DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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State Demonstrations Group

November 2, 2026

Emma Sandoe
State Medicaid Director
Oregon Health Authority
500 Summer St, NE E49
Salem, OR 97301

Dear Director Sandoe:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Oregon's Final Report for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Oregon Health Plan" (Project No: 11-W-00415/10 and 21-00073/10). This report covers the demonstration period from March, 2020 to December, 2023. CMS determined that the Final Report, submitted on August 28, 2026 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

In accordance with 42 CFR 431.424(c), the approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

Program Integrity
States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA

and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Oregon Health Plan section 1115 demonstration.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2026.11.02 12:37:10 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Sasha Zolynas, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

OREGON HEALTH AUTHORITY
Health Policy and Analytics Division
Office of Health Analytics

2026

Oregon Health Plan Section 1115(a) Waiver COVID-19 PHE CHIP Amendment

Evaluation Report

Other formats and languages

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Executive Summary

Background and questions

In 2023, Oregon applied for and was approved to amend the Oregon Health Plan section 1115(a) demonstration, which allowed the state more flexibility in providing health care coverage to specific populations during the COVID-19 Public Health Emergency (PHE). The Amendment applied to populations covered by the Children's Health Insurance Program (CHIP) and provided continuous coverage with current benefits for individuals determined ineligible for CHIP due to a change in circumstances. The Amendment was authorized retroactively beginning March 1, 2020, and applied to CHIP beneficiaries through December 31, 2023.

Oregon conducted an evaluation to understand how the Amendment impacted health care coverage and access for CHIP beneficiaries during the COVID-19 PHE. The evaluation assessed the impact of the Amendment on CHIP enrollment and renewal rates, gaps in coverage, and utilization of health care services, as well as the number of CHIP beneficiaries who were affected by the Amendment and the costs associated with its implementation. The evaluation also considered the experiences of state workers implementing the Amendment, including lessons learned and recommendations for future demonstrations.

Methodology

The evaluation used a mixed-methods approach, combining quantitative CHIP enrollment and claims data with qualitative data from interviews with state workers. Descriptive analyses of quantitative data were used to assess trends over time and changes between a historical comparison period and the demonstration. Simple linear regression was used to test for statistically significant differences in coverage gaps and health care utilization between the demonstration and historical comparison populations.

Evaluators conducted interviews with eight state staff who played various roles in the implementation of the Amendment. Qualitative data analysis software was used to analyze interview data and themes were identified using a deductive coding approach.

Findings

Overall, findings suggest the Amendment impacted CHIP beneficiaries and state agency staff positively. The Amendment allowed Oregon to provide continuous health care coverage to more than 250,000 CHIP beneficiaries who otherwise would have lost coverage during a vulnerable time characterized by a

global pandemic. In addition, results showed that beneficiaries under the Amendment experienced fewer coverage gaps and days without coverage as well as improved continuity of care compared with those in the historical population. The CHIP Amendment was also associated with more frequent utilization of health care services among beneficiaries in the demonstration population, particularly behavioral and preventive health care services.

Findings from qualitative data confirmed the positive effects of the Amendment on CHIP beneficiaries and further detailed the impact on state workers responsible for implementing federal policies. Interviewees described the Amendment's benefits and explained the potentially disastrous consequences had the Amendment not been possible. Interviewees were clear: not only would the state have had to "kick children off of health care coverage during a public health emergency" (Interview participant), but it would have also required a significant shift in state operations, affecting systems and staff at a time when they were adjusting to a remote working environment in a global pandemic.

Lessons learned and recommendations

The results of the evaluation support several recommendations, including the extension of continuous healthcare coverage, improving communications to staff and the public, ensuring contingency plans are detailed and in place for future emergencies, and fostering a collaborative workplace that encourages teamwork.

Background

In an effort to assist states in responding to the COVID-19 Public Health Emergency (PHE), the Centers for Medicare and Medicaid (CMS) developed a new section 1115(a) demonstration opportunity under Title XIX of the Social Security Act. States were offered different options and flexibilities under the demonstration opportunity, which was announced by CMS on March 22, 2020 in State Medicaid Director Letter (SMDL) #20-002 and on March 3, 2022 in State Health Official Letter (SHO) #22-001. On May 10, 2023, Oregon responded with a request to amend the Oregon Health Plan section 1115(a) demonstration (Project Number 11-W-00415/21-00013/0). Oregon's request was approved by CMS on August 9, 2023.

The Children's Health Insurance Program (CHIP) amendment (hereafter: "the Amendment") allowed Oregon more flexibility in providing health care coverage to CHIP beneficiaries who became ineligible during the PHE due to a change in circumstances. The Amendment extended continuous coverage with current benefits for individuals determined ineligible for CHIP due to a change in circumstances, and the same health care delivery system for the provision of services in the same manner as under the State's current plan. The Amendment was authorized retroactively beginning March 1, 2020, and applied to CHIP beneficiaries through December 31, 2023, when Oregon's CHIP designation changed from State CHIP (SCHIP) to Medicaid CHIP (MCHIP/Medicaid expansion).

Overall, this demonstration allowed Oregon to provide continuous eligibility to 253,097 CHIP beneficiaries during a vulnerable time characterized by a global pandemic. This represents 87% of all CHIP beneficiaries maintaining CHIP coverage during the evaluation period under the Oregon Health Plan (OHP), Oregon's state Medicaid program.

Evaluation and Implementation Questions

Evaluation questions

This evaluation sought to understand how the Amendment, which provided continuous CHIP eligibility to an otherwise CHIP ineligible population, impacted health care coverage and access during the COVID-19 PHE. Evaluators hypothesized that the continuous eligibility policy minimized beneficiaries' coverage gaps and improved continuity of care, which supported positive health care utilization outcomes during the PHE. Evaluators addressed these hypotheses and assessed the impact of the Amendment via the following evaluation questions.

Evaluation question 1: What impact did the continuous eligibility Amendment, authorized by the COVID-19 PHE, have on CHIP enrollment and renewal rates between March 1, 2020, and December 31, 2023?

- Evaluation question 1a: To what extent did beneficiaries experience gaps in coverage during the demonstration? How did these gaps compare to historical gaps in coverage? How did these gaps differ among subgroups of interest?
- Evaluation question 1b: How many beneficiaries were impacted by the Amendment? Did the number of beneficiaries impacted by the Amendment differ among subgroups of interest?

Evaluation question 2: What impact did the Amendment have on beneficiaries' utilization of health care services?

- Evaluation question 2a: To what extent did beneficiaries utilize health care services during the demonstration? How did this compare to beneficiaries' utilization of health care services historically?
- Evaluation question 2b: Were there differential impacts of the Amendment on the utilization of health care services among subgroups of interest?

Implementation questions

A second aim of the evaluation was to understand how the Amendment was implemented, including processes used, barriers faced, and successes achieved. Evaluators used the following questions to address this second aim.

Implementation question 1: How much did the demonstration Amendment cost?

Implementation question 2: What were the experiences of state officials implementing the Amendment?

- Implementation question 2a: What were the biggest successes and challenges?
- Implementation question 2b: What were the lessons learned for future demonstrations?
- Implementation question 2c: What best practices do state officials recommend for future demonstrations?

Methodology

The evaluation used a mixed-methods approach, combining quantitative CHIP enrollment and claims data with qualitative interview data. The evaluation period covers from the start of the Amendment and subsequent policy change until Oregon's CHIP designation changed from SCHIP to MCHIP, specifically March 1, 2020, through December 31, 2023.

Quantitative evaluation methods

Quantitative analyses drew from enrollment, claims, and demographic data to address evaluation questions 1a, 1b, 2a, and 2b, as well as implementation question 1. These analyses included beneficiaries enrolled in CHIP options covered by the Amendment: SCHIP, From Conception to End of Pregnancy (FCEP), and postpartum. Measures were compared between the demonstration population (members enrolled in any of these CHIP options during the evaluation period) and a historical comparison population of members enrolled in any of these CHIP options during the two-year period that preceded the demonstration (March 1, 2018, through February 29, 2020).

Quantitative data

Evaluators used Medicaid enrollment and claims data from Oregon's ONE Eligibility System and Medicaid Management Information System (MMIS). Demographic data came from Oregon's Race, Ethnicity, Language, and Disability (REALD) data repository, as well as MMIS and the ONE Eligibility System.

These data sources provided information on CHIP members and their enrollments and renewals, gaps in coverage, and health care utilization during the demonstration period and historical comparison period. Demographic data allowed for stratification of the demonstration population by subgroups of interest including age, sex (using the binary classification available in enrollment data), primary race/ethnicity, language used at home, disability, and geographic region of residence.

