity: Training materials are focusing on how teaching staff how to go over notices with members; community partners are frequently contacted by members with questions - this allows workers to highlight key messaging as needed***

Adopted	**Communication Strategies and Priorities** As appropriate, incorporate the following outreach and contact methods into communications plans: - Digital: phone call, email, text message - Paper-based communication: poster, flyer, letter - Community partner and direct OHA outreach - Media platforms: social media, radio, television, other methods of advertising - Other methods the meet the needs of priority populations and members who are difficult to reach ***State activities: the communications and outreach plan includes digital, paper-based, community partner, and partial media, and other methods for reaching priority populations through the work of the Metropolitan Group.***
Adopted	**Communication Strategies and Priorities** Provide proper training for agency staff and partners engaging in redetermination-related outreach and communications with MAP enrollees, community-based organizations (CBOs), Coordinated Care Organizations (CCOs), and other partners. ***State activity: eligibility staff are receiving regular training on the upcoming work, including how to engage with members and recipients and external partners.***
Will explore further	**Communication Strategies and Priorities** Ensure all written communication identifies that OHP/health care coverage does NOT impact a person's immigration status or count towards a public charge determination. ***State activity: although this information is not currently on notices, it is possible it could be added through a low-effort work item if the***

	modification does not require a change request, and will be explored for feasibility to apply prior to the start of redeterminations.
Adopted	**Communication Strategies and Priorities** Support schools and youth-serving organizations in outreach. ***State activity: outreach and communications tools will be developed for schools that work with school-based health centers and youth-serving organizations through the Metropolitan Group contract.***
Adopted	**Communication Strategies and Priorities** OHA and ODHS develop and disseminate content that CCOs and Providers can use to share notices through their own communication channels such as MyChart. ***State activity: partner and provider tools can be disseminated through whichever channels are most effective to reach members and recipients.***
Adopted	**Communication Strategies and Priorities** When appropriate, use written communication when relaying information. Written communications should be as brief as possible, use plain language, and avoid technical jargon. Explain technical jargon when it must be used. ***State activity: All notices being sent to individuals through the ONE system are going through an iterative Human-Centered Design process that involves community voice and feedback. The Marketplace has letters drafted which are as concise and simple to understand as possible. The team has taken care to ensure the correct amount of information is included to help individuals make their best educated decision on next steps as possible while not being overwhelming. Our aim is to ensure technical jargon is avoided or explained in each letter, keeping verbiage as plain language and simple as possible. The team will be doing a thorough plain language review once all feedback has been gathered from interested parties.***

The CPWG recommends that OHA and ODHS focus resources on supporting **Unhoused Populations** including outreach, policy approaches, communication strategies and collaborations with organizations serving unhoused populations. Strategies and approaches

should seek to take a person-centered and cross-organization approach to reduce barriers and support enrollment. **(10 recommendations total)**	
Not adopted	**Unhoused Populations - Communication Strategies and Priorities** Provide food and other basic needs at redeterminations outreach events for unhoused populations. ***State activity: this recommendation may be adopted by community-based organizations but was not funded by HB 4035.***
Adopted	**Unhoused Populations: Unhoused Youth – Community Strategies and Priorities** Develop intentional youth-centered approaches to ensure medical coverage for youth experiencing homelessness. ***State activity: Youth-centered approaches will be developed with community based organizations serving youth and the Youth Experiencing Homelessness Program of SSP***
Adopted	**Unhoused Populations: Unhoused Youth – Community Strategies and Priorities** Consider convening homeless youth serving agencies to solicit input on outreach and communication strategies. ***State activity: This is occurring through the work under the Metropolitan Group contract***
Adopted	**Unhoused Populations: Unhoused Youth – Community Strategies and Priorities** Enlist young people with lived experience with homelessness in creating outreach materials and strategies and compensate them for their time. ***State activity: This is occurring through the work under the Metropolitan Group contract***

Adopted	**Unhoused Populations - Communication Strategies and Priorities** Work with HUD Continuum of Care sites to conduct outreach to unhoused populations. ***State activity: OHA has bi-weekly connections with the HUD Continuum of care sites through the Statewide Oregon Unhoused Response & Recovery Network for COVID-19 and Wildfires https://www.oregon.gov/ohcs/get-involved/Pages/oregon-unhoused-response-recovery-network-covid-19-wildfires.aspx***
Adopted	**Unhoused Populations - Communication Strategies and Priorities** Work with Oregon Department of Human Services Self Sufficiency programs to conduct outreach to unhoused populations. ***State activity: Outreach will be conducted through the Youth Experiencing Homelessness Program of SSP***
Adopted	**Unhoused Populations** Develop ways for homeless serving agencies and programs to check to see if someone needs to do redetermination and connect them to resources. ***State activity: CPOP will continue to find ways in which to ensure that the houseless serving organizations are able to assist or connect members to assisters. Providing access to non contracted organizations raises some privacy concerns and may be challenging to overcome. However CPOP recognizes and values members having access to assisters at important touch points within the community and is committed to building that network and referral networks.***
Adopted	**Unhoused Populations** Explore ways to develop "no wrong door" approaches and mechanisms for homeless service providers to be able to ensure that coverage is not lost by being able to update information. ***State activity: CPOP will seek houseless serving organizations who are not currently contracted to provide assistance to join the network of assisters and provide the ongoing support to do this work.***

