



KATE BROWN
Governor

November 7, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

The State of Oregon submits to the Centers for Medicare and Medicaid Services the enclosed Section 1115 Demonstration Waiver amendment application for Oregon's current 1115 Substance Use Disorder Demonstration (11-W00362/10). This amendment would ensure individuals with incomes between 138 and 200 percent of the federal poverty level (FPL) that are currently enrolled in Medicaid (also known as the Oregon Health Plan, or OHP) under the Families First Coronavirus Response Act (FFCRA) are able to maintain coverage following the expiration of the federal Public Health Emergency (PHE) until the establishment of a Basic Health Program (BHP).

Oregon is committed to ensuring access to affordable, comprehensive coverage for all individuals throughout the state. In 2021, the people of Oregon experienced the highest rate of insurance coverage in our state's history, reaching 95.4 percent, due to continuous OHP coverage during the COVID-19 pandemic. The largest coverage gains were among low-income adults with incomes between 138 and 200 percent of the FPL, who went from 82 percent coverage in 2019 to 92 percent coverage in 2021, following implementation of the FFCRA. Historically, people in this income category face the highest rates of uninsurance, the highest rates of "delayed care due to cost," and the least access to affordable, employer-sponsored coverage compared to individuals in higher income groups. This population is also susceptible to "churn", or gaps in coverage due to short-term income changes, changing family circumstances, or challenges in navigating the state's redeterminations process. Ensuring continued, equitable, and accessible coverage for people just above Medicaid eligibility following the expiration of the PHE is essential to reducing these coverage gaps and improving health outcomes for this population. To that end, Oregon House Bill 4035 (2022) directed the state to create a glidepath for people in this income category to transition from FFCRA coverage to a new, permanent coverage solution.

This demonstration is intended to provide temporary OHP coverage for people between 138 and 200 percent FPL while the state establishes a new, permanent BHP for this population. An estimated 55,000 individuals who potentially would have lost OHP coverage due to being over-income during the 14-month post-PHE redetermination process will remain covered as a result of this demonstration. This will offer Oregon time to operationalize a BHP that will be administered by our Medicaid Managed Care entities, Coordinated Care Organizations (CCOs), and is envisioned to cover services similar to the OHP service package with low to no enrollee costs. Following the implementation of a BHP, almost everyone covered by this waiver will transition to the CCO-administered BHP.

Under federal law, Oregon is prohibited from auto-enrolling American Indian/Alaska Native (AI/AN) OHP members in CCOs. Accordingly, 40 percent of AI/AN adult OHP members receive their coverage fee-for-service. Because Section 1331 does not allow for fee-for-service BHP coverage, the only OHP population 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 therefore proposes that AI/AN individuals between 138 and 200 percent FPL be exempt from the CCO-administered BHP, and instead receive OHP coverage through this demonstration. This will ensure that everyone in Oregon, including AI/AN members enrolled in fee-for-service OHP, has continuous coverage up to 200 percent FPL.

This SUD 1115 Demonstration Amendment provides Oregon with a valuable opportunity to prevent coverage loss after the PHE among those most at risk for uninsurance, and to take one step closer to eliminating health inequity in our state by 2030. We look forward to continuing to work with the Centers for Medicare and Medicaid Services and the federal waiver review team on this amendment as we collectively expand access to comprehensive, affordable health coverage across Oregon.

Thank you for your time and consideration,

Sincerely,



Governor Kate Brown

KB:rd

**Proposed Amendment to
Oregon’s Substance Use Disorder (SUD) 1115 Demonstration
Waiver Number 11-W00362/10**

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted. If additional space is needed, please supplement your answer with a Word attachment);

Oregon is seeking an amendment to the state’s Substance Use Disorder (SUD) 1115 demonstration (waiver number 11-W00362/10) that seeks to expand Oregon Health Plan (OHP) eligibility to include certain individuals with incomes between 138 – 200% FPL.

- 2) Include the rationale for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

Under the 2020 Families First Coronavirus Response Act (FFCRA), individuals enrolled in state Medicaid programs were provided continuous Medicaid coverage for the duration of the federal public health emergency (PHE). Following the expiration of the PHE, states will be required to begin redetermining eligibility for all enrolled Medicaid members within 12 months. Under current eligibility rules in Oregon, most adults with incomes above 138% of the federal poverty level (FPL) will be determined ineligible for Medicaid coverage (also known as the Oregon Health Plan, or OHP). Many of these individuals would be eligible for highly subsidized coverage through the Marketplace, but the transfer between Medicaid and the Marketplace is not seamless and can result in people losing coverage. Further, some of those individuals may have their income exceed Medicaid eligibility levels for short periods of time, resulting in needlessly disruptive shifts between Medicaid coverage, either on Oregon’s Fee-For-Service program or through Coordinated Care Organizations (CCOs), and qualified health plans in the Marketplace.

Continuous OHP coverage during the COVID-19 pandemic increased Oregon’s health insurance coverage rate from 94% in 2019 to 95.4% in 2021, with significant coverage gains particularly among Black/African American individuals (insurance rates increased from 91.8% in 2019 to 95% in 2021). The largest coverage gains were among low-income adults, particularly those in the 138 – 200% FPL range.¹

Prior to the federal public health emergency (PHE), compared to other Oregonians, individuals in the 138 – 200% FPL range faced the highest rates of uninsurance, the highest rates of “delayed care due to cost” and experienced the least access to affordable, employer-sponsored

¹ “Direction and Vision for the Bridge Program,” Presentation to the Bridge Program Task Force. May 10, 2022. Presented by J. Vandehey. Available here: <https://olis.oregonlegislature.gov/liz/202111/Downloads/CommitteeMeetingDocument/255346>.

coverage compared to individuals in higher income groups. This was also the population that was most likely to experience coverage gaps throughout the year (also known as “churn”), due to short-term income changes, changing family circumstances, or challenges with navigating the state’s redetermination process. Continuous OHP coverage during the COVID-19 pandemic was found to have significantly decreased the state’s rate of “churn”. In September 2019, 34% of “new” Medicaid enrollees that month were individuals that had previously been enrolled in Medicaid less than a year ago. In 2021, with continuous enrollment policies in place due to the ongoing PHE, only 8% of new Medicaid enrollees were individuals that previously been enrolled in Medicaid but lost coverage within the last year.²

This demonstration would enable individuals with incomes between 138 – 200% FPL that are currently enrolled in OHP under FFCRA to retain OHP coverage following the expiration of the federal PHE, ensuring their continued access to affordable and comprehensive coverage through their existing plan and its network of providers. Oregon estimates nearly 60,000 individuals currently enrolled in OHP have incomes between 138 – 200% FPL and would be at risk of becoming uninsured following the expiration of the federal PHE, especially without any additional coverage support in place at the time of OHP redeterminations.

To address these issues, the State is currently exploring implementing a Basic Health Program (BHP) under Section 1331 of the Affordable Care Act (ACA) for this population.³ The State is currently planning that the BHP would be offered through the same Coordinated Care Organizations (CCOs)—Oregon’s Medicaid managed care plans—that serve the Medicaid population. The demonstration is intended to maintain eligibility for individuals enrolled in OHP who would otherwise be found ineligible with incomes up to 200% FPL so that they remain covered in their current delivery system until the State can implement the BHP.

Upon implementation of the BHP, the eligibility group established under this Demonstration would be reduced to cover only American Indians/Alaska Natives (AI/AN) with incomes from 138-200% FPL. All other enrollees would be transitioned to the BHP, with appropriate noticing. AI/AN populations would remain eligible through Medicaid so that the State could continue to give these enrollees the option of receiving fee-for-service coverage, as they have today, rather than requiring that they receive coverage through a CCO, as would be necessary in the BHP.

- 3) Describe the hypotheses that will be tested/evaluated during the Demonstration’s approval period and the plan by which the State will use to test them (if additional space is needed, please supplement your answer with a Word attachment);

Oregon hypothesizes that expanding OHP eligibility to income individuals with incomes between 138 – 200% FPL will improve insurance coverage rates, reduce “churn,” reduce rates of delayed care due to cost, and improve access to health care for this group of low-income Oregonians. Oregon will continue to track rates of coverage, Medicaid churn, rates of delayed

² “New health insurance survey data show record-high health coverage for people in Oregon,” Oregon Health Authority News Release. February 8, 2022. Available here: <https://content.govdelivery.com/accounts/ORDHS/bulletins/309bb7f>

³ See House Bill 4035 (2022 Regular Session) for more information on the State’s plans to ensure continuity of coverage after the end of the PHE . Available here: <https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureDocument/HB4035/Enrolled>. The State is also exploring alternative pathways to achieve similar ends, such as creating a BHP-like product using a waiver under Section 1332 of the ACA.

care due to cost, and health access measures to evaluate these impacts as a result of expanding Medicaid eligibility.