Costs were defined as Coordinated Care Organization (CCO) capitation payments and Medicaid fee-for-service (FFS) claims payments. Demonstration costs per member per month (PMPM) include these payments for CHIP members who would have lost coverage without the Amendment, for any periods during the demonstration when they had CHIP coverage.

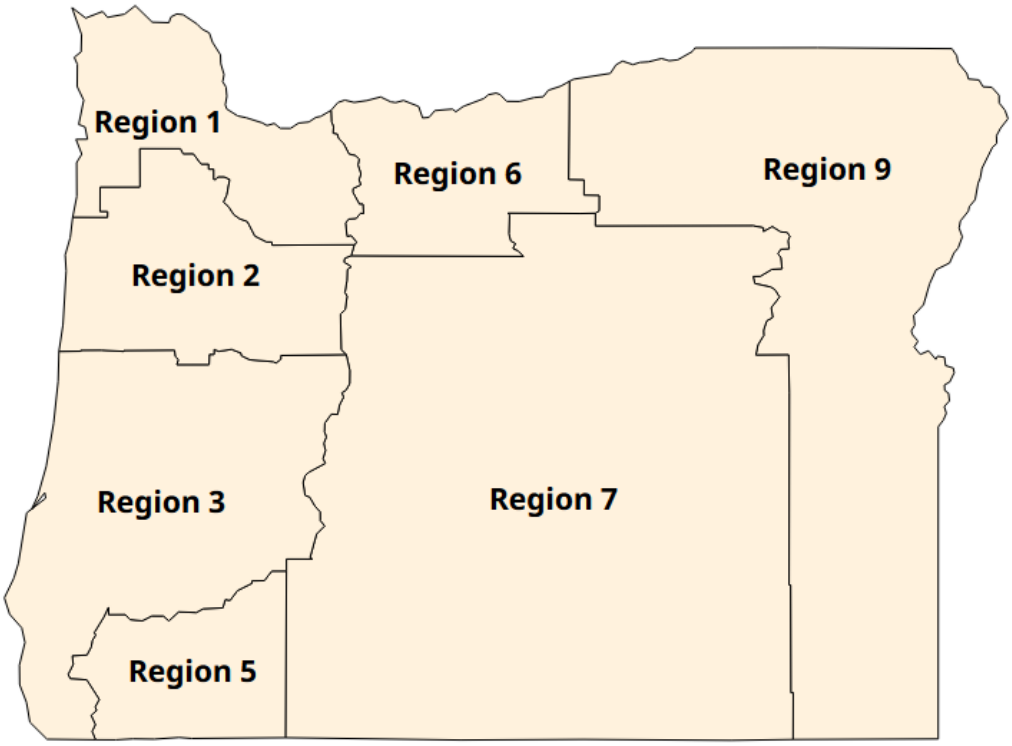
Quantitative analytic methods

Descriptive analyses were used to assess trends over time and changes between the historical comparison period and the demonstration. To address evaluation questions 1a and 2a, simple linear regression was used to test for statistically significant differences in coverage gaps and health care utilization between the demonstration and historical comparison populations.

Gaps in coverage and days without coverage among CHIP members during the demonstration and historical period are reported as percentages of gaps or percentages of days without coverage among all Medicaid members during the same period. Because coverage gaps lasting less than 30 days are likely to appear in enrollment data due to artificial reasons, rather than reflecting actual procedural gaps, analyses focused on gaps of 30 days or more.

To assess geographic trends, evaluators mapped results by member residence using Oregon's health care preparedness regions. The state is divided into regions for purposes of emergency response, allowing for unique health care approaches that are flexible, scalable, and sensitive to the diverse needs of local communities. A map of these regions is shown in Figure 1.

Figure 1: Map of Oregon's health care preparedness regions



Oregon is organized into seven regions for health care preparedness purposes:

- Region 1 surrounds the Portland metro area
- Region 2 includes the central Willamette Valley

- Region 3 is the southern Willamette Valley — plus Coos and Curry counties
- Region 5 comprises Jackson and Josephine counties
- Region 6 includes the central Columbia River Gorge
- Region 7 is central-southern Oregon
- Region 9 includes the eastern Gorge and eastern Oregon bordering Idaho

Regions 4 and 8 are located in southern Washington state and are not included in Oregon data.

Qualitative evaluation methods

Qualitative data was collected via interviews with Oregon Health Authority (OHA), Oregon's state Medicaid agency, and partnering agency staff involved in the implementation and administration of the Amendment.

Qualitative data

Evaluators conducted interviews with OHA and partnering agency staff. Interviews were conducted over Microsoft Teams, lasted between 45 – 60 minutes, and followed a set of guiding questions. Participants were asked about their role during the implementation of the Amendment, challenges faced, successes achieved, lessons learned, and recommendations for best practices in the future. Interviews were recorded and transcribed.

Evaluators collaborated with current Medicaid eligibility staff to develop a list of ten potential interview participants. The list included staff involved in the development and implementation of the Amendment. Evaluators recruited interview participants via email using pre-written scripts that explained the purpose of the evaluation and included a draft of the interview guide for reference. Evaluators contacted potential interview participants up to three times. In total, eight staff agreed to participate and were interviewed. One staff declined an interview due to their lack of involvement in the Amendment, and the other staff member did not respond to email invitations.

Qualitative analytic methods

Interview transcripts were reviewed against their recordings and cleaned by a member of the evaluation team prior to analysis to ensure qualitative data validity. Evaluators used NVivo Qualitative Data Analysis Version 15 software to analyze the interview data and identify themes. Interview transcripts were double coded by evaluators using a deductive coding approach; the coding

framework was based on the CMS approved evaluation and implementation questions.

Interview participants

All interview participants were employed by either OHA or Oregon Department of Human Services (ODHS) during the Amendment demonstration and at the time of their interview. Participants reported being employed by the State for as little as six years to as many as 28 years. Interview participants' roles during the demonstration included eligibility policy analyst, business analyst, and public benefit specialist (Table 1). While some interview participants had assumed new positions and titles since the COVID-19 PHE, all interview participants continued to work in similar eligibility and Medicaid policy related areas.

In general, interview participants' job responsibilities during the demonstration included interpreting and implementing federal policies, developing eligibility system updates, and drafting communication materials regarding system and eligibility updates. Two interview participants helped draft the CHIP Amendment waiver proposal; seven helped implement the waiver once it was approved by CMS.

Table 1: Interview Participants' Roles During the Demonstration

Participant number	Role
1	Integrated Eligibility, Policy Analyst
2	Medicaid Plan, Senior Analyst
3	Integrated Eligibility, Senior Policy Analyst
4	Eligibility Partnership Business Information, Senior Business Analyst
5	Eligibility Partnership Business Information, Senior Correspondence Analyst
6	Oregon Eligibility Partnership, Public Benefits Specialist
7	Oregon Eligibility Partnership, Policy Analyst
8	Integrated Eligibility, Policy Analyst

Findings

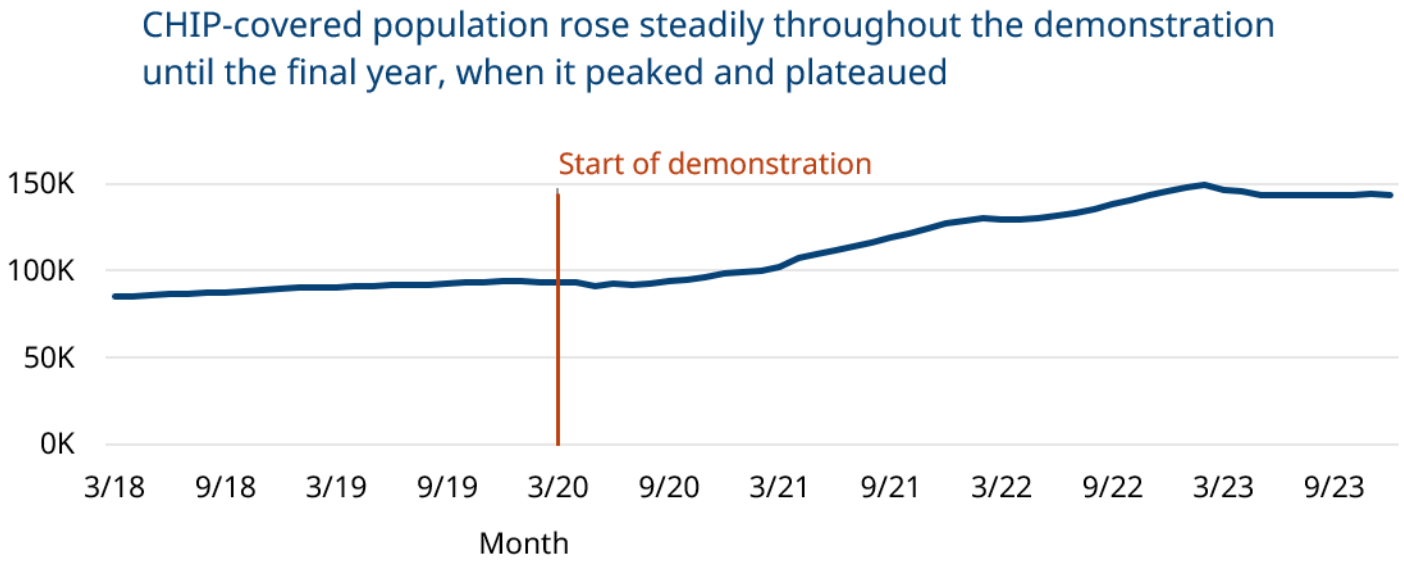
Evaluation questions

This evaluation sought to understand how the Amendment, which provided continuous CHIP eligibility to an otherwise CHIP ineligible population, impacted health care coverage and access during the COVID-19 PHE.