Adopted	**Unhoused Populations** For unhoused populations, implement a presumptive eligibility process as is done within hospital settings at other health care provider settings including but not limited to doctor's offices, clinics and other health settings. ***State activity: presumptive eligibility for any population is already available at hospital settings and the existing presumptive eligibility process is appropriate for use by community partners outside of hospital settings.***
In review	**Unhoused Populations** Prioritize 1 on 1 in-person support for unhoused. Navigators are most effective method to support unhoused individuals. Increase access to navigators – provide in-field access to navigators. ***State activity: opportunities to expand access to navigators within the scope of HB 4035 appropriations is still under development.***
The CPWG recommends that OHA and ODHS frame **Language Access** as language justice and equip staff and those serving individuals going through the redeterminations process who prefer a language other than English with the assistance and support in their preferred language including broad communication (in preferred languages) of services available. **(5 recommendations total)**	
Adopted	**Language Access/ Language Justice** To increase and improve communications, ensure that medical assistance program recipients, providers and partners have equitable access and knowledge about language services. [This is about ONE System customer service and language line access and promotion.] ***State activity: ODHS staff utilize language line services for phone communications with any individual that has requested contact in a language not spoken by the ODHS worker***
Adopted	**Language Access / Language Justice** Use language line to communicate with MAP recipients in their preferred language.

	State activity: ODHS staff utilize language line services for phone communications with any individual that has requested contact in a language not spoken by the ODHS worker
Adopted	**Language Access/ Language Justice** Provide document translations in individual's recipient's preferred language. ***State activity: the state continues to troubleshoot issues with accurate and timely translation of materials in the recipient's preferred written language.***
Will explore further	**Language Access / Language Justice** See and train eligibility staff on how to best work with interpreters. ***State activity: this is an excellent suggestion and ODHS will be exploring options for contracting with a trainer to bring this specific education to staff.***
Will explore further	**Language Access / Language Justice** State to engage in extensive outreach around language specific phone lines for accessing the VEC/ONE call center. ***State activity: the state will explore this further.***
The CPWG recommends OHA and ODHS prioritize resources to support **Navigating Insurance Transitions** as OHP members transition from one form of coverage to another and, wherever possible, utilize a no wrong door approach that reduces the burden on individuals and families to navigate in silos from one system to another with specific focus and attention on individuals' high priority populations. **(4 recommendations total)**	
Adopted	**Navigating Insurance Transitions** OHA and ODHS should develop a collaborative plan to support OHP members transitioning to Medicare or off dual eligibility, including training

	and support for SHIBA volunteers and local Aging and Disability Resource Centers. ***State activity: the state is working with APD to identify the best ways to support the transition of this population through data sharing, proactive outreach, and navigation services.***
Will explore further	**Navigating Insurance Transitions** ODHS should affirmatively look at LTSS members who have reported to any agency that they are over resource/income, and then proactively reach out to them to advise on allowable financial planning and other resources or taking other allowable and appropriate actions to avoid being terminated from Medicaid. ***State activity: the state will explore this option further prior to the beginning of redeterminations.***
Adopted	**Navigating Insurance Transitions** When sending health coverage denial letters and notices, include information about navigational assistance and similar resources that people can use to help transition to another form of coverage. ***State action: this information is included in the denial letter.***
Will explore further	**Navigating Insurance Transitions** OHA should identify and prioritize individuals who are medically complex or have multiple health needs and provide additional navigation assistance to support OHP renewals. ***State activity: the state will explore options for identifying these individuals and supporting renewal and transition.***
Migrant and Seasonal Farmworkers (1 recommendation total)	
Adopted	**Migrant and Seasonal Farmworkers** Provide support and resources tailored to the specific needs and circumstances of migrant and seasonal farm workers.

	State activity: migrant and seasonal farmworkers are an identified priority audience for the Metropolitan Group work.
The CPWG recommends that OHA and ODHS leverage, elevate, partner with and compensate accordingly **Community Partners** to reach populations throughout the state, particularly high priority populations. **(8 recommendations total)**	
TBD	**Community Partners** The state legislature, through OHA and ODHS should ensure funding continues for current Community Partner organizations who are certified OHP assisters and expand funding to new organizations to fill in the geographical and cultural gaps where assisters currently aren't reaching. ***State activity: additional funding for these resources is contingent on budget decisions by the legislature.*** ***The Marketplace will continue to partner with interested community partner organizations who are certified OHP and Marketplace assisters (currently over 1,200 trained certified assisters in both OHP and Marketplace). The Marketplace will be expanding to new organizations that focus on identified geographical and cultural gaps (see presentation and feedback request presented to CPWG on 12/15/2022). We are also expanding a specific grant program to support AI/AN individuals, which will be called the Tribal Health Grant Program for Oregon Tribal Nations who are interested.***
Adopted	**Community Partners** Community Partners should be further empowered in scope and through ONE System Changes to support all benefits redetermination. ***State activity: future changes to the ONE System will all***
TBD	**Community Partners** Increase funding for assisters when application assisters are asked to track more information, perform more services such as supporting health care navigation for individuals new to benefits, and conduct more reporting.