- 4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate (if additional space is needed, please supplement your answer with a Word attachment);

This demonstration will operate statewide, just as the current OHP does.

- 5) Include the proposed timeframe for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

This amendment will take effect upon approval, with coverage in the new eligibility category taking effect on the 1st day of the month following the end of the PHE (which is when the FFCRA continuous coverage requirement no longer applies). For all individuals enrolled under this demonstration other than AI/AN enrollees, this demonstration will end when the State implements its BHP. For enrollees who are AI/AN, this demonstration would remain in place for the length of the underlying 1115 approval.

- 6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems (if additional space is needed, please supplement your answer with a Word attachment).

This demonstration will not affect or modify any other components of the State's current Medicaid and CHIP programs outside of eligibility.

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

Eligibility Chart
Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
N/A		

Optional State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Individuals with incomes between 138 - 200% FPL and under age 65 who were previously enrolled in the Oregon Health Plan and were determined no longer eligible for the Oregon Health Plan on the basis of income	1902(a)(10)(A)(ii)(XX), 42 CFR 435.218	138-200% of FPL
Individuals with incomes between 138 - 200% FPL and under age 65 who are AI/AN (<i>group begins after launch of full BHP; prior to launch of full BHP, coverage would be provided via eligibility group above</i>)	1902(a)(10)(A)(ii)(XX), 42 CFR 435.218	138-200% of FPL

Expansion Populations

Eligibility Group Name	N/A	Income Level
N/A		

- 2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment);

The State's standards and methodologies for determining Medicaid eligibility will still apply, but eligible income levels would now include 138 - 200% FPL. Additionally, the State would evaluate whether the individual was currently enrolled in OHP at the time of redetermination.⁴ Only those currently enrolled in OHP would be eligible to continue coverage under this Demonstration; new applicants would continue to receive coverage through the Marketplace until the BHP launches. Once the full BHP launches, all AI/AN with incomes from 138-200% FPL would be eligible for coverage under the Demonstration, regardless of whether they were previously enrolled in OHP.

- 3) Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a

⁴ This includes individuals whose income is 138-200% at the initial redetermination after the end of the PHE or individuals whose incomes later exceed 138% FPL.

Word attachment);

N/A The populations are not “expansion populations.” In any event, there are no enrollment caps.

- 4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs (if additional space is needed, please supplement your answer with a Word attachment);

The projected number of individuals who would be eligible for the Demonstration is roughly 55,000 people. These are individuals currently enrolled in OHP. Following implementation of the BHP, this number would be reduced to cover only AI/AN individuals in order to maintain the option of receiving fee-for-service coverage that they have today, rather than require that they receive coverage through a CCO. This population is approximately 2,000 enrollees based on the AI/AN share of statewide enrollment in the ACA-expansion eligibility category.

- 5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment);

The State would continue to apply the same post-eligibility treatment rules as in the current program.

- 6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment); and

In addition to determining that an individual has a qualifying income of 138 – 200% FPL, the State would also be required to determine that those income-qualifying individuals were previously enrolled in OHP coverage at the time of redetermination.

- 7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if

additional space is needed, please supplement your answer with a Word attachment).

Not applicable.

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:
 Yes No (if no, please skip questions 3 – 7)

- 2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:
 Yes No (if no, please skip questions 8 - 11)

- 3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package

- 4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:
 - Federal Employees Health Benefit Package
 - State Employee Coverage
 - Commercial Health Maintenance Organization
 - Secretary Approved

**Please note that, in accordance with section 1937(a)(2)(B) of the Act, the following populations are exempt from benchmark equivalent benefit packages: mandatory pregnant women, blind or disabled individuals, dual eligibles, terminally ill hospice patients, individuals eligible on basis of institutionalization, medically frail and special medical needs individuals, beneficiaries qualifying for long-term care services, children in foster care or receiving adoption assistance, mandatory section 1931 parents, and women in the breast or cervical cancer program. Also, please note that children must be provided full EPSDT benefits in benchmark coverage.

- 5) In addition to the Benefit Specifications and Qualifications form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

**Benefit
Chart**

Benefit	Description of Amount, Duration and Scope	Reference

**Benefits Not
Provided**

Benefit	Description of Amount, Duration and Scope	Reference

Please refer to List of Medicaid and CHIP Benefits: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Medicaid-and-CHIP-Benefits.pdf>, when completing this chart.

- 6) Indicate whether Long Term Services and Supports will be provided.

Yes (if yes, please check the services that are being offered) No

In addition, please complete the: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.

- | | |
|--|--|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Home Health Aide |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Personal Care Services |
| <input type="checkbox"/> Adult Day Health Services | <input type="checkbox"/> Habilitation – Residential Habilitation |
| <input type="checkbox"/> Habilitation – Supported Employment | |
| <input type="checkbox"/> Habilitation – Day Habilitation | <input type="checkbox"/> Habilitation – Pre-Vocational |
| <input type="checkbox"/> Habilitation – Other Habilitative | <input type="checkbox"/> Habilitation – Education (non-IDEA Services) |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Day Treatment (mental health service) |
| <input type="checkbox"/> Psychosocial Rehabilitation | <input type="checkbox"/> Clinic Services |
| <input type="checkbox"/> Environmental Modifications
(Home Accessibility Adaptations) | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Non-Medical Transportation | <input type="checkbox"/> Special Medical Equipment (minor assistive devices) |
| <input type="checkbox"/> Home Delivered Meals Personal | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Emergency Response | <input type="checkbox"/> Nursing Services |
| <input type="checkbox"/> Community Transition Services | <input type="checkbox"/> Adult Foster Care |
| <input type="checkbox"/> Day Supports (non-habilitative) | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Supported Living Arrangements | <input type="checkbox"/> Private Duty Nursing |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Adult Companion Services |
- Supports for Consumer Direction/Participant Directed Goods and Services
- Other (please describe)

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

- Yes (if yes, please address the questions below)
- No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program (if additional space is needed, please supplement your answer with a Word attachment);

- b) Include the minimum employer contribution amount (if additional space is needed, please supplement your answer with a Word attachment);
 - c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing (if additional space is needed, please supplement your answer with a Word attachment); and
 - d) Indicate how the cost-effectiveness test will be met (if additional space is needed, please supplement your answer with a Word attachment).
- 8) If different from the State plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).
- 9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

- a) will test a unique and previously untested use of copayments;
- b) is limited to a period of not more than two years;
- c) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;
- d) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and
- e) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

Please refer to Information on Cost Sharing <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Information-on-Cost-Sharing-Requirements.pdf> requirements for further information on statutory exemptions and limitations applicable to certain populations and services.

- 10) Indicate if there are any exemptions from the proposed cost sharing (if additional space

is needed, please supplement your answer with a Word attachment).

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:
 Yes
 No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

- 2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration’s expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms (if additional space is needed, please supplement your answer with a Word attachment);

- 3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:
 Managed care
 Managed Care Organization (MCO),
 Prepaid Inpatient Health Plans (PIHP)
 Prepaid Ambulatory Health Plans (PAHP)
 Fee-for-service (including Integrated Care Models)
 Primary Care Case Management (PCCM)
 Health Homes
 Other (please describe)

- 4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Delivery System Chart

Eligibility Group	Delivery System	Authority

- 5) If the Demonstration will utilize a managed care delivery system:
- a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?
 - b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);
 - c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);
 - d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and
 - e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).
- 6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment);
- 7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).
- Yes No
- 8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please

supplement your answer with a Word attachment);

There will be no deviation from existing State plan provider payment rates.

- 9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment); and

There will be no deviation from the payment and contacting requirements under 42 CFR Part 438.

- 10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).

Quality-based supplemental payments will remain the same as they are currently administered under OHP.

Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

- 1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment);

Coverage under this demonstration would become effective as of the first day of the month following the end of the PHE.

- 2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

For eligible individuals (i.e., individuals with incomes between 138 – 200% FPL and previously enrolled in OHP at the time of redetermination), the State will determine eligibility during the redetermination process following the end of the PHE (and any subsequent redetermination, whether annual or triggered by a reported change in circumstances). If the State concludes that an individual is eligible for coverage under this Demonstration, such individual will receive a notice and be automatically enrolled into OHP, maintaining the same Coordinated Care Organization (CCO) in which they were previously enrolled.