Evaluation question 1: The Amendment's impact on enrollment and renewal rates

The number of beneficiaries who had CHIP coverage during each month of the Amendment demonstration and historical comparison period is shown in Figure 2. The historical period saw modest increases in the CHIP-covered population, from a low of 85,513 to a high of 93,903 members. The number of CHIP members climbed more rapidly during the demonstration, to a peak of 149,170 beneficiaries in February 2023. Following this peak, the number of members dropped slightly and plateaued for the remainder of the demonstration.

Figure 2: CHIP beneficiaries during the demonstration and historical comparison period, by month



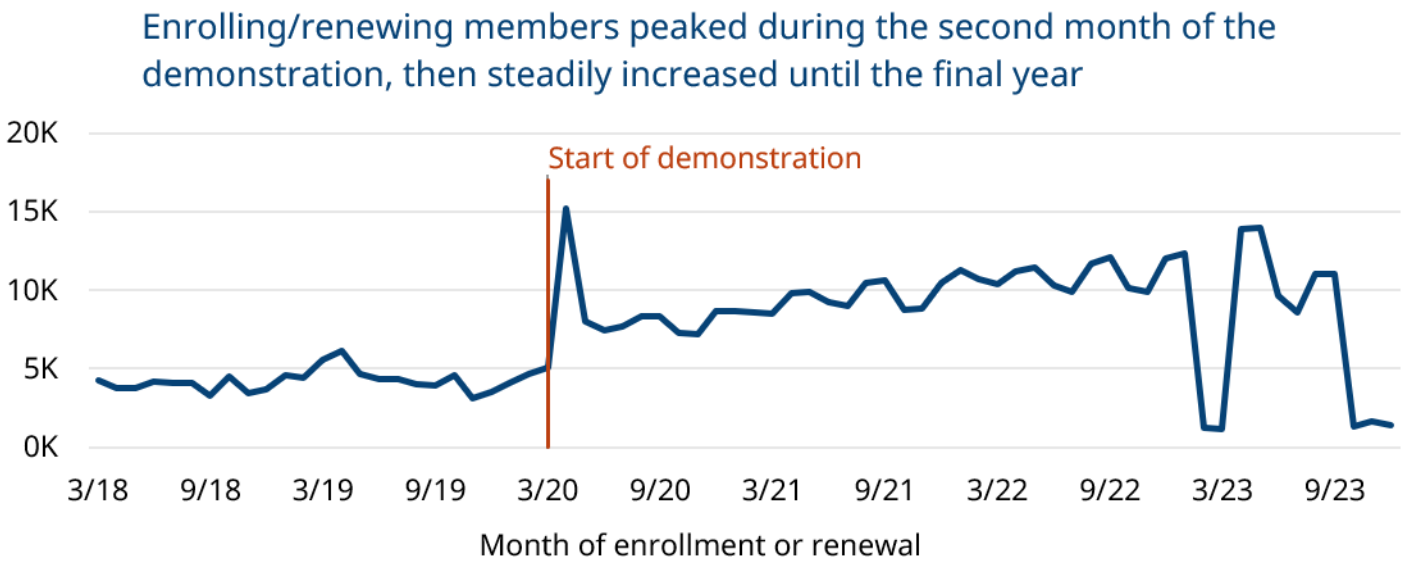
Overall, 290,905 members had CHIP coverage at some point during the demonstration (compared with 175,996 during the historical period).

CHIP enrollments and renewals

Figure 3 shows the enrollments and renewals that drove the changes in the CHIP-covered population. The number of enrolling/renewing members rapidly

peaked at over 15,000 during the second month of the demonstration, after which it settled into a fairly steady rise throughout most of the demonstration. In February and March 2023, enrolling/renewing members dropped precipitously due to the start of the unwinding period, as children (including those in the CHIP-covered population) were some of the first to have their eligibility redetermined. The number of enrolling/renewing members peaked again to 13,949 in the second quarter of 2023 and fluctuated through the end of the demonstration.

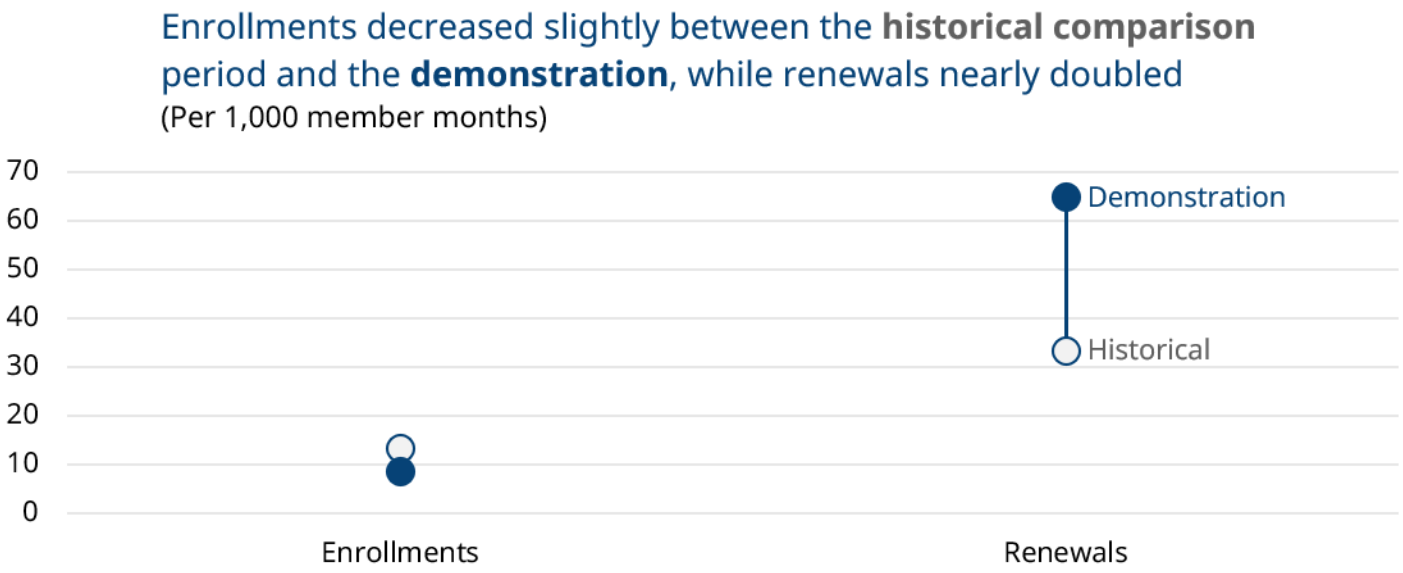
Figure 3: Number of beneficiaries who enrolled in or renewed their CHIP coverage during the demonstration or historical comparison period, by month



A total of 201,873 members (69.3% of all CHIP members) enrolled or renewed their CHIP coverage during the demonstration. By comparison, 78,645 members (44.7%) enrolled or renewed during the historical period.

To more directly compare the demonstration and historical period, Figure 4 presents CHIP enrollments and renewals individually and normalized per 1,000 member months (mm). Enrollments decreased from 13.4 to 8.6 per 1,000 mm between the historical period and demonstration. Renewals, conversely, nearly doubled from 33.4 to 65.0 per 1,000 mm. These trends suggest fewer coverage gaps and improved continuity of care for CHIP members during the demonstration; this finding is further supported in the subsequent section on gaps in coverage.