	State activity: the state supports this recommendation, additional funding for these resources is contingent on budget decisions by the legislature.
Adopted	**Community Partners** Increase trust and improve communication between agencies and community partners by: a. Providing consistent avenues for community partners to share technical and operational issues that impact them most, and b. Addressing issues and removing related barriers in a timely and transparent way. ***State activity: weekly and monthly forums for community partners will be available to hear from partners on technical and operational challenges and to problem solve how the state can support the removal of those barriers.***
Adopted	**Community Partners – Communication Strategies and Priorities** Use application assisters to help AI/AN and other enrollees understand what notifications/letters mean and what action(s) are required when they receive one. ***State activity: The Marketplace is standing up a grant program to specifically for Medicaid unwinding to focus support to AI/AN enrollees. Funding will be directed to any interested Oregon Tribal Nations. In addition interested AI/AN application assisters will have direct contact information to the Marketplace's Tribal Liaison.***
Adopted	**Community Partners** Use feedback from and the voice of trusted community partners to understand experiences of OHP members going through redeterminations. ***State activity: campaign advisors will be recruited from trusted community partners that serve OHP member populations for the Metropolitan Group work.***

Will explore further	**Community Partners** – **Justice Involved Populations** State should ensure application assisters in every jail in Oregon through technical assistance and Community Partners in order to integrate access to coverage into the discharge process in ways adapted to local community need. This may include prioritizing Community Partner working in county jails in each Oregon county. Understand and connect with jail and those leaving incarceration so that all individuals leaving jail settings have OHP active at release. ***State activity: the state will explore additional opportunities to support community partners who serve justice-involved populations during the PHE Unwinding.***
Partially adopted	**Community Partners - Language Access** Fund the community partners who work with people who prefer language other than English to host in person community "Renew OHP" events, and have people be able to renew right there. ***State activity:***
The CPWG recommends that OHA and ODHS focus **Data and Dashboard Reporting** on areas providing greater understanding of potential inequities among priority populations, are easily understandable and accessible to read and use and are used to inform and strengthen services. **(9 recommendations total)**	
Adopted	**Data and Dashboard Reporting – Workforce** State agencies should develop and share contingency plans and mitigation strategies, including supporting and training eligibility workers and other staff, to address service issues, discrepancies, equity issues, and other problems made visible by the online data dashboard. ***State activity: the dashboard is still being finalized but this is one of the intended uses of the reported information.***
Adopted	**Data and Dashboard Reporting**

	Collect and publicly report data, such as percent of member appeals compared by equity and language access markers, and use this to inform improvements to the redeterminations process. ***State activity: information about member appeals is a required component of CMS reporting.***
Adopted	**Data and Dashboard Reporting** The public-facing dashboard should include hover-over definitions to explain what each term means in plane language and in an applicable way. ***State activity: this will be a component of the dashboard.***
Adopted	**Data and Dashboard Reporting** The public-facing dashboard should track number and percentage of people **who responded after they received a notice that their benefit was terminated** with ability to view data by geography, demographics, and preferred/primary language and READLD. ***State activity: this will be a component of the dashboard.***
Adopted	**Data and Dashboard Reporting** The public-facing dashboard should track number and percentage of people **who do not renew because they did not respond to information that was requested** from the state with ability to slice by geography, demographics, and preferred/primary language and/or READLD-D. ***State activity: this will be a component of the dashboard.***
Adopted	**Data and Dashboard Reporting** The public-facing dashboard should track what type of insurance coverage OHP members have at the end of the redeterminations process (e.g., track those remaining on OHP, those moving to the Marketplace, those in the temporary extended benefits program, those who are uninsured, those are dually enrolled in Medicare and Medicaid, those who are otherwise double-covered, etc.). ***State activity: this will be a component of the dashboard.***

Not adopted	**Data and Dashboard Reporting – Non-Modified Adjusted Gross Income (MAGI) Populations** The public-facing dashboard should track renewals for MAGI separately from non-MAGI. ***State activity: while this information will be reported to CMS, the public-facing dashboard will not report by eligibility category.***
Not adopted	**Data and Dashboard Reporting** On online dashboard, include live, real-time wait times to the ONE call center so that individuals calling in know the estimated wait time before calling. Include live wait times when people call in, so they have a real-time estimate. ***State activity: real-time data on call center wait time is not currently available through the dashboard.***
Partially adopted	**Data and Dashboard Reporting** The dashboard should include additional information, such as: a. Wait times, wait times by language, dropped calls, and dropped calls by language. b. Phone access, including calls that come in, how many calls answered, how many dropped, etc.
The CPWG recommends that OHA and ODHS prioritize overall **Accessibility and Disability Access** so that high-priority populations in need of accommodations and support receive those in a proactive and person-centered way. **(6 recommendations total)**	
Adopted	**Accessibility and Disability Access** Extend deadlines up to 90 days for medical assistance program (MAP) enrollees and increase the promotion and use of accessible application assisters to give people individuals accessing OHP through non-MAGI services the time and additional support needed to correctly apply for coverage and respond to requests for information.

Adopted	**Accessibility and Disability Access** Identify and implement strategies to provide additional time and resources to people who face additional barriers when trying to understand notices and what is required of them to verify eligibility, such as people disabilities, elderly persons, and people with limited English proficiency. ***State activity: The Marketplace has an extensive support network of trained applications assisters and insurance agents/brokers, that speak many languages, live in rural communities, and support communities that may have been harmed by health inequities. The Marketplace has a close partnership with the Senior Health Insurance Benefits Assistance (SHIBA) program along with assisters and insurance agents/brokers who support persons eligible for Medicare. The Marketplace Transition Team is also standing up a call center to support individuals with questions on how to transition from Medicaid to the Marketplace. This call center will have customer service representatives that speak multiple languages, will have access to translation services, and will be trained on how to help individuals who have questions about transitioning from Medicaid to the Marketplace. Individuals have 60 days prior to the end of the special enrollment period (SEP) due to no longer being eligible for Medicaid. In addition, CMS has opened an extended "unwinding" SEP from March 31, 2023-July 31, 2024 for people who have lost Medicaid during the unwinding process to enroll through the Marketplace. The Marketplace team will focus outreach to help people avoid a gap in health coverage by enrolling before their Medicaid benefits end.***
Partially adopted	**Accessibility and Disability Access – Community Partners** State should staff eligibility workers using a model that increases overall staffing ratios and ensures higher ratios for populations whose redeterminations will require additional support, such as non-MAGI renewals. State should look at Community Partners within this to leverage redeterminations that only eligibility workers can do vs. those that Community Partners can do. ***State activity: hiring eligibility workers is based on legislative budget decisions, however the state is exploring this recommendation further.***
Adopted	**Accessibility and Disability Access**