- 3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).

The State will use existing CCOs to provide Demonstration benefits. The State will not need to conduct procurement in order to administer this Demonstration.

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf> includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

Oregon understands that the state must demonstrate budget neutrality for this amendment to Oregon's SUD demonstration waiver. Because individuals covered under this demonstration are eligible for coverage under the State Plan pursuant to Section 1902(a)(10)(A)(ii)(XX), the State expects that these populations will be treated as "hypothetical" populations for budget neutrality expenditures held to a per capita expenditure calculation. Due to this assumption, the with and without waiver estimates are equal.

The per member per month (PMPM) calculations and annual trend rate for the 138-200% FPL population are assumed to be those approved by CMS in September 2022 for the ACA Adults Medicaid eligibility group (MEG) under the broader Oregon Health Plan Demonstration (Found in Table 11a, Demonstration 11-W-00415/10 terms and conditions). The PMPMs are adjusted to accommodate the April to March demonstration year of the underlying SUD demonstration.

Please refer to the "OHP Bridge-to-Bridge Workbook" Attachment for full budget neutrality assumptions and calculations. The Bridge-to-Bridge population is added as Hypothetical Test 3. Due to uncertainty related to Oregon's timing for implementing the Basic Health Program, the waiver application provides a conservative timeline that includes per capita amounts and projected member months lasting the duration of the underlying SUD approved waiver period. As outlined elsewhere in this application, upon implementation of the BHP, the eligibility group established under this Demonstration would be reduced to cover only American Indians/Alaska Natives (AI/AN) with

incomes from 138-200% FPL.

Oregon also requests the terms and conditions for the SUD demonstration be amended to include the language in Sections 12.17 and 12.18 of the recently approved OHP demonstration (Project Number 11-W-00415/10) pertaining to future adjustments to budget neutrality.

Comparison of OHP Demonstration Test to Proposed Bridge-to-Bridge Test									
<i>Hypothetical Budget Neutrality Test 1 from Oregon OHP Demonstration (11-W-00415/10)</i>									
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY21	DY22	DY23	DY24	DY25
ACA Adults	PC	Both	\$709.82	5.5%	\$758.95	\$800.69	\$844.73	\$891.19	\$940.21
<i>Proposed Hypothetical Budget Neutrality Test 3 For Bridge-to-Bridge Amendment to SUD Demonstration</i>									
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year DY20	Trend Rate	DY1	DY2	DY3	DY4	DY5
138-200% BTB	PC	Both	\$709.82	5.5%	NA	\$758.95	\$779.82	\$822.71	\$867.96

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) Provide a list of proposed waivers and expenditure authorities; and

Comparability 1902(a)(10)(B): To the extent necessary to vary the amount, duration, and scope of services to individuals, insofar as is necessary to limit coverage of individuals under the optional eligibility category authorized under 1902(a)(10)(A)(ii)(XX) to those individuals who were

enrolled in OHP at the time of redetermination.

Comparability 1902(a)(10)(B): To the extent necessary to vary the amount, duration, and scope of services to individuals, insofar as is necessary to limit coverage of individuals under the optional eligibility category authorized under 1902(a)(10)(A)(ii)(XX) to those individuals who are AI/AN.

- 2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

The waiver to limit enrollment in the new Medicaid eligibility category to those individuals who were enrolled in OHP at the time of redetermination is needed in order to effectuate the goals of reducing churn and ensuring ongoing coverage for eligible people after the PHE ends. Upon the implementation of Oregon's BHP, members in this category will be transitioned to the BHP with the exception of AI/AN members, who will remain on OHP as described below.

The waiver to limit the permanent coverage category to AI/AN members will enable Oregon to cover AI/AN individuals with income 138-200% FPL through the Oregon Health Plan so as to enable member choice between CCO coverage or to remain in Fee-For-Service coverage as enabled by federal regulation. This new category will be available to AI/AN members who are Medicaid-enrolled prior to the end of the PHE and to new AI/AN applicants once Oregon launches its Basic Health Program.

Please refer to the list of title XIX and XXI waivers and expenditure authorities: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf> that the state can reference to help complete this section. CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

Section VIII – Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding State Health Official Letter: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

- 1) Start and end dates of the state's public comment period (if additional space is needed, please supplement your answer with a Word attachment);

Oregon posted the SUD 1115 Demonstration draft application on August 1, and held

public comment from August 1, 2022 through Sep 7, 2022.

- 2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment);

Oregon certifies that the state provided public notice of the application on the state website (Oregon.gov) on the "Helping Oregonians Maintain Coverage After the Public Health Emergency Ends" page at the following link:

<https://www.oregon.gov/oha/PHE/Pages/phe-maintain-coverage.aspx>.

The notice was also recorded on the Secretary of State page in the Oregon Records Management Solution for the August 2022 notice. This record can be found at the following link:

<http://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/8909512>

- 3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment).

Oregon certifies that the state convened 2 public hearings, on August 24th hosted by OHA and August 31st hosted by the Medicaid Advisory Committee. Both hearings included teleconferencing and web capability, the recordings links, public notice, and hearing materials can be found at the following link:

<https://www.oregon.gov/oha/PHE/Pages/phe-maintain-coverage.aspx>

- 4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment);

Oregon certifies that three electronic mailing lists were used to notify the public of the above-mentioned hearings. These lists were the 1115 waiver list, OHP Provider Updates list and OHP Stakeholders list. Together these lists were used to notify approximately 29,000 people of the public comment period and hearings for this demonstration. The OHP Provider Updates and OHP Stakeholders lists include provider organizations and associations, Coordinated Care Organizations (CCOs), individual providers, licensing boards, community partners, and state and county contacts. Recipients on these lists were also invited to join the 1115 waiver list for updates. All three of these lists are open to the public and anyone can sign up to receive updates through them.

- 5) Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);

The state received nine public comments, two verbal comments made during the hearings and nine submitted in writing through the designated email. Nine comments were in

support and two were opposed. The two comments in opposition clarified that they were not opposed to the 1115 demonstration specifically, but to the associated Basic Health Program. Please see the attached “Public Comments for SUD 1115 Amendment” document for a summary of comments received and copies of complete comments for further reference.

- 6) Summary of the state’s responses to submitted comments, and whether or how the state incorporated them into the final application (if additional space is needed, please supplement your answer with a Word attachment); and

The state received no comments requiring incorporation or alteration to the final application. All comments received the following standard email response:

“Thank you for offering feedback on the SUD 1115 Bridge to the Bridge Amendment. We have documented your comment, and will follow up if additional questions arise.”

- 7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state’s approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation (if additional space is needed, please supplement your answer with a Word attachment).

The state certifies that tribal consultation was conducted in accordance with the consultation process outlined in the state’s approved Medicaid State plan. This included the submission of a Dear Tribal Leaders Letter (DTLL) and a presentation to the Oregon Tribes. The DTLL was submitted to the Oregon Tribes on August 22nd, and the presentation to the tribes was delivered on October 12th at SB 770 Health & Human Services Cluster Meeting. Tribal health directors indicated strong support for the demonstration. Additionally, OHA is currently in consultation with the tribes regarding the BHP associated with this demonstration.

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).

Section IX – Demonstration Administration

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title: Dana Hittle, Interim State Medicaid Director
Telephone Number: 503-945-6491
Email Address: dana.hittle@dhsosha.state.or.us

SUMMARY

Public Comments Received

SUD 1115 Bridge to the Bridge Amendment

The Oregon Health Authority sought public comment from August 1, 2022 through September 7, 2022 on Oregon's application to amend its freestanding SUD 1115 Demonstration in preparation for the federal Public Health Emergency unwinding. A notification was posted on the [Secretary of State website](#) on August 1, notifying the public that the formal public comment period was underway, and inviting written comment to be submitted to 1115sud.bridgeamendment@dhsosha.state.or.us. As part of this process, two virtual public hearings were held on August 24th and August 31st. The first was a standalone meeting and the second was hosted and run by the Oregon Medicaid Advisory Committee. Attendees were provided with a presentation on the background, pathways and plan relating to the SUD 1115 Amendment. Presentation materials and recordings were posted to OHA's website [Helping Oregonians Maintain Coverage After the Public Health Emergency Ends](#).