Figure 4: CHIP enrollments and renewals during the demonstration and historical comparison period per 1,000 member months



The number of enrollments and renewals per 1,000 mm during the demonstration period was also disaggregated by subgroup of interest. Most groups did not vary substantially from the overall rate of 73.6 enrollments/renewals per 1,000 mm. Notable but predictable exceptions include members under 1 year of age, who enrolled at much higher rates, and members who were aging out of the program and therefore did not tend to enroll or renew. Members who selected "Other" for language used at home (excluding sign language) had 45.5 enrollments/renewals per 1,000 mm, a much lower rate than any other language group. Other subgroups with the lowest rates of enrollments/renewals were Hispanic or Latino/a/x/e members, members with hearing disabilities, and members living in northwestern and central Oregon. See Appendix for tables and figures with additional details on members' enrollments and renewals by subgroup of interest.

Gaps in coverage

As Figure 5 shows, increasing numbers of beneficiaries in the historical comparison population were experiencing gaps in coverage when the demonstration began, at which point the trend reversed.

Figure 5: Number of CHIP beneficiaries experiencing a gap in coverage (of any length) during the demonstration or historical comparison period, by month

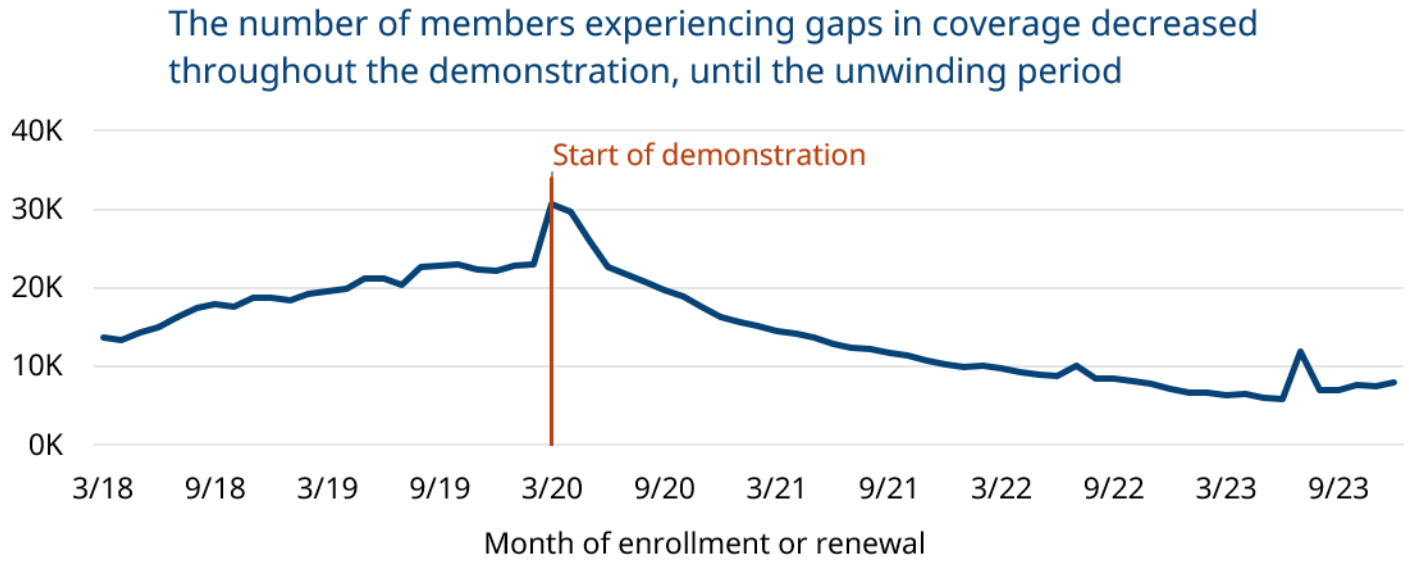


Figure 6: Number of gaps in coverage experienced by CHIP beneficiaries during the demonstration and historical comparison period, by length of gap

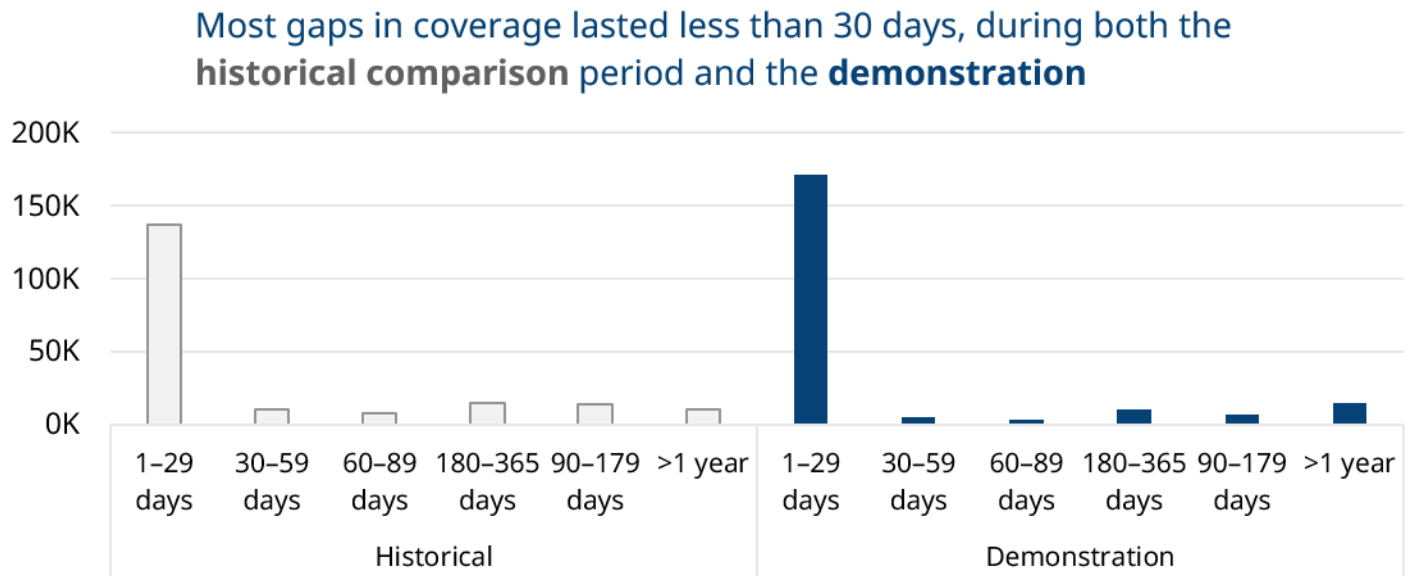
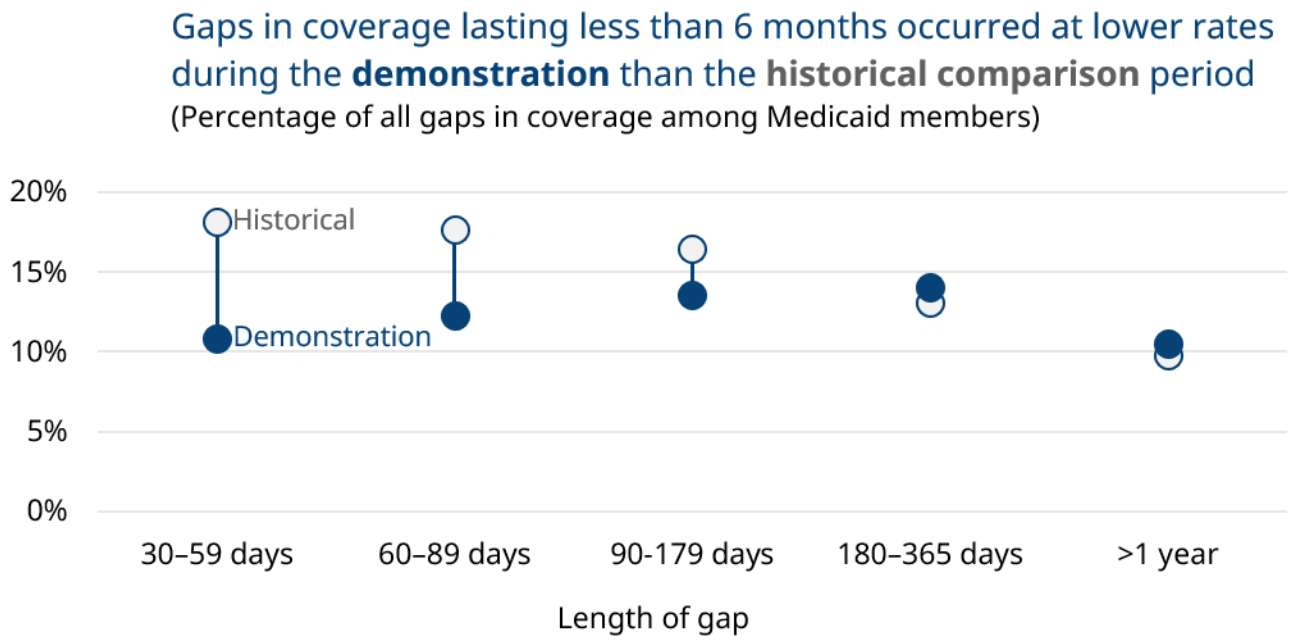


Figure 6 reveals that the majority of these gaps (70.3% during the historical period and 80.7% during the demonstration) lasted under 30 days. Because

gaps in coverage lasting less than 30 days are likely to appear in enrollment data as artifacts and may not represent actual coverage gaps, results after this point include only gaps lasting 30 days or longer. Overall, 29.4% of members in the comparison population experienced a gap of at least 30 days during the historical period.