	Require caseworkers to reach out to provide personal attention and support to help individuals receiving Non-MAGI OHP if they have not responded in the first 30 or 60 days. ***State activity: ODHS (APD and ODDS) have plans in place for regular reporting of individuals receiving LTSS benefits, and therefore have a case manager, to local offices for specific outreach to those individuals who may have not yet engaged in the renewal process. Additionally, APD is creating a plan to focus monthly client contacts on ensuring that those receiving long-term services and supports have all the information needed to be able to successfully engage in the renewal process.***
Adopted	**Accessibility and Disability Access** Use video communication, when/if possible, and offer American Sign Language interpretation for meetings with application assisters, community-based organizations, community partners, and other partners. ***State activity: Video communication is planned through the work under the Metropolitan Group contract and with OHA Health Equity Strategy and Content Team within Communications***

Expiration of the Public Health Emergency

OHA flexibilities that will continue after the PHE ends

Table 8. Continuous flexibilities post-PHE, OHA

Description	Authority
Telehealth reimbursements equal to reimbursement for face-to-face visits:	State Plan Amendment (SPA) 20-0006 (approved 4/10/20) SPA 22-00013 (approved 8/12/2022)
Coverage of COVID-19 testing, in-home or lab processed	SPA 20-0010 (approved 6/18/2020) SPA 22-0011 (approved 7/22/2022) The American Rescue Plan requires this coverage to continue for one year past the end of the PHE.
Provider reimbursement for language interpreter services (spoken or signed) provided during a health care visit	SPA 20-0017 (approved 11/17/20) SPA 22-0009 (approved 5/25/2022)
Coverage of monoclonal antibody treatment or any COVID-19 drug treatments under FDA Emergency Use Authorization	SPA 21-0014 (approved 10/1/2021)
HIPAA-compliant remote methods in lieu of face-to-face visits permitted for Home and Community-Based Services (HCBS) 1915(i) services: ■ Needs-based eligibility criteria evaluations and re-evaluations ■ Person-centered service plan development and completion ■ Home-Based Habilitation, HCBS Behavioral Habilitation, and Psychosocial Rehabilitation Services	SPA 20-0011 (approved 4/24/2020) SPA 21-0013 (approved 12/23/2021)
Ambulance “treat in place” or “aid call” reimbursement equal to the rate for advanced life support (to ease the burden on hospital emergency rooms when transport is not necessary, but treatment is provided)	SPA 20-0014 (approved 7/30/2020)

ODHS flexibilities that will continue after the PHE ends

Table 9. Continuous flexibilities post-PHE, ODHS

Description	Authority
HCBS 1915(k) Plan flexibilities:	1135 waiver (approved 5/8/2020)

Description	Authority
■ Allow use of an alternate method to obtain beneficiary and provider signatures when written signature is not possible ■ Allow two Medicaid home-delivered meals per day instead of one.	SPA 21-0020 (approved 2/7/2022)
Nursing facility ventilator program rate increase	SPA 20-0007 (approved 4/10/2020) SPA 21-0019 (approved 2/2/2022)
HCBS 1915(j) flexibilities: ■ Waive the three consecutive months of tenancy as a condition of eligibility. ■ Use the risk assessment and monitoring instrument by telehealth if the participant agrees to participate in this manner. ■ In-person evaluation is not considered necessary in order to properly assess or monitor.	SPA 20-0009 (approved 6/3/2020)

What's expiring

A full list of expiring authorities will be available on the PHE Unwinding website by March 31, 2023.

Appendix

Projected volume of medical renewals per month (approximate)

To inform potential workload associated with medical renewals, the State has conducted several “dry runs” using the recommended sequencing logic. The most recent dry run (dry run #3) was completed in late February 2023. The table below outlines the projected volumes of medical renewals.