Public Commentors

No feedback on the amendment was offered during the public hearings. Nine written comments were submitted via the project email. Comments were submitted by:

1. Adam Zarrin, **The Leukemia & Lymphoma Society (LLS)**
2. Carrie Nyssen, **American Lung Association**
3. Christina Bodamer, **American Heart Association (AHA)**
4. Dan Cushing, **Coalition for a Healthy Oregon (COHO)**
5. Jeff Collins, **Kaiser Permanente of the Northwest**
6. Kristen Downey, **Providence Health & Services**
7. Madonna McGuire Smith, Miriam Goldstein, Nathan Schaefer of **Pacific Northwest Bleeding Disorders (PNBD), Hemophilia Federation of America (HFA), and National Hemophilia Foundation (NHF)**
8. Nathan Schaefer, **National Hemophilia Foundation (NHF)**
9. Seth M. Greiner, **National Multiple Sclerosis Society (NMSS)**



September 1, 2022

Patrick Allen
Director
Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301

Re: Proposed Amendment to Oregon's 1115 Demonstration

Dear Director Allen:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on Oregon's proposed amendment to its 1115 demonstration.

At The Leukemia & Lymphoma Society, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma and improve patients' and their families' quality of life. We support that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare.

LLS is committed to ensuring that Oregon's Medicaid program provides quality and affordable healthcare coverage. The end of the COVID-19 public health emergency (PHE), which will terminate the Medicaid continuous eligibility provisions within the PHE and trigger a mandatory process of redetermining eligibility for all Medicaid enrollees, has the potential to jeopardize the health and wellbeing of tens of thousands of vulnerable Oregon residents. LLS appreciates the state's consideration of the effects that the unwinding of the PHE will have on patients and supports the state's proposal to expand Medicaid eligibility to adults with incomes between 138% and 200% of the federal poverty level who were previously enrolled in Medicaid coverage at the time of redetermination. This proposal is an innovative policy to preserve Oregon patients' access to care.

The ending of the COVID-19 PHE will be one of the most significant enrollment events in the history of Medicaid. Approximately 15.8 million people are expected to lose Medicaid coverage at the end of the PHE.ⁱ For blood cancer patients, it is vital to have steady and uninterrupted access to the providers, treatments, and medications necessary to manage their disease. Ensuring that individuals have reliable coverage will help minimize disruptions in their treatment and support optimal survivorship outcomes. This waiver amendment will preserve Medicaid coverage for up to 55,000 individuals, per the state's estimate.

This waiver amendment will help to eliminate coverage gaps that often occur when individuals transition from Medicaid to marketplace coverage, a transition that could worsen health disparities. For example, one study found that only 3% of children and adults disenrolled from Medicaid were successfully enrolled in Marketplace coverage within a year, with gaps in coverage greater for people of color.ⁱⁱ Oregon's proposed changes will be an essential component of addressing health equity during the unwinding of the PHE.



This waiver amendment will benefit the state by reducing the administrative burden and churn of patients moving on and off coverage. Research shows that 8% of patients disenrolled from Medicaid or CHIP are re-enrolled within the year.ⁱⁱⁱ Churn results in gaps in coverage which can affect patients' ability to access care. Those who experience churn are more likely to delay care and have decreased use of preventive services and prescribed medications.^{iv} The reduction in churn would reduce the administrative costs associated with Medicaid for the state. One study found that the administrative cost of churn was between \$400 and \$600 per person.^v Allowing individuals that fall within the proposed expanded eligibility limits to stay enrolled will benefit both patients and the state.

As Oregon moves forward with this proposal, it will be important to have a clear implementation plan that minimizes the administrative burden on patients to mitigate coverage losses. For example, the state should clarify whether patients will need to fill out any paperwork to enroll in the demonstration and what steps consumers may need to take to enroll in the state's Basic Health Plan ultimately. LLS urges you to make enrollment and transition processes as simple and smooth as possible for patients and consumers.

LLS supports Oregon's proposed waiver to maintain coverage for Oregonians at the end of the COVID-19 PHE. Thank you for the opportunity to provide comments.

Sincerely,

Adam Zarrin
Director of Government Affairs, West
The Leukemia & Lymphoma Society

ⁱ Buettgens, Matthew, Green, Andrew. "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Urban Institute, March 2022. Available at: [What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?: Updated Projections of Medicaid Coverage and Costs \(urban.org\)](https://www.urban.org/research/publication/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency)

ⁱⁱ "Transitions Between Medicaid, CHIP, and Exchange Coverage." MACPAC, July 2022. Available at: [Transitions Between Medicaid, CHIP, and Exchange Coverage \(macpac.gov\)](https://www.macpac.gov/research/transitions-between-medicaid-chip-and-exchange-coverage/)

ⁱⁱⁱ "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP." MACPAC, October 2021. Available at: [An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP \(macpac.gov\)](https://www.macpac.gov/research/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip/)

^{iv} Sugar, Sarah, et al. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2021. Available at: [medicaid-churning-ib.pdf \(hhs.gov\)](https://www.hhs.gov/ashpe/sites/default/files/medicaid-churning-ib.pdf)

^v Swartz, Katherine, et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End of Calendar Year Is Most Effective." Health Affairs, 34.7. July 2015. Available at: [Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective | Health Affairs](https://www.healthaffairs.org/content/34/7/1257)



September 6, 2022

Patrick Allen
Director
Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301

Re: Proposed Amendment to Oregon's 1115 Demonstration

Dear Director Allen:

The American Lung Association appreciates the opportunity to submit comments on Oregon's proposed amendment to its 1115 demonstration.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 36 million Americans living with lung diseases, including more than 577,000 Oregonians. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association is committed to ensuring that Oregon's Medicaid program provides quality and affordable healthcare coverage. The end of the COVID-19 public health emergency (PHE) will be a critical period to ensure that patients who no longer qualify for Medicaid coverage maintain access to quality, affordable coverage without gaps in care that jeopardize their health and wellbeing. The Lung Association appreciates the state's consideration of the effects that the unwinding of the PHE will have on patients and supports the state's proposal to expand Medicaid eligibility to adults with incomes between 138% and 200% of the federal poverty level who were previously enrolled in Medicaid coverage at the time of redetermination. This proposal is an innovative policy to preserve access to care for patients in Oregon.

It is likely that the ending of the COVID-19 PHE will be one of the most significant enrollment events in the history of Medicaid. Approximately 15.8 million people are expected to lose Medicaid coverage at the end of the PHE.¹ For patients with lung disease, this can lead to dangerous gaps in coverage without access to regular care and prescriptions to manage their conditions. Without these medications and regular access to providers, their disease could become irreversibly worse. Gap in coverage will also stop patients from accessing potentially life-saving preventive services such as lung cancer screening and tobacco cessation. This waiver amendment will preserve Medicaid coverage for up to 55,000 individuals, per the state's estimate.

This waiver amendment will help to eliminate coverage gaps that often occur when individuals transition from Medicaid to marketplace coverage, a transition that could worsen health disparities. For example, one study found that only 3% of children and adults disenrolled from Medicaid were

successfully enrolled in Marketplace coverage within a year, with gaps in coverage greater for people of color.² Oregon's proposed changes will therefore be an important component of addressing health equity during the unwinding of the PHE.

This waiver amendment will benefit the state by reducing the administrative burden and churn of patients moving on and off coverage. Research shows that 8% of patients who are disenrolled from Medicaid or CHIP are re-enrolled within the year.³ Churn results in gaps in coverage which can affect patients' ability to access care, and those who experience churn are more likely to delay care and have decreased use of preventive services and prescribed medications.⁴ The reduction in churn would in turn reduce the administrative costs associated with Medicaid for the state. One study found that the administrative cost of churn was between \$400 and \$600 per person.⁵ Allowing individuals that fall within the proposed expanded eligibility limits to stay enrolled will benefit both patients and the state.

As Oregon moves forward with this proposal, it will be important to have a clear implementation plan that minimizes the administrative burden on patients to mitigate coverage losses. For example, the state should clarify whether patients will need to fill out any paperwork to enroll in the demonstration, and well as what steps consumers may need to take to ultimately enroll in the state's Basic Health Plan. The Lung Association urges you to make enrollment and transition processes as simple and smooth as possible for patients and consumers.

The Lung Association supports Oregon's proposed waiver to maintain coverage for Oregonians at the end of the COVID-19 PHE. Thank you for the opportunity to provide comments.