To facilitate more direct comparison between the demonstration and historical period, Figure 7 displays coverage gaps experienced by CHIP members as a percentage of the number of coverage gaps experienced by all Medicaid members during each period. The proportion of Medicaid gaps experienced by CHIP beneficiaries decreased between the historical period and the demonstration for all gaps shorter than six months. The effect was most pronounced for shorter gaps (decreasing from 18.1% to 10.9% for gaps lasting 30–59 days). The demonstration population experienced a slightly higher proportion of Medicaid gaps lasting six months or longer, as compared to the historical population. However, these gaps may include periods when members did, in fact, have coverage (for example, if they had employer-provided insurance or were living in another state).

Figure 7: Number of gaps in coverage experienced by CHIP beneficiaries during the demonstration and historical comparison period, as a percentage of all Medicaid members' gaps in coverage



For all gaps lasting at least 30 days, Figure 8 shows the percentage of Medicaid members' coverage gaps and the percentage of Medicaid members' days without coverage experienced by CHIP beneficiaries during each period. The proportion of Medicaid coverage gaps experienced by CHIP members decreased from 14.2% during the historical period to 12.0% during the

demonstration. Days without coverage experienced by CHIP beneficiaries (as a percentage of days without coverage experienced by all Medicaid members) decreased from 11.6% to 10.6%.

Figure 8: Number of gaps in coverage and days without coverage experienced by CHIP beneficiaries during the demonstration and historical comparison period, as a percentage of all Medicaid members' gaps/days without coverage



The number of days without coverage CHIP beneficiaries experienced, as a percentage of days without coverage experienced by all Medicaid members during the demonstration, varied by subgroup of interest. The highest proportions of Medicaid members' days without coverage were seen among members age 1–5 years, female members, Native Hawaiian and Pacific Islanders, members who use Spanish and English (plus other languages) at home, individuals with learning disabilities, and residents of northwestern, northern, and eastern Oregon. See Appendix for tables and figures with additional details on members' coverage gaps by subgroup of interest.

Table 2 summarizes results of a simple linear regression that tested for a statistically significant effect of the demonstration on the number of days without coverage experienced by CHIP members (excluding gaps lasting under 30 days). The demonstration was associated with a statistically significant decrease in days without coverage (approximately 14.9 fewer days, on average).

Table 2: Association between days without coverage and demonstration

Term	Estimate	Std. Error	Statistic	P-value
(Intercept)	66.034	0.403	163.753	0.000
Demonstration	-14.868	0.511	-29.103	<0.001

Evaluation question 2: The Amendment's impact on beneficiaries' utilization of health care services

Over the course of the demonstration, 94.7% of all CHIP beneficiaries had at least one claim, an increase from 92.9% during the historical comparison period. Figure 9 shows, for each month during the demonstration and historical comparison period, the number of CHIP members who had at least one claim. This measure remained fairly steady throughout the historical period but rose during the demonstration to a peak of 134,862 members in May 2023.

Figure 9: Number of beneficiaries with at least one claim during the demonstration or historical comparison period, by month

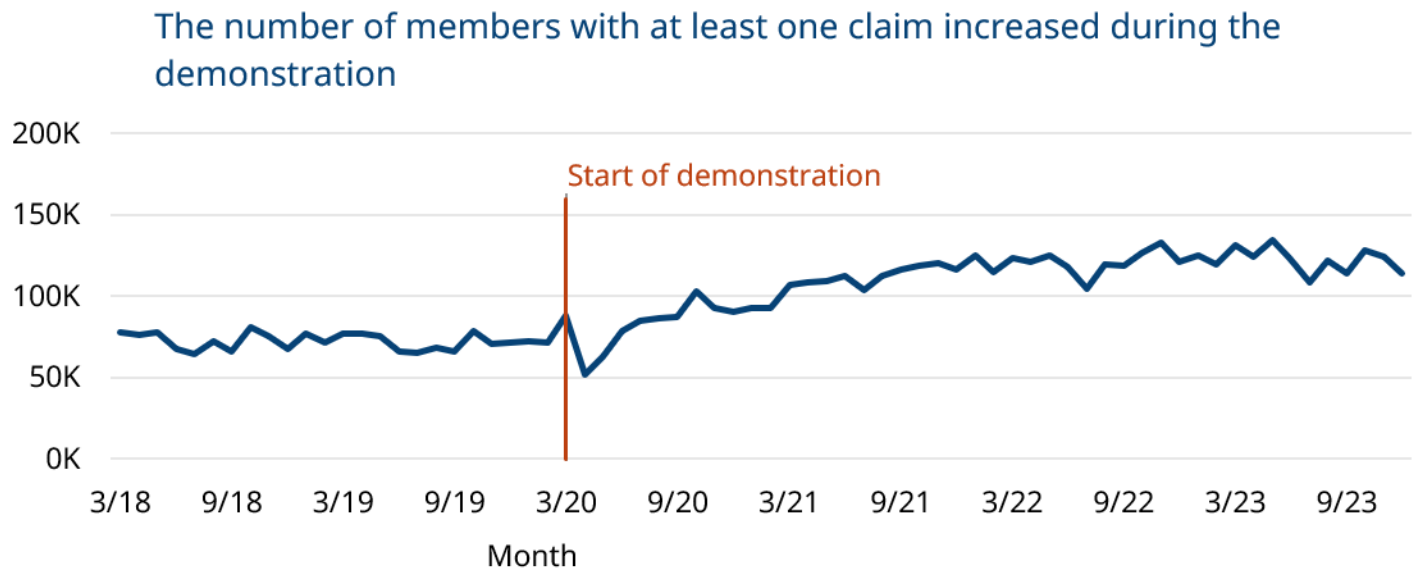


Figure 10 compares the number of claims per 1,000 mm between the historical comparison period and the demonstration, for four types of claims: behavioral health appointments, emergency department visits, inpatient visits, and preventive/routine health care services (defined as dental exams, vision exams, and well-care visits). CHIP members had higher rates of claims in all four categories during the demonstration as compared with the historical period. Behavioral health appointments saw the biggest rise, from 246.7 to 355.9 per 1,000 mm (a 44% increase). Rates for the other claim types also increased, but by far less. Table 3 summarizes utilization among CHIP beneficiaries during the

demonstration and historical comparison period, for each category and for all claims. Comparisons between the historical and demonstration period are challenging due to changes in COVID-19 trends, public health guidance, and health care system capacity throughout the PHE, which likely influenced members' health care utilization.