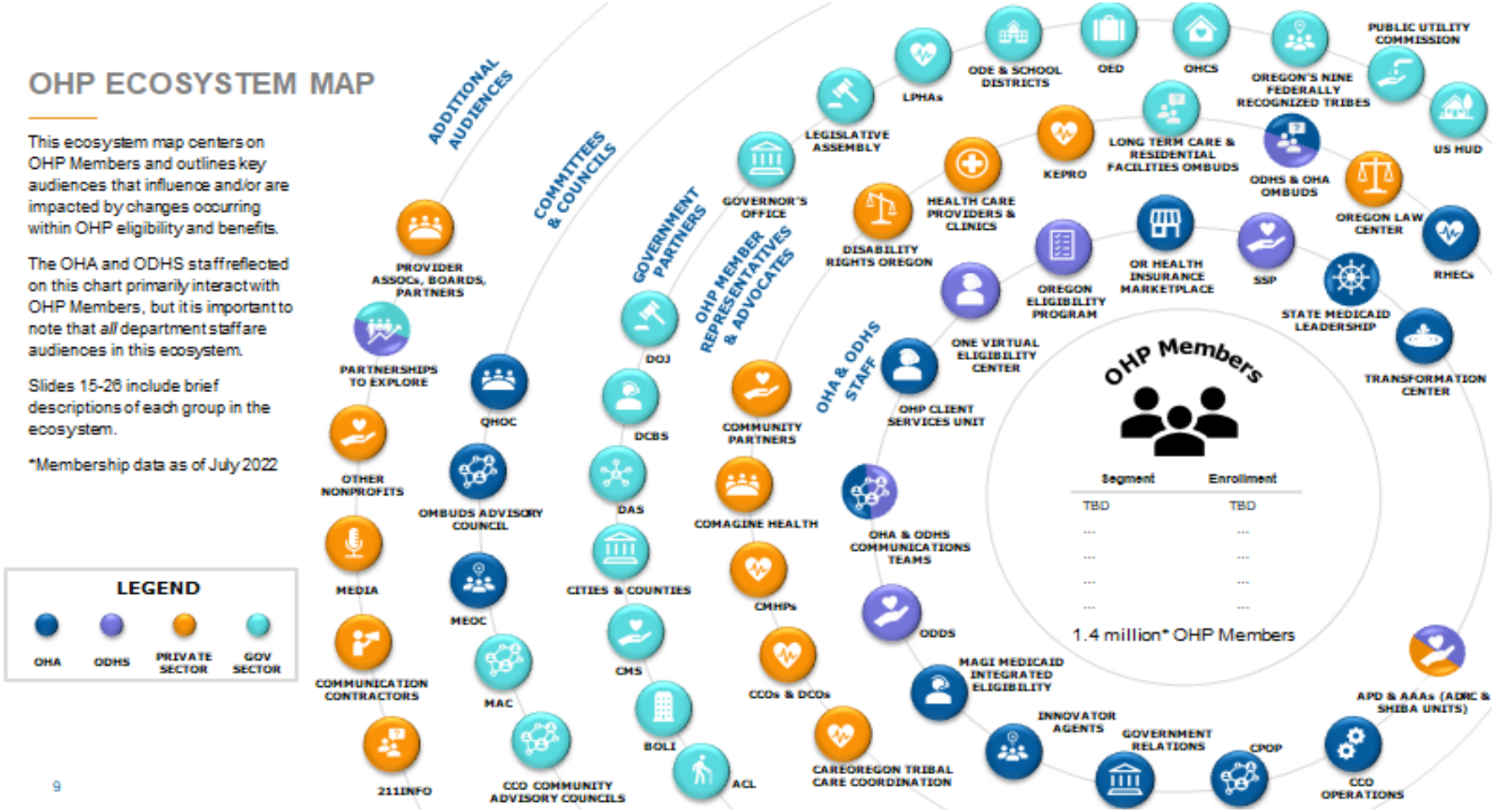
Table 1. Projected Dry Run Volume

Renewal Initiation Month	**Renewal Due Date Month***	**Anticipated Renewal Workload**
April 2023	June 2023	Approx. 105,000
May 2023	July 2023	Approx. 101,000
June 2023	August 2023	Approx. 67,000
July 2023	September 2023	Approx. 65,000
August 2023	October 2023	Approx. 66,000
September 2023	November 2023	Approx. 90,000
October 2023	December 2023	Approx. 97,000
November 2023	January 2024	Approx. 101,000
December 2023	February 2024	Approx. 100,000
January 2023	March 2024	Approx. 98,000

- = Recipients have until the end of the following month after the Renewal Due Date to return their renewal packet.

Audience Ecosystem Map

Visual 1. OHP Ecosystem Map



SNAP Emergency Allotment Change Journey

Visual 2. SNAP EA Change Guide

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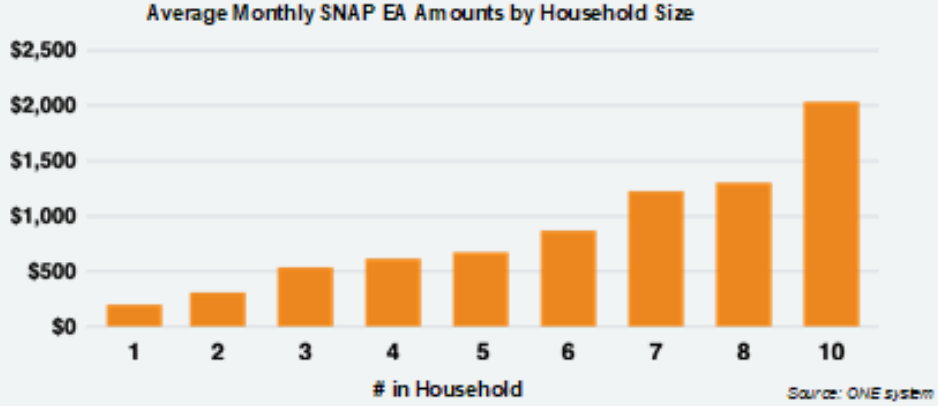
Overview: Emergency Allotments (EA) for SNAP Recipients

Emergency Allotments (EA) were a temporary strategy and additional support authorized by Congress to help people experiencing low or no income and receiving SNAP benefits deal with the hardships of the COVID-19 pandemic.