Sincerely,



Carrie Nyssen
Senior Director, Advocacy

¹ Buettgens, Matthew, Green, Andrew. "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Urban Institute, March 2022. Available at: https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf

² "Transitions Between Medicaid, CHIP, and Exchange Coverage." MACPAC, July 2022. Available at: <https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf>

³ "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP." MACPAC, October 2021. Available at: <https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf>

⁴ Sugar, Sarah, et al. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2021. Available at: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf

⁵ Swartz, Katherine, et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End of Calendar Year Is Most Effective." Health Affairs, 34.7. July 2015. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204>

September 6, 2022

Patrick Allen, Director
Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301

Re: Proposed Amendment to Oregon's 1115 Demonstration

Dear Director Allen:

The American Heart Association (AHA) appreciates the opportunity to submit comments on Oregon's proposed amendment to its 1115 demonstration.

As the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, the American Heart Association (AHA) represents millions of Americans suffering from cardiovascular disease (CVD) and stroke. In the United States, CVD is the leading cause of death, and stroke is among the leading causes of disability, with high blood pressure, or hypertension, among the most important risk factors leading to CVD. The AHA believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Nationally, about 1 in 10 adults with Medicaid coverage are estimated to have some form of CVD, with 6 in 10 having multiple chronic conditions.¹ Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid serves as the coverage backbone for the healthcare services these individuals need.

It is likely that the ending of the COVID-19 public health emergency (PHE) will be one of the most significant enrollment events in the history of Medicaid, with approximately 15.8 million people expected to lose Medicaid coverage at the end of the PHE.² This will be a critical period for states to ensure that patients who no longer qualify for Medicaid coverage are able to maintain access to quality, affordable coverage, without gaps in care. Such gaps can and will jeopardize the overall health and wellbeing of Medicaid recipients. The AHA appreciates the Medicaid agency's forward-thinking perspective regarding the impact the unwinding of the PHE may have on patients; and supports the state's proposal to expand Medicaid eligibility to adults with incomes between 138% and 200% of the federal poverty level who were previously enrolled in Medicaid coverage at the time of redetermination. This innovative policy proposal shows the agency's level of commitment to maintain access to care for patients in Oregon.

This waiver amendment will preserve Medicaid coverage for up to 55,000 individuals, per the state's estimate, and will also help to eliminate coverage gaps that often occur when individuals transition from Medicaid to marketplace coverage—a transition that could worsen health disparities. For example, one study found that only 3% of children and adults disenrolled from Medicaid were successfully enrolled in Marketplace coverage within a year, with gaps in coverage greater for people of color.³ Oregon's proposed changes will therefore be an important component of addressing health equity during the unwinding of the PHE.

As Oregon moves ahead with this proposal, it will be important for agency leadership to develop a clear implementation plan that minimizes the administrative burden on patients to mitigate coverage losses. For example, the state should clarify whether patients will need to complete specific paperwork to enroll in the demonstration, as well as identify any steps Medicaid recipients may need to take to ultimately enroll in the state's Basic Health Plan. Also, the proposed waiver amendment will benefit the state by reducing the administrative burden and churn of patients moving on and off coverage. Research shows that 8% of patients who are disenrolled from Medicaid or CHIP are re-enrolled within the year.⁴ Churn results in gaps in coverage which can affect patients' ability to access care, and those who experience churn are more likely to delay care and have decreased use of preventive services and prescribed medications.⁵ The reduction in churn would in turn reduce the administrative costs associated with Medicaid for the state. One study found that the administrative cost of churn was between \$400 and \$600 per person.⁶ Allowing individuals that fall within the proposed expanded eligibility limits to stay enrolled will benefit both patients and the state.

The AHA urges you to establish enrollment and transition processes that are simple and less cumbersome for Medicaid patients and consumers. The American Heart Association enthusiastically supports Oregon's proposed waiver to maintain coverage for Oregonians at the end of the COVID-19 PHE. Thank you for the opportunity to provide comments.

Sincerely,

Christina Bodamer
Government Relations Regional Lead Western States
American Heart Association

¹ Chapel, JM, Ritchey MD, Zhang D, Wang G. Prevalence and medical costs of chronic diseases among Medicaid beneficiaries. *AJPM*. 2017; 53(6); 5143-5154.

² Buettgens, Matthew, Green, Andrew. "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Urban Institute, March 2022. Available at: [What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?: Updated Projections of Medicaid Coverage and Costs \(urban.org\)](https://www.urban.org/policy-centers-and-programs/publications-reports/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency?_ga=2.141111111.164444444.164444444.164444444)

³ "Transitions Between Medicaid, CHIP, and Exchange Coverage." MACPAC, July 2022. Available at: [Transitions Between Medicaid, CHIP, and Exchange Coverage \(macpac.gov\)](https://www.macpac.gov/wp-content/uploads/2022/07/Transitions-Between-Medicaid-CHIP-and-Exchange-Coverage-2022.pdf)

⁴ "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP." MACPAC, October 2021. Available at: [An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP \(macpac.gov\)](https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP-2021.pdf)

⁵ Sugar, Sarah, et al. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2021. Available at: [medicaid-churning-ib.pdf \(hhs.gov\)](https://www.hhs.gov/ashpe/operations/medicaid-churning-ib.pdf)

⁶ Swartz, Katherine, et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End of Calendar Year Is Most Effective." *Health Affairs*, 34.7. July 2015. Available at: [Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective | Health Affairs](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4611111/)



September 2, 2022

Health Policy and Analytics Bridge Program Team
Attn: Michelle Hatfield
500 Summer St. NE, 5th Floor, E65
Salem, OR 97301

Subject: Comment in support of §1115 Substance Use Disorder (SUD) Waiver, "Bridge to the Bridge Amendment"

Coalition for a Healthy Oregon (COHO) is comprised of seven of the state's coordinated care organizations (CCOs), all of which are deeply committed to Oregon's innovative Medicaid program and achieving health equity in our state. **We are writing in support Oregon's application to maintain Oregon Health Plan coverage for certain individuals with incomes between 138 - 200% of the federal poverty guideline.**

The language of HB 4035 (2022), the legislative record, and public statements from Oregon Health Authority clearly specify this new benefit ought to build upon the Oregon Integrated and Coordinated Health Care Delivery System, i.e., CCOs. We agree this is best approach to continue transforming health care for the betterment of Oregonians' health and equity.

COHO submitted written testimony on May 10 to the Joint Task Force on the Bridge Health Care Program urging the Task Force to incorporate key policy elements in its final proposal: center the member experience, ensure provider participation, and leverage the successful, local model. That letter is attached for your reference.

The continuity of patient care is extremely important, and therefore we urge you to approve the continuation of coverage while working to build on the successes of Oregon's local care model.

Sincerely,

Advanced Health
AllCare Health
Cascade Health Alliance, LLC
InterCommunity Health Network CCO
Trillium Community Health Plan
Umpqua Health Alliance
Yamhill Community Care

Enclosure





May 10, 2022

From: Coalition for a Healthy Oregon
To: Joint Task Force On the Bridge Health Care Program
Subject: **CCO Principles for a Successful Bridge Health Care Program**

Co-Chair Steiner Hayward, Co-Chair Prusak, and Members of the Task Force,

House Bill 4035, enacted in the 2022 Legislative Session, raises the exciting possibility of improving health coverage and continuity of care for Oregonians with a focus on reducing the uninsured rate and achieving health equity. The language of HB 4035, the legislative record, and public statements from Oregon Health Authority clearly specify this new benefit ought to build upon the Oregon Integrated and Coordinated Health Care Delivery System, i.e., coordinated care organizations (CCOs). **The seven CCOs in Coalition for a Healthy Oregon (COHO) call your attention to following policy considerations.** We request these principles be incorporated in your proposal pursuant to Section 4 of the bill.

Center the Member Experience

- 1) Use current CCOs to maintain continuity of care**—It is critically important to expand enrollment within existing CCOs rather than create a new layer/silo of health care delivery. Existing CCOs have relationships with members, providers, and community stakeholders; there are robust systems in place to ensure quality and accountability.
- 2) Benefit package should be as close to Oregon Health Plan as possible**—Members will lose trust in the system if they do not understand why they can no longer access services they rely upon.
- 3) Movement from CCO to Bridge Program should not be disruptive for members or providers.**
- 4) Maximize flexibilities for CCO outreach**—This includes outreach to current CCO members, as well as providers and community-based organizations (CBOs) on the redetermination process and the move to the new Bridge Program.

Ensure Provider Participation

5) Capitation based funding—Budgeting on a per-person (capitated) basis encourages the adoption of value-based payments, which aligns with state policy goals.