Figure 10: Number of claims among CHIP beneficiaries during the demonstration and historical comparison period, per 1,000 member months

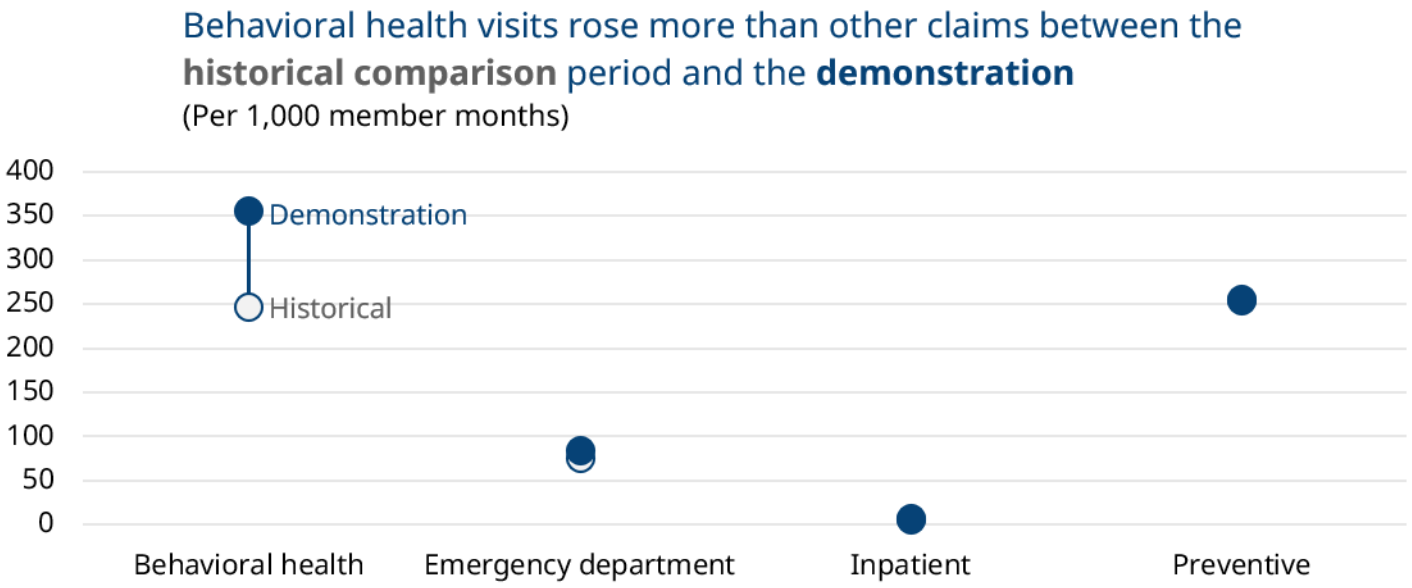


Table 3: Health care utilization among CHIP beneficiaries during the demonstration and historical comparison period

Claim type	Number (%) members with at least one claim: Historical	Number (%) members with at least one claim: Demonstration	Claims per 1,000 member months: Historical	Claims per 1,000 member months: Demonstration
All claims	163,459 (92.9%)	275,569 (94.7%)	1,590.5	1,799.5
Behavioral health	34,272 (19.5%)	82,309 (28.3%)	246.7	355.9
Emergency department	51,172 (29.1%)	118,978 (40.9%)	76.4	84.3

Claim type	Number (%) members with at least one claim: Historical	Number (%) members with at least one claim: Demonstration	Claims per 1,000 member months: Historical	Claims per 1,000 member months: Demonstration
Inpatient	11,916 (6.8%)	35,618 (12.2%)	6.3	7.5
Preventive	142,940 (81.2%)	246,372 (84.7%)	254.2	256.1

The number of claims per 1,000 mm varied by type of claim and subgroup of interest. The lowest health care utilization, for overall claims, was seen among members age 1–5 years, male beneficiaries, members whose race was not listed, members who use Russian and/or Ukrainian at home, non-disabled members, and members living in northern and eastern Oregon.

Substantial variation existed in utilization across different types of claims. Behavioral health visits were the most common claim of the four types studied and contributed to the observed variation between subgroups. Region 9 (in eastern Oregon) had one of the highest utilization rates in the state across each type of claim except for behavioral health visits, for which it had the lowest rate. See Appendix for tables and figures with additional details on members' health care utilization by subgroup of interest.

Table 4 summarizes results of simple linear regressions that tested for statistically significant effects of the demonstration on members' claims per 1,000 member months. The demonstration was associated with a statistically significant increase in utilization for all claims. Specifically, the estimates shown in Table 4 indicate CHIP members covered by the demonstration had significantly more claims per 1,000 member months, on average, than CHIP members in the historical comparison period. The effect of the demonstration on behavioral health utilization was the most prominent, with estimates indicating CHIP members in the demonstration had approximately 564 more behavioral health claims per 1,000 member months than members in the historical comparison period. At the individual level, this means the average CHIP member covered by the demonstration had about 7 more behavioral health claims per year than those in the comparison group (564*12/1,000=6.8).

Table 4: Association between CHIP beneficiary claims and demonstration

Claim Type and Term	Estimate	Std. Error	Statistic	P-value
All claims: (Intercept)	3,117.924	35.720	87.288	0.000
All claims: Demonstration	2,119.728	45.253	46.842	<0.001
Behavioral health: (Intercept)	469.856	16.600	28.305	<0.001
Behavioral health: Demonstration	564.473	21.030	26.841	<0.001
Emergency department: (Intercept)	165.860	2.245	73.865	0.000
Emergency department: Demonstration	112.304	2.845	39.478	<0.001
Inpatient: (Intercept)	18.267	0.331	55.136	0.000
Inpatient: Demonstration	10.180	0.420	24.254	<0.001
Preventive: (Intercept)	473.919	3.191	148.507	0.000
Preventive: Demonstration	228.473	4.043	56.512	<0.001

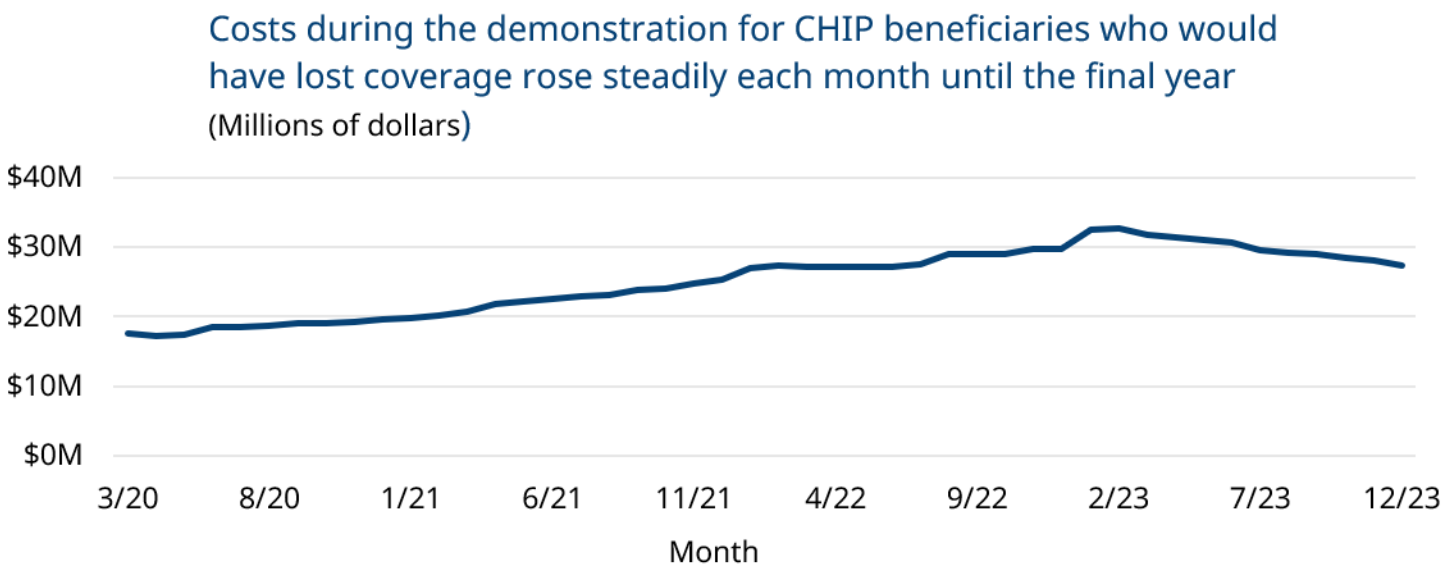
Implementation questions

The implementation questions focused on the implementation of the Amendment, including processes used, barriers faced, and successes achieved.