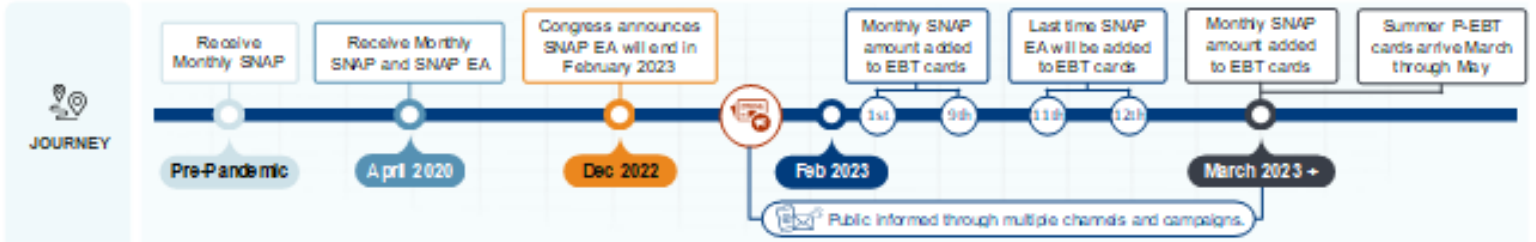
As a result, people receiving SNAP also received emergency food benefits on their EBT card each month. These emergency food benefits have provided people in Oregon with $1.9 billion in additional money for food since April 2020.

The Consolidated Appropriations Act (2023) law recently passed by Congress ends SNAP EA after the February 2023 issuance. **This means by March 2023, all SNAP households will return to only receiving their SNAP benefit at the beginning of the month, with no additional food benefit added mid-month.**

This chart shows the average monthly SNAP EA amount by the number of people in a household to provide a point of reference and is not exact.



Journey Map: Emergency Allotments (EA) for SNAP Recipients



STAGES

Pre-Pandemic

Before April 2020, individuals and families received monthly SNAP benefits based on their income and other factors, like the number of people in their households.

Emergency Food Benefits Begin

To help during the COVID-19 pandemic, the federal government allows states to provide extra food benefits to eligible SNAP households. These extra benefits are formally known as EAs.

Congress Sets End Date For SNAP EA

Congress passes the 2023 Consolidated Appropriations Act in December 2022, which ends SNAP EA in February 2023.

Emergency Food Benefits End

In February 2023, individuals and families receive:

- Notice via mail that temporary SNAP EA benefits will end and how to prepare.
- Monthly SNAP benefits between the 1st and 9th day of the month.
- Final SNAP EA benefits around the 11th or 12th day of the month.

Regular SNAP Continues

- Individuals and families continue to receive SNAP benefits on their EBT (Oregon Trail) card and are notified 45 days before benefits will end (15 days prior to final month) that it is time to re-apply.
- Eligible families begin receiving cards with a one-time sum of retroactive 2022 Summer Pandemic EBT benefits ($391 per child).

ACTIONS

To prepare for the end of emergency food benefits, people can:

- Check their regular SNAP benefit amount so they can budget.
- Report changes in income or # of people in household which may increase their regular SNAP food benefits.
- Know what food supports are in their area and contact state and local partners.

Visit page 5 for details

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Sample Scenarios and Common Challenges

Scenario 1: Individual

An individual applies for SNAP during the pandemic and begins receiving $233 every month in combined SNAP and SNAP EA benefits. Under normal circumstances, this person would only receive $23 in regular SNAP benefits. When emergency allotments end, this person will experience a sharp decrease in their monthly benefits and may not understand why.

Anticipating needs

Unless this individual's address is up-to-date and they receive advance notice directly through the mail or indirectly through social or other media, they will likely be surprised and confused by the decrease in their monthly food benefits and will contact the state for help.

Scenario 2: Family of three

A family of three receives a monthly SNAP benefit of $500 per month. Due to the COVID-19 emergency, this family begins receiving an additional $530 in SNAP EA for a monthly total of $1,030 to put toward food, freeing up money for other necessities, like rent and utilities. When emergency allotments end, this family's monthly food budget will be reduced by $530.

Anticipating needs

This family may need help accessing other ways to pay for their housing and energy costs so they can shift their budget to accommodate a steep drop in monthly food benefits. They may benefit from state and federal programs that provide rental, housing, and utility bill assistance.

CHALLENGES

Confusion over drop in food benefits
People may not know SNAP EAs are extra food benefits, especially if they began receiving SNAP during the COVID-19 pandemic when these temporary emergency supports were already in place.

Little or no time to adjust to decrease in food benefits
People may not have enough time to understand what's happening and ask questions. Others may not receive direct notice in the mail if their mailing address is out of date.

Hard to find benefit amounts
People will not be told how much of the extra benefits they will lose but can use ebtEDGE.com or the ONE system to find their monthly SNAP amount. This can be challenging for people who lack access to or struggle with technology.

Difficulty accessing critical food supports
People living in food deserts or who need help finding and accessing food banks and similar resources may struggle to fill the gaps in their food benefits once SNAP EAs end.

High cost of living and related factors
Rising prices for food, goods, and services only worsen the challenges people will face when they lose their SNAP EAs.

https://www.oregon.gov/oha/PHE/Documents/SNAP-EA-Persona-Journey.pdf

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How SNAP Households Can Prepare

1 Check monthly SNAP benefit amounts at ebtEDGE.com or by logging into your ONE account at one.oregon.gov.

2 Report any changes in income or # of people in household:

- Online: one.oregon.gov
- Call the ONE Customer Service Center at 1-800-699-9075 (ODHS accepts all relay calls), Monday through Friday, from 7 a.m. to 6 p.m. Pacific Time.
- Visit a local office:
  - Find a local Aging and People with Disabilities Office at https://www.oregon.gov/dhs/Offices/Pages/Seniors-Disabilities.aspx
  - Find a Self-Sufficiency Office at www.oregon.gov/DHS/offices/pages/self-sufficiency.aspx
- Mail: ONE Customer Service Center, PO Box 14015, Salem, OR 97309
- Fax: 503-378-5628