6) Provider rates should be high enough to sustain the network—A robust provider network is critical protect patient access and choice as well as to support providers from the BIPOC community and other marginalized communities.

7) Additional administrative burden should be minimized.

Leverage The Successful, Local Model

8) Use the CCO model as a basis for plan requirements—This includes local governance, care coordination, Social Determinants of Health and Equity programs, and quality measures, including incentive metrics.

9) Ensure budget neutrality to the state General Fund by maximizing federal funds and existing infrastructure.

10) Provide flexibility and assistance for existing CCOs to meet any new capital reserves or other requirements for offering the Bridge Health Care Program—This is especially needed for CCOs not currently enrolled as health plans on the exchange.

Thank you for your dedication to this important work. We offer our assistance if you have any questions or policy considerations for our experts to review.

Sincerely,

Advanced Health
AllCare Health
Cascade Health Alliance, LLC
InterCommunity Health Network CCO
Trillium Community Health Plan
Umpqua Health Alliance
Yamhill Community Care



September 6, 2022

Health Policy and Analytics Bridge Program Team

Attn: Michelle Hatfield

500 Summer St. NE, E65

Salem, OR 97301

Submitted via email: 1115SUD.BridgeAmendment@dhsosha.state.or.us.

Re: Section 1115 SUD Waiver - Bridge to the Bridge Amendment Application

Dear Bridge Program Team:

Kaiser Permanente appreciates the opportunity to submit comments to the Oregon Health Authority (OHA) on its proposed amendment to its Section 1115 SUD waiver Bridge to the Bridge amendment application. Kaiser Permanente is the largest private integrated healthcare delivery system in the U.S., delivering health care to 12.5 million members in eight states and the District of Columbia.¹ Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Kaiser Permanente serves nearly 70,000 Oregonians as a delegated subcontractor to Health Share of Oregon in the Portland metro area and PacificSource in Marion and Polk counties, on a capitated basis. Kaiser Permanente also participates as a primary care provider under PacificSource in Lane County. Additionally, Kaiser Permanente is a delegated Dental Care Organization within the Health Share of Oregon network, serving members in the Portland metropolitan area.

Kaiser Permanente supports programs and policies that ensure all individuals have access to affordable, high-quality health care. We are supportive of the 'Bridge to the Bridge', but we have concerns, however, with the impact of the Basic Health Plan (BHP) on Oregon's established exchange enrollment, provider rates and networks.

Kaiser Permanente offers the following comments on this 1115 waiver amendment proposal:

We Support Continuous Coverage. Consistent with our support of universal coverage and our support of Cover All People, now referred to as Healthier Oregon, we offered our support for OHA's efforts to expand coverage in its proposed renewal of the OHP 1115 Demonstration Waiver for the 2022-2027 time period.² That proposal seeks to implement continuous enrollment for children up to the age of 6 and transitioning youth. We also support OHA's proposal to implement two-year continuous eligibility for all OHP members. Continuous eligibility will keep people covered, mitigate churn, and allow members to access their providers for care without disruption. Kaiser Permanente has long supported expanding access to coverage and efforts to facilitate enrollment changes when families

¹ Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the medical care needs of Kaiser Permanente's members.

² Renewal of the Oregon Health Plan (OHP) 1115 Demonstration Waiver for the 2022-2027 demonstration period Available at: <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-Waiver-Application-Final.pdf>

move coverage types. We look forward to working with the State to identify strategies to fill gaps for individuals ineligible for subsidies on the exchange.

Maintaining insurance coverage, especially for those likely to transition between OHP and exchange coverage, is an important strategy to achieve universal coverage and provide continuity of care. The imminent Medicaid redetermination process will challenge public, private and community-based resources to assist as many of the current OHP beneficiaries as possible. Knowing that this will require tremendous effort in an abbreviated period, Kaiser Permanente supports temporarily giving individuals additional time to remain on Medicaid, to assure that they have adequate time to manage the administrative processes associated with redetermination and coverage transitions.

The Interaction of BHP and Continuous Coverage Provisions Is Concerning. We do not, however, support the implementation of a permanent Bridge/BHP for people between 138% and 200% of the federal poverty level (FPL). Our concerns are threefold: (1) the BHP is a blunt policy tool that has the potential to do more harm than good, (2) these potential harms and a fully envisioned mitigation strategy must be understood before moving forward with any waiver request, and (3) Oregon is lagging in preparations for redeterminations and must quickly build a communications and outreach plan for current OHP enrollees and the estimated 245,000 (or 82%) people who may lose coverage and are ineligible for a BHP.

The BHP captures individuals with incomes between 138-200% of the Federal Poverty Level (FPL), which the state estimates is roughly 55,000 (or 18%) of the 300,000 who may lose coverage. A BHP is uncharted territory for the state, since the ACA established the BHP as an alternative coverage option for low- and moderate-income populations at a time when the individual market had not yet stabilized. New York and Minnesota established BHPs in 2015 to build upon existing state programs established prior to the passage of the ACA. No other states have adopted a BHP since 2015. Accordingly, we have significant concerns about a BHP's impact on mature exchange premiums, provider rates, and enrollment.

A BHP not only captures 55,000 people potentially losing Oregon Health Plan coverage, but also removes 32,500 people from the Marketplace (an estimated 22-24% of current enrollees) and places them in the BHP without choice. This removal and redirection of almost a quarter of the Marketplace to a BHP has the potential to be significantly destabilizing. The remaining 82,800 people with subsidized plans on the Marketplace will be impacted to varying degrees. For example, for the average 21-year-old in Multnomah County at 201% FPL on a subsidized bronze plan, we estimate their costs could go up over 50%, with steeper increases for the average 40- and 60-year-olds in the same plan, location and income. In addition to consumer impacts, the State has not established clear BHP provider rates other than to indicate they will be some fraction above current Oregon Health Plan rates, putting additional financial pressure on providers in the midst of a years-long pandemic,

We support the state moving forward with the 'Bridge to the Bridge' to allow for additional time to complete administrative processes and coverage transitions. Going forward, continuous coverage in Medicaid as envisioned in the extension of the current 1115 waiver is our recommended strategy for mitigating churn, rather than designing, developing and implementing an additional program such as a BHP at an already challenging time. Lastly, we also encourage state efforts to nurture a robust State Based Marketplace to help improve the member experience in enrolling in and choosing health coverage.

In sum, Kaiser Permanente stands ready to work with CMS and OHA through the development of continuous coverage options but does not support the development of a permanent BHP as such an option.

* * *

Kaiser Permanente appreciates the opportunity to provide comments on the Oregon 1115 waiver. We welcome the opportunity to work with CMS and OHA on the implementation of the initiatives in the waiver. Thank you for considering our comments. If you have questions, please contact me at jeff.a.collins@kp.org or Elizabeth Edwards at elizabeth.m.edwards@kp.org.

Very truly yours,

A black rectangular redaction box covering the signature of Jeff Collins.

Jeff Collins
President, Kaiser Permanente of the Northwest



September 7, 2022

Health Policy and Analytics Bridge Program Team
Attn: Michelle Hatfield
500 Summer St. NE, E65
Salem, OR 97301
Submitted via email: 1115SUD.BridgeAmendment@dhsosha.state.or.us.

RE: Section 1115 SUD Waiver – Bridge to Bridge Amendment Application

Dear Ms. Hatfield:

As the largest health care provider in Oregon, Providence is committed to ensuring that Oregonians have access to high-quality, affordable health care. We support efforts to ensure that the Medicaid population is able to maintain coverage with limited disruption. Since the inception of Coordinated Care Organizations (CCO) in 2011, our operational and clinical leaders have actively participated on six CCO boards and countless CCO work groups across the state. Today, Providence is fully accountable for more than 57,000 Health Share of Oregon members in the Portland-metro area alone, of that, 42,500 are assigned to our Providence Medical Group (PMG) for primary care.

Providence is a strong advocate for sustainable Medicaid funding and opportunities to expand the Oregon Health Plan. Our goals of improved population health and managing the total cost of care are rooted in our ability to provide affordable health care coverage to all Oregonians. This coupled with efforts to simplify the enrollment process by reducing the churn population through the adoption of proven, simplified enrollment will reduce the burden on members and administrative costs associated with enrollment.

While we share the OHA's goals to minimize disruption post-public health emergency, we are concerned that the proposed 1115 SUD waiver for a bridge to a suggested Basic Health Plan (BHP) is premature and infers decisions that have not been made by the Task Force or approved by the Oregon Health Policy Board.