Implementation question 1: Cost of the Amendment

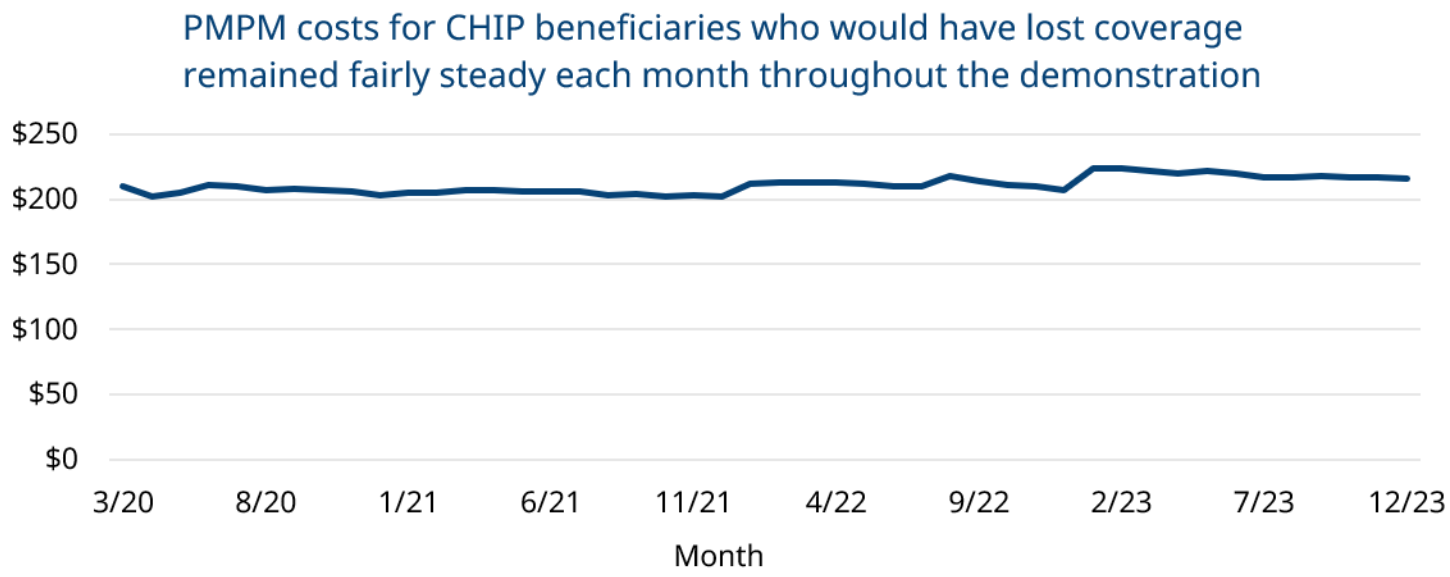
The Amendment provided continuous CHIP coverage to 253,097 members who would have otherwise lost coverage. The total cost of CHIP coverage during these members' covered months during the demonstration was $1,154,220,808.94. Costs include CCO capitation payments and FFS claims payments for CHIP members who would have lost coverage without the Amendment, for any periods during the demonstration when they had CHIP coverage. CHIP members who retained coverage due to the amendment were identified through enrollment data from the ONE system. Figure 11 displays these costs during each month of the demonstration. Rising costs largely mirrored the growth in the CHIP population during the demonstration (shown in Figure 2). Monthly costs peaked at $32,755,462.37 in February 2023, followed by decreases through the unwinding period.

Figure 11: CHIP costs (CCO capitation payments and FFS claims payments) during the demonstration, for beneficiaries who would have lost coverage



CCO capitation payments were $1,098,898,647.92 (or 95.2% of total costs), while FFS payments were $55,322,161.02 (4.8%). This amounted to $211.59 PMPM for these members who would have lost coverage. Figure 12 displays costs PMPM and confirms that increasing costs were driven by the size of the CHIP population, rather than rising per member costs. PMPM costs were fairly steady throughout the demonstration, remaining between $201.90 and $223.44 each month.

Figure 12: CHIP costs (CCO capitation payments and FFS claims payments) per member per month during the demonstration, for beneficiaries who would have lost coverage



Implementation question 2: Experiences of state officials implementing the Amendment

The main objective of the PHE's continuous coverage benefit for CHIP recipients was to reduce member churn and maintain continuity of care during the uncertain times associated with the COVID-19 pandemic. Seven of the interview participants agreed that the continuous coverage benefit reduced churn and increased CHIP members' continuity of care. The remaining interview participant – a business analyst – did not feel comfortable commenting on the CHIP Amendment's impact on health care coverage churn due to their lack of experience in that field.

When talking about churn and gaps in health care coverage, interview participants cited cumbersome renewal-application requirements (n=3) and income fluctuations (n=2) as reasons for why members cycle on and off OHP. Interview participants believed churn was detrimental to both the members themselves and the state's health care system, as churn and the resulting disruptions in continuity of care lead to worse health outcomes (n=2), challenges finding providers (n=2), and more expensive health care costs (n=1).

> "It becomes very difficult to have continuity of care when you are cycling on and off of health coverage…it jeopardizes your health, mental and physical and behavioral, because you don't have that continuity of care. And also for some it makes it more likely that they won't seek care anyway." –Interview Participant

> "Ultimately, it really is more expensive when you have people that are falling off all the time as opposed to continuous coverage where they're getting the preventative care and not having the unmet need and so over time it should be less expensive." –Interview Participant

Developing the waiver

Interview participants explained that Oregon needed to apply for a waiver during the COVID-19 PHE due to the state's Medicaid and CHIP program structure. While most states at the time included CHIP in their larger Medicaid program, Oregon, along with a few other states, administered CHIP separately from Medicaid. When the Families First Coronavirus Response Act (FFCRA) and subsequent PHE were first announced, Oregon and the other separate CHIP (SCHIP) states assumed the continuous eligibility requirement applied to both Medicaid and CHIP members. Once state officials realized the FFCRA policy did not cover CHIP members, impacted states immediately began working with CMS to draft waiver proposals and ensure continuous eligibility was extended to CHIP recipients.

> "CMS was pretty actively involved with states on those kind of things, particularly once it was pointed out numerous times about our particular program and how it didn't make sense not to include CHIP with Medicaid…because how, as a policy, could you even fathom that this was a fair thing to do is to kick children off of health care coverage during a public health emergency." –Interview Participant

Impact of the waiver

When discussing the impact of the waiver on staff members' job responsibilities, development of the enrollment system, member enrollment, and member communications, evaluators found it was easiest to frame the conversation as a counterfactual. Rather than ask interview participants about the impact the waiver had on the aforementioned categories, evaluators asked what *would* have happened if the continuous coverage policy had *not* been extended to CHIP recipients, i.e., if the waiver had not been offered and the Amendment not approved.

Evaluators found the counterfactual framing to be more prudent for two reasons. First, the state had initially included CHIP recipients in the implementation of the COVID-19 PHE continuous eligibility provision. If the Amendment had not been approved the state would have had to retroactively remove the continuous eligibility protection from CHIP recipients, and they would have lost their continuous coverage. Evaluators were keen to understand how this would have impacted CHIP recipients during the PHE as well as the effect this action would have had on OHA staff and the enrollment system.

Second, unlike many other SCHIP states who operate their CHIP programs separate from Medicaid (and in some cases via different agencies), Oregon historically operated its SCHIP and Medicaid programs seamlessly under the Oregon Health Plan (OHP). This meant that, for members and their families, the application and enrollment process simply involved providing information and receiving a determination of eligibility for medical benefits (i.e., OHP). Specifics about which benefit program (i.e., CHIP or Medicaid) covered which family member were only viewable by agency staff on the back end. This approach ensured a user-friendly member experience and made it easier for members to understand their coverage. If the CHIP Amendment had not been approved and the continuous eligibility provision had only applied to those covered by Medicaid and not CHIP, Oregon's seamless operation of OHP and members' experiences would have been compromised. Framing the conversation about the impact of the Amendment as a counterfactual allowed evaluators to more fully understand how significant such a change would have been.

Staff job responsibilities and enrollment system changes

In general, interview participants indicated that the implementation of the Amendment did not have a dramatic impact on their job responsibilities. Because the Amendment allowed them to continue with the system changes they had already been developing to accommodate for the PHE and continuous eligibility across all Medicaid and CHIP members, their daily tasks remained the same. Many respondents noted that their job priorities shifted because of the pandemic but explained these shifts would have occurred regardless of the approval of the CHIP waiver.

All the respondents emphasized the eligibility system-related difficulties and problems that would have arisen if the Amendment had not been approved (n=8). They explained that without Amendment approval, eligibility analysts would not only have had to undo many of the systems changes they had developed in response to the PHE, but they would have also had to develop new processes to parse out CHIP members from Medicaid members. Moreover, one respondent noted that it was unlikely staff would have been able to roll back the continuous eligibility-related system changes that had just been implemented in order to exclude CHIP members in a timely fashion, and thus the state would have been at risk for non-compliance with CMS regulations.

> "If that was the case then that would be really burdensome to make sure in the system we could pull CHIP out separately from all the other types of assistance, and then update the logic and retrain all of that information, and communicate with Oregonians. That would be very difficult." –Interview participant

Member enrollment and communications

All interview participants noted that enrollment processes and member communications would have been complicated if the Amendment had not been approved (n=8). When discussing how the state would have communicated the distinction between Medicaid and CHIP members and the provision of continuous eligibility protections, the varying enrollment requirements, and the need to rollback benefits during the PHE, interview participants used terms like difficult (n=4), messy (n=3), disaster (n=1), and confusing (n=1).