3 Access local food resources and support:

- Find food resources in the community: needfood.oregon.gov
- Find a local food bank or pantry: foodfinder.oregonfoodbank.org
- Learn about government programs and community resources for older adults and people with disabilities:
  - Aging and Disability Resource Connection of Oregon at 1-855-673-2372 or www.adrcoforegon.org.
- Dial 2-1-1, or text your zip code to 898-211, www.211info.org
- Connect with a local Community Action Agency: www.caporegon.org

OregOneligibility

Redeterminations Resequencing Recommendations – ONE System logic details

Table 2. Main Population Groups

Group	Description	Sequence
Parent Caretaker	Cases with at least one individual receiving program benefits which indicate they are a parent or caretaker relative of a child in their home	Front loaded
Child Medicaid	Cases with at least one individual receiving Medicaid under the age of 19	Front loaded except any cases with people aging out (age 19) during the PHE (back loaded)
SSI Recipients	Cases with at least one individual receiving Supplemental Security Income benefits	Front loaded
Pregnancy and Newborn	Cases with at least one individual receiving program benefits indicating that they are pregnant or within the postpartum eligibility period, or indicating that they're a child under the age of 1 year	Back loaded
Services - 1	Cases with at least one individual receiving OHP Plus and Long-Term Care Services whose income is over the regular OHP limits – they're eligible at a higher income threshold because of their Long-Term Care Service needs.	Spread throughout
Services - 2	Cases with at least one individual who is eligible for OHP Plus and is also receiving Long Term Care Services.	Spread throughout
MSP Only	Cases with at least one individual not receiving OHP coverage, but receiving assistance paying for their Medicare premiums	Spread throughout
Others	Any case with no individuals captured by the groups listed above	Spread throughout

After cases are assessed to see if they fit in any of the groups above, they go through an additional set of "filters" to see if any of the following apply:

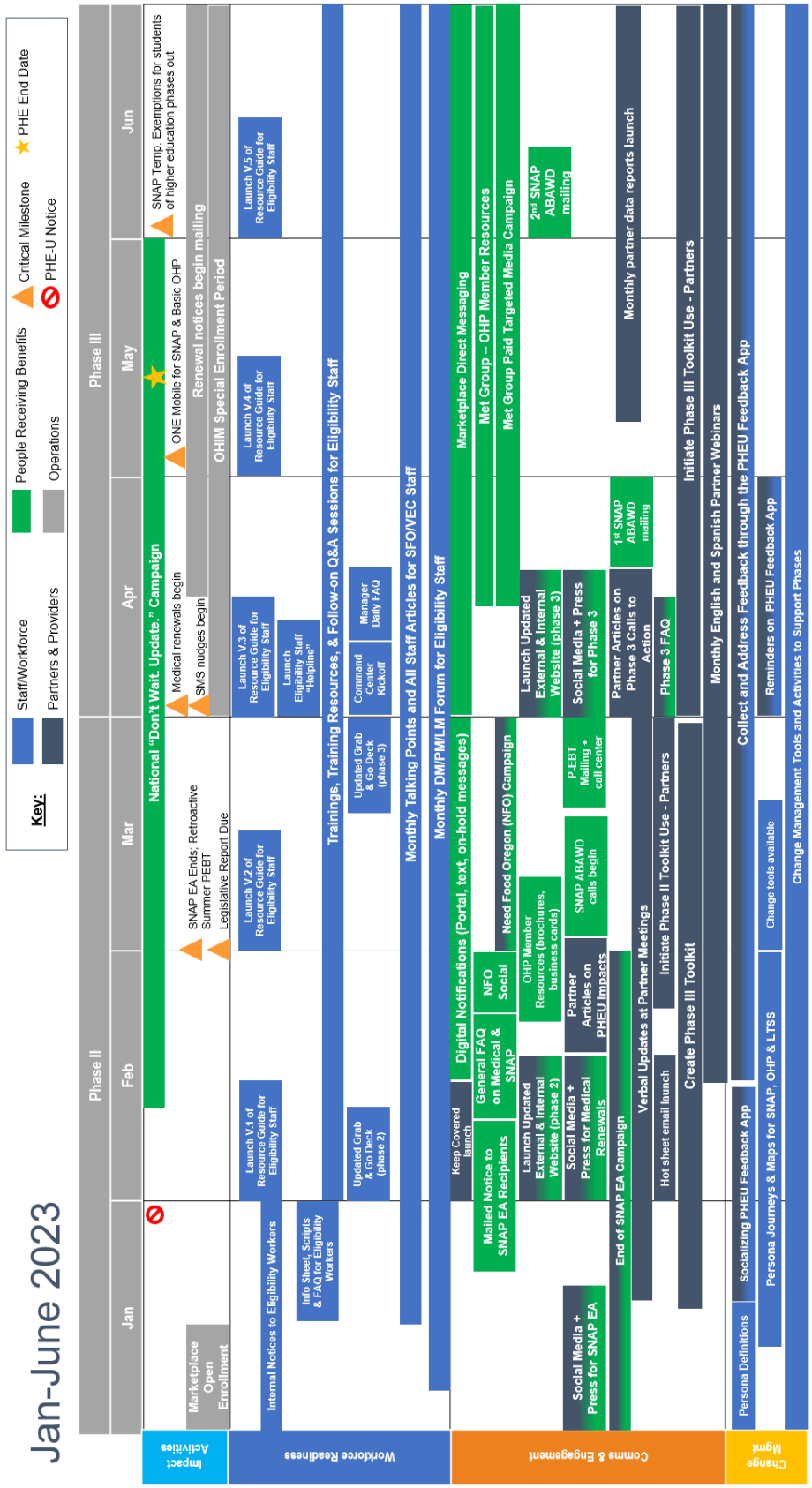
Table 3. Population Subgroups

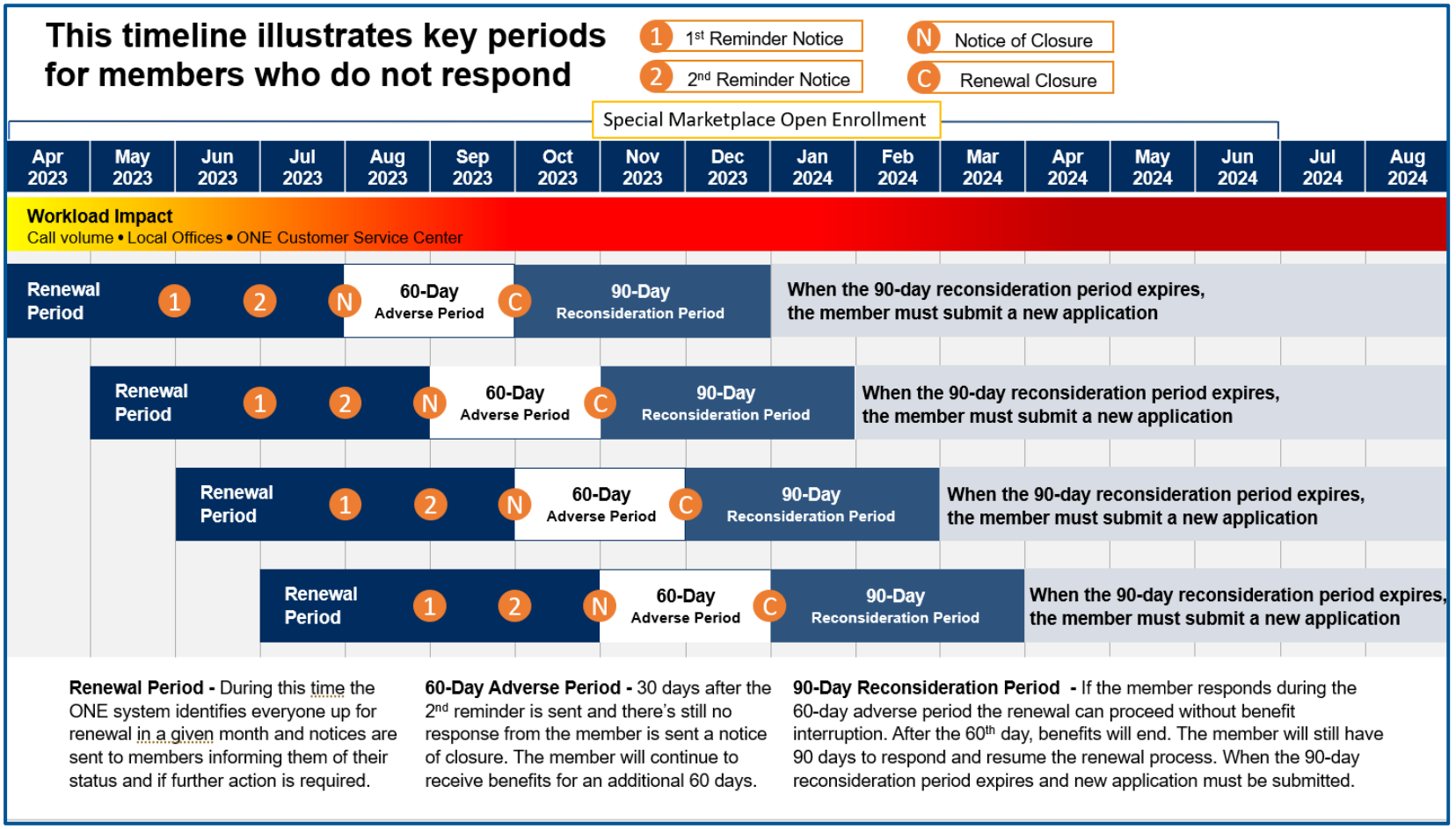
Sub-Group	Description	Sequence
COVID exemptions	Cases with at least one individual who is identified as receiving a financial or non-financial COVID exemption, indicating that they've maintained eligibility solely due to PHE protections.	Guiding principle: Workgroup supports an approach for redeterminations to be conducted in a manner that best preserves insurance coverage for as many people as possible for as long as possible while following best practices for transitioning to Marketplace or other health plans and considering capacity of application assisters
Bridge Plan	Cases with at least one individual likely to be eligible for the Bridge Plan; they meet all non-financial eligibility criteria, with income below 200% FPL	Back loaded
Presumptive Disability Population	Cases with at least one individual who is receiving presumptive disability benefits and have not provided verification of disability, but have remained open due to the PHE	Spread throughout
AI/AN Population	Cases with at least one individual who is identified as American Indian/Alaska Native.	*Back loaded Exception: Front load cases that can be quickly/easily redetermined as eligible for OHP to allow for more focused on cases that may need additional outreach and support.
Houseless Population	Cases with a case address, or at least one individual address, which is identified as 'No Permanent address'	Spread throughout with no redeterminations in January
SNAP	Cases with at least one individual who is receiving both medical and SNAP benefits	Spread throughout
Non-English Language	Cases with at least one individual who indicates that their primary language is something other than English	Spread throughout

Sub-Group	Description	Sequence
Others	Any case with no individuals captured by the groups listed above	Spread throughout

**Sequencing decision made through Tribal Consultation.*

Visual 3. Phase II and early-Phase III Communications Activities with Key Audiences





Visual 4. OHP Renewals Operational Timeline