The waiver language ties continuation of Medicaid to the establishment of a BHP, but the decision to implement a BHP in Oregon has not been finalized or approved

Only two other states have established a BHP and that was in 2015, before COVID changed the health care landscape. While Oregon's BHP taskforce has determined it *may* be feasible to implement a BHP, they are awaiting critical information: CMS's proposed changes to funding formulas, federal policy change, and the results of an actuarial analysis. This uncertainty coupled with the timeline to implement, and the fact that Oregon does not have a state-based insurance exchange make the probability of establishing an operational BHP in an abbreviated timeframe a high-risk solution to solve redetermination.

There are risks with pinning the success of Medicaid redetermination to the BHP

A BHP in Oregon would remove 32,500 people from the Marketplace, which will directly impact consumers increasing their cost by more than 50% and may destabilize the Marketplace. Managing the nearly 1.4 million Medicaid redeterminations while simultaneously trying to develop and implement a BHP will be incredibly complex and deserves focused, collaborative discussions about how this plan will be operationalized, how it will be funded, what the implications are for CCOs, how it impacts individuals under 200% FPL that are enrolled on the individual market currently, and the OHA's capacity to do this work at the same time as redeterminations.

Providence is committed to being a collaborative partner as this work moves forward and appreciates the opportunity to provide comments in the 1115 SUD waiver. We believe this work can happen in a manner that maintains the integrity of the Oregon Health Plan, Oregon's insurance exchange, and continues Oregon's history of innovation in health care.

Sincerely,

A black rectangular redaction box covers the signature area. A small handwritten mark is visible below the box.

Kristen Downey
Director, Government Affairs - Oregon
Providence Health & Services



VIA EMAIL

1115SUD.BridgeAmendment@dhsosha.state.or.us

September 7, 2022

Patrick Allen, Director
Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301

RE: Proposed Amendment to Oregon's Section 1115 Demonstration Waiver

Dear Director Allen:

Pacific Northwest Bleeding Disorders (PNWBD), Hemophilia Federation of America (HFA) and the National Hemophilia Foundation (NHF) hereby submit the following comments in response to the Oregon Health Authority's proposed revisions to the Section 1115 Demonstration Waiver for the Oregon Health Plan (OHP).

Who We Are

PNWBD, HFA, and NHF are non-profit organizations representing individuals with bleeding disorders nationwide. Our missions are to ensure that persons with inherited bleeding disorders such as hemophilia have timely access to quality medical care, therapies, and services, regardless of their financial circumstances or place of residence.

About Bleeding Disorders

Hemophilia is a rare, genetic bleeding disorder affecting about 30,000 Americans that impairs the ability of blood to clot properly. Without treatment, people with hemophilia bleed internally. This is sometimes due to trauma but can also simply result from everyday activities. Bleeds can lead to severe joint damage and permanent disability, or even – with respect to bleeds in the head, throat, or abdomen – death. Related conditions include von Willebrand disease, another inherited bleeding disorder that is estimated to affect more than three million Americans.

Patients with bleeding disorders have complex, lifelong medical needs. They depend on prescription medications (clotting factor or other injectable treatments) to treat or avoid painful bleeding episodes that can lead to advanced medical issues. Current treatments are highly effective and allow individuals to lead healthy and productive lives. However, these therapies are also extremely expensive, costing anywhere from \$300,000 to \$1 million or more per year depending on the severity of the disorder and whether complications such as an inhibitor are present. As a result, low-income individuals and families coping with bleeding disorders are at great risk if they lack affordable health insurance. Medicaid provides essential coverage for this segment of the bleeding disorders population.

PNWBD, HFA, and NHF remain committed to ensuring that the Oregon Health Plan (OHP) provides quality and affordable health coverage. As you are aware, the expiration of the COVID-19 public health emergency (PHE) will jeopardize access to care for roughly 55,000 OHP enrollees (potentially including individuals with bleeding disorders) who will no longer be

Medicaid-eligible and need to promptly transition to affordable coverage to prevent life-threatening treatment disruptions.

As a result, we greatly appreciate the Authority's consideration of the impact the unwinding of the PHE will have on these enrollees and strongly support your proposal to expand Medicaid eligibility to adults earning 138-200 percent the federal poverty level, if they were enrolled in Medicaid coverage at the time of redetermination. This proposal is an innovative and proactive effort to preserve access to care for low-income Oregonians and should be a model for other states.

The proposed waiver amendment will help to eliminate coverage gaps that often occur when individuals transition from Medicaid to ACA Marketplace coverage--a transition that could worsen health disparities. For example, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that only three percent of children and adults disenrolled from Medicaid were able to successfully enroll in Marketplace coverage within a year, with people of color often ending up uninsured¹. The Authority's creation of a coverage alternative will therefore be an important component of addressing health equity during the unwinding of the PHE.

This amendment will also benefit the state by reducing the administrative burden and churn of Medicaid enrollees cycling on and off coverage. Research shows that eight percent of those disenrolled from Medicaid or CHIP are re-enrolled within the year². Churn results in gaps in coverage which can affect an enrollee's ability to access care. Furthermore, those who experience churn are more likely to delay care and have decreased use of preventive services and prescribed medications³.

The reduction in churn would in turn lower the administrative costs associated with Medicaid for Oregon. One study found that the administrative cost of churn was between \$400-600 per person⁴. Allowing individuals who fall within the proposed expanded eligibility limits to stay enrolled will thus benefit both enrollees and the state.

As Oregon moves forward with this proposal, it will be important to have a clear implementation plan that minimizes the administrative burden on enrollees to mitigate coverage losses. For example, the state should clarify whether individuals will need to fill out any paperwork to enroll in the demonstration, as well as what steps they may need to take to ultimately enroll in the state's Basic Health Plan. We urge the Authority to make all enrollment and transition processes as simple and smooth as possible for those losing Medicaid coverage.

¹ "Transitions Between Medicaid, CHIP, and Exchange Coverage." MACPAC, July 2022. Available at: [Transitions Between Medicaid, CHIP, and Exchange Coverage \(macpac.gov\)](#)

² "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP." MACPAC, October 2021. Available at: [An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP \(macpac.gov\)](#)

³ Sugar, Sarah, et al. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2021. Available at: [medicaid-churning-ib.pdf \(hhs.gov\)](#)

⁴ Swartz, Katherine, et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End of Calendar Year Is Most Effective." Health Affairs, 34.7. July 2015. Available at: [Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Year Is Most Effective | Health Affairs](#)

Our organizations fully support the Authority's effort to create a coverage alternative for Oregonians losing Medicaid coverage at the end of the COVID-19 PHE. Please feel free to contact any of us as listed below with any questions or for additional information.

Sincerely,



Madonna McGuire Smith
Executive Director
Pacific Northwest Bleeding Disorders
m.mcguiresmith@pnwbd.org

A handwritten signature in blue ink that reads "Miriam Goldstein".

Miriam Goldstein
Acting Vice President, Public Affairs
Hemophilia Federation of America
m.goldstein@hemophiliafed.org

A handwritten signature in blue ink that reads "Nathan M. Schaefer".

Nathan Schaefer, MSW
Vice President, Public Policy
National Hemophilia Foundation
nschaefer@hemophilia.org



NATIONAL HEMOPHILIA FOUNDATION
for all bleeding disorders

Sept. 1, 2022

Patrick Allen
Director
Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301

Re: Proposed Amendment to Oregon's 1115 Demonstration

Dear Director Allen:

The National Hemophilia Foundation appreciates the opportunity to submit comments on Oregon's proposed amendment to its 1115 demonstration.

The National Hemophilia Foundation (NHF) is a national non-profit organization that represents individuals with bleeding disorders across the United States. Our mission is to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence.

NHF is committed to ensuring that Oregon's Medicaid program provides quality and affordable healthcare coverage. The end of the COVID-19 public health emergency (PHE) will be a critical period to ensure that patients who no longer qualify for Medicaid coverage maintain access to quality, affordable coverage without gaps in care that jeopardize their health and wellbeing. NHF appreciates the state's consideration of the effects that the unwinding of the PHE will have on patients and supports the state's proposal to expand Medicaid eligibility to adults with incomes between 138% and 200% of the federal poverty level who were previously enrolled in Medicaid coverage at the time of redetermination. This proposal is an innovative policy to preserve access to care for patients in Oregon.

It is likely that the ending of the COVID-19 PHE will be one of the most significant enrollment events in the history of Medicaid. Approximately 15.8 million people are expected to lose Medicaid coverage at the end of the PHE.ⁱ NHF estimates that, nationwide, 25-30% of bleeding disorders patients are on Medicaid. In many cases these patients are our most vulnerable. This waiver amendment will preserve Medicaid coverage for up to 55,000 individuals, per the state's estimate.