> "It would have been kind of a mess if we…had to have come back and said, "actually you're not eligible because these new provisions didn't actually apply to you." That would have been really complicated to tell people in a way that would make sense at a 6th grade reading level, which our correspondences are legally required to do, and do so in plain language." –Interview participant

Some interview participants were particularly concerned with the optics of providing continuous eligibility to adults and some children but not all children (n=3). One of these respondents indicated it is likely the state would have used general funds to ensure continuous coverage to all children, regardless of CHIP versus Medicaid status, however the process of allocating general funds can be lengthy and arduous.

> "In the public perception, understanding that it's all kind of very black and white information, it would have looked as though Oregon was protecting everybody's coverage except for this group of kids." –Interview participant
>
> It just would have been extremely messy and complicated to try to parse out and nuance [between Medicaid and CHIP]…we do tell them what program they're eligible for, but we try to make it more friendly than "Medicaid and CHIP." So it's "Oregon Health Plan." And I think it would have been, there would have been a lot to consider with the communications to all the different things." –Interview participant

Many interview respondents emphasized how confusing the policies would have been for families with multiple children who were eligible for different benefits, for example, a family with a child covered by Medicaid and a child covered by CHIP (n=6). Interview respondents explained that without the Amendment, children in the same household might have experienced differences in coverage eligibility, creating situations where one child maintained their health care coverage and the other lost their health care coverage. Moreover, even in households with all children falling under the same eligibility group, understanding the nuances between Medicaid and CHIP

is difficult and thus communicating the change in coverage would have led to many questions from members.

One of the interview respondents who was more involved with the communications and correspondences aspects of Medicaid and CHIP benefits noted that because the Amendment allowed the state to provide continuous coverage for all Medicaid and CHIP members, communications and correspondences with members did not need to change. The ability to keep correspondence consistent not only avoided public confusion but also minimized the need for additional staff training and communications during an already busy and chaotic time.

Successes

When reflecting on the biggest successes of the Amendment, interview participants highlighted two main topics: 1) maintaining vulnerable Oregonians' continuity of care and health care coverage (n=6), and 2) state officials' ability to work collaboratively as a team to accomplish a common goal (n=4). Interview participants noted that Oregonians experienced *"some of the best [health] insurance rates in the country"* during this period. Moreover, a few interview participants underscored how providing health care coverage to Oregonians during this time improved Oregonians' day-to-day stability and well-being (n=3).

> "We were able to retain coverage. We didn't have disparate treatment when it came to children." –Interview participant
>
> "People got to keep health coverage in an extremely stressful time…[health insurance] was one thing [Oregonians] didn't have to worry about." –Interview participant

Half of the interview participants talked about the state's collaborative approach to the Amendment and commitment to keep Oregonians healthy (n=4). These participants described how despite the many challenges state officials faced during this period, including the public health emergency itself, the shift to remote work, and ensuring continuity of care, "*state officials really stepped up. They made a lot of decisions that were for the good of people*."

Many interview participants explained that immediately preceding the PHE, the state had been rolling out an integrated benefits enrollment system known as the ONE Eligibility System (n=7). They noted that this rollout was a major lift for OHA and ODHS irrespective of the pandemic, and the fact that state officials were able to launch this new system while also addressing the ever-changing health care coverage landscape during the PHE demonstrates the competence and capabilities of state officials at the time.

> "It was such a stressful time and I vividly remember sitting in a room with totally different groups of people with different end goals, and just that partnership went so well. I can't say enough good things about it. It felt really good to be in a room where everybody's focus was supporting Oregonians and how can we make the best, safest choice for the public?" –Interview participant

Moreover, one interview participant speculated that the state's success in juggling all these challenges and ensuring Oregonians had health care coverage boosted the public's understanding and appreciation of OHP.

> "The outreach and protection that Oregon put in place during this emergency created a much more cohesive statewide picture of OHP and think it created awareness of OHP in areas where there might not have been." –Interview participant

Challenges

In addition to successes, interview participants reflected on the challenges associated with the Amendment. Because the Amendment inherently corresponded directly with the COVID-19 pandemic, many interview respondents struggled to disentangle challenges with the pandemic and shelter-in-place orders and the Amendment more specifically. In general, interview participants noted that many of the challenges they experienced during this time-period would have occurred regardless of the Amendment. Interview participants identified four key challenges (Table 5).

Table 5: Interview Participant Identified Challenges

Challenge	n
Eligibility system updates	4
COVID-19 pandemic	3
Federal guidance	2
Communication with the public	2

Eligibility system changes

Half of the interview participants referenced the planned eligibility system updates as a major challenge during the implementation of the Amendment (n=4). Participants explained that prior to the onset of the pandemic, the state had been developing a new eligibility system – known as the ONE Eligibility System – that was set to launch in April 2020. Although the official launch was

delayed until July 2020, managing the roll out of a massive new system while also balancing the fast-paced and high-stress environment created by COVID-19 led to challenges.

> "This was like extra survival mode. It's been a long race that we've been running. We were in the middle of a huge system design. We had an online eligibility system that was just Medicaid/CHIP, and we were upgrading that system to become an integrated eligibility system with all of the other public assistance programs…so it was a very intense period, not just because of COVID." –Interview participant

COVID-19 pandemic

Unsurprisingly, some participants regarded the COVID-19 pandemic itself as a challenge (n=3). Specifically, these participants talked about the difficulties associated with pressing deadlines and time-sensitive tasks while also adjusting to working remotely. Moreover, these participants explained that rules and guidance were constantly changing and it was difficult to keep track of the most up to date information while also adjusting to the new work environment and virtual world.

> "I would say the biggest hurdle was really implementing these policy changes and getting eligibility workers to understand all of the changes while being fully remote." –Interview participant

Federal guidance

Two interview participants cited the delayed receipt of federal guidance and general timeline requirements as a challenge (n=2). Although these participants understood the federal government and CMS were also reacting in real-time to the obstacles brought on by the pandemic, the lack of timely guidance and clarification on rules created unnecessary confusion amongst state workers. Moreover, interview participants explained that the timeline expectations of implementing eligibility changes and the Amendment more specifically were very condensed and expedited.

> "One of the biggest hurdles that we continually bump up against is when clarification is requested from CMS. Usually, we need clarification on a certain eligibility decision point, and functionality can be dependent upon that eligibility decision point and oftentimes we are essentially making decisions on eligibility functionality pending CMS confirmation of the interpretation of the policy." –Interview participant

> "The guidance and flexibility and options offered by CMS, some of it was delayed. Yeah, I think the delayed guidance was not helpful…We just had to do so much so quick." –Interview participant

Communicating with the public

In addition to the various internal challenges discussed by interview participants, two participants who were more involved in public communication aspects of the Amendment and eligibility requirements mentioned challenges with public facing correspondence. These interview participants explained that it was difficult to convey new guidelines and eligibility requirements to the public, when these guidelines were not yet fully understood by state staff. Additionally, although continuous eligibility meant members no longer needed to verify their income for medical benefits, automated communications requesting income verification were still sent out from the integrated eligibility system, leading to a lack of clarity regarding members' benefits status.

> "We would tell people when their eligibility started for a particular program but we did not necessarily communicate the continuous eligibility information…we would still go ahead and send out requests for information such as at renewal when somebody has to say, verify income, we would send them the notice that says "you're due for renewal. You have to verify your income."…And so it made it a little bit confusing, I think, for folks when they saw notices saying that they would have to provide something, and if they did not provide that thing, they would nonetheless receive a notice a little bit later that says they've been approved." –Interview participant

Lastly, the varying eligibility requirements of different social service programs during this time, despite the existence of one application for all services in Oregon, increased confusion. For example, under the PHE and the Amendment, members maintained continuous eligibility for Medicaid and CHIP benefits and were approved for continued coverage even if they did not respond to income verification requests. These provisions were not extended to other benefit programs like SNAP, which did not offer continuous eligibility during the PHE and would terminate if members did not verify their income. As a result, members who were eligible for medical benefits and other programs received multiple notices from the state with seemingly different instructions, requests, and outcomes.

Lessons learned and best practices for future demonstrations

Interview participants reflected on lessons learned and provided suggestions for future demonstrations based on the successes and challenges they had

previously referenced. Specifically, interview participants cited two lessons learned and best practices (Table 6).

Table 6: Interview Participant Identified Lessons Learned and Best Practices

Lessons