This waiver amendment will help to eliminate coverage gaps that often occur when individuals transition from Medicaid to marketplace coverage, a transition that could worsen health disparities. For example, one study found that only 3% of children and adults disenrolled from Medicaid were successfully enrolled in Marketplace coverage within a year, with gaps in coverage greater for people of color.ⁱⁱ Oregon's proposed changes will therefore be an important component of addressing health equity during the unwinding of the PHE.

7 Penn Plaza · Suite 1204
New York, NY · 10001
(800) 42.HANDI · (212) 328.3700 · fax (212) 328.3777
www.hemophilia.org · info@hemophilia.org



NATIONAL HEMOPHILIA FOUNDATION
for all bleeding disorders

This waiver amendment will benefit the state by reducing the administrative burden and churn of patients moving on and off coverage. Research shows that 8% of patients who are disenrolled from Medicaid or CHIP are re-enrolled within the year.ⁱⁱⁱ Churn results in gaps in coverage which can affect patients' ability to access care, and those who experience churn are more likely to delay care and have decreased use of preventive services and prescribed medications.^{iv} The reduction in churn would in turn reduce the administrative costs associated with Medicaid for the state. One study found that the administrative cost of churn was between \$400 and \$600 per person.^v Allowing individuals that fall within the proposed expanded eligibility limits to stay enrolled will benefit both patients and the state.

As Oregon moves forward with this proposal, it will be important to have a clear implementation plan that minimizes the administrative burden on patients to mitigate coverage losses. For example, the state should clarify whether patients will need to fill out any paperwork to enroll in the demonstration, and well as what steps consumers may need to take to ultimately enroll in the state's Basic Health Plan. NHF urges you to make enrollment and transition processes as simple and smooth as possible for patients and consumers.

NHF supports Oregon's proposed waiver to maintain coverage for Oregonians at the end of the COVID-19 PHE. Thank you for the opportunity to provide comments.

Sincerely,



Nathan Schaefer
Vice President of Public Policy
National Hemophilia Foundation

ⁱ Buettgens, Matthew, Green, Andrew. "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Urban Institute, March 2022. Available at: [What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?: Updated Projections of Medicaid Coverage and Costs \(urban.org\)](https://www.urban.org/research/publication/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency?updated-projections-of-medicaid-coverage-and-costs)

ⁱⁱ "Transitions Between Medicaid, CHIP, and Exchange Coverage." MACPAC, July 2022. Available at: [Transitions Between Medicaid, CHIP, and Exchange Coverage \(macpac.gov\)](https://www.macpac.gov/research/transitions-between-medicaid-chip-and-exchange-coverage/)

ⁱⁱⁱ "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP." MACPAC, October 2021. Available at: [An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP \(macpac.gov\)](https://www.macpac.gov/research/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip/)



NATIONAL HEMOPHILIA FOUNDATION

for all bleeding disorders

^{iv} Sugar, Sarah, et al. “Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic.” Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2021. Available at: [medicaid-churning-ib.pdf \(hhs.gov\)](#)

^v Swartz, Katherine, et al. “Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End of Calendar Year Is Most Effective.” Health Affairs, 34.7. July 2015. Available at: [Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective | Health Affairs](#)



September 7, 2022

Patrick Allen
Director
Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301

Re: Proposed Amendment to Oregon's 1115 Demonstration

Dear Director Allen:

The National Multiple Sclerosis Society (Society) appreciates the opportunity to submit comments on Oregon's proposed amendment to its 1115 demonstration.

MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. Nearly one million Americans live with this disease, and most people are diagnosed between the ages of 20 and 50, when they are in their prime working years. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The Society is committed to ensuring that Oregon's Medicaid program provides quality and affordable healthcare coverage. The end of the COVID-19 public health emergency (PHE) will be a critical period to ensure that patients who no longer qualify for Medicaid coverage maintain access to quality, affordable coverage without gaps in care that jeopardize their health and wellbeing. The Society appreciates the state's consideration of the effects that the unwinding of the PHE will have on patients and supports the state's proposal to expand Medicaid eligibility to adults with incomes between 138% and 200% of the federal poverty level who were previously enrolled in Medicaid coverage at the time of redetermination. This proposal is an innovative policy to preserve access to care for patients in Oregon.

It is likely that the ending of the COVID-19 PHE will be one of the most significant enrollment events in the history of Medicaid. Approximately 15.8 million people are expected to lose Medicaid coverage at the end of the PHE.¹ Access to affordable, high quality health care is essential for people with MS to live their best lives, and health insurance coverage is essential for people to be able to get the care and treatments they need. Without health insurance, people living with MS do not have access to the services and treatments to manage symptoms and slow their disease course. Studies show that early and ongoing treatment with a disease-modifying therapy (DMT) is the best way to modify the course of the disease, slow the accumulation of disability and protect the brain from damage due to MS. Adherence to medication is a key element of treatment effectiveness. Many MS DMTs are now available, including some generics, but in 2022, the median annual price of the MS DMTs is close to \$94,000, up nearly \$25,000 from 2015. Six of the MS DMTs have increased in price more than 200%



since they came on market, with nine now priced at over \$100,000. Without prescription drug coverage provided by Medicaid, medications to treat MS would be financially out of reach. Gaps in treatment can lead to disease progression and increased, possibly irreversible, disability. People who receive treatment for a complex disease like MS, who rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions, cannot afford a sudden gap in their care. This waiver amendment will preserve Medicaid coverage for up to 55,000 individuals, per the state's estimate.

This waiver amendment will help to eliminate coverage gaps that often occur when individuals transition from Medicaid to marketplace coverage, a transition that could worsen health disparities. For example, one study found that only 3% of children and adults disenrolled from Medicaid were successfully enrolled in Marketplace coverage within a year, with gaps in coverage greater for people of color.² Oregon's proposed changes will therefore be an important component of addressing health equity during the unwinding of the PHE.

This waiver amendment will benefit the state by reducing the administrative burden and churn of patients moving on and off coverage. Research shows that 8% of patients who are disenrolled from Medicaid or CHIP are re-enrolled within the year.³ Churn results in gaps in coverage which can affect patients' ability to access care, and those who experience churn are more likely to delay care and have decreased use of preventive services and prescribed medications.⁴ The reduction in churn would in turn reduce the administrative costs associated with Medicaid for the state. One study found that the administrative cost of churn was between \$400 and \$600 per person.⁵ Allowing individuals that fall within the proposed expanded eligibility limits to stay enrolled will benefit both patients and the state.

As Oregon moves forward with this proposal, it will be important to have a clear implementation plan that minimizes the administrative burden on patients to mitigate coverage losses. For example, the state should clarify whether patients will need to fill out any paperwork to enroll in the demonstration, and well as what steps consumers may need to take to ultimately enroll in the state's Basic Health Plan. The Society urges you to make enrollment and transition processes as simple and smooth as possible for patients and consumers.

The Society supports Oregon's proposed waiver to maintain coverage for Oregonians at the end of the COVID-19 PHE. Thank you for the opportunity to provide comments.

Sincerely,

Seth M. Greiner
Senior Manager, Advocacy
National Multiple Sclerosis Society

¹ Buettgens, Matthew, Green, Andrew. "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Urban Institute, March 2022. Available at: [What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?: Updated Projections of Medicaid Coverage and Costs \(urban.org\)](https://www.urban.org/research/publication/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency?updated-projections-of-medicaid-coverage-and-costs)

² "Transitions Between Medicaid, CHIP, and Exchange Coverage." MACPAC, July 2022. Available at: [Transitions Between Medicaid, CHIP, and Exchange Coverage \(macpac.gov\)](https://www.macpac.gov/reports/2022/transitions-between-medicaid-chip-and-exchange-coverage/)



³ “An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP.” MACPAC, October 2021. Available at: [An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP \(macpac.gov\)](https://www.macpac.gov/2021/10/20/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicare-and-chip/)

⁴ Sugar, Sarah, et al. “Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic.” Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2021. Available at: [medicaid-churning-ib.pdf \(hhs.gov\)](https://www.hhs.gov/ashpe/operations/medicaid-churning-ib.pdf)

⁵ Swartz, Katherine, et al. “Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End of Calendar Year Is Most Effective.” Health Affairs, 34.7. July 2015. Available at: [Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective | Health Affairs](https://www.healthaffairs.org/content/34/7/1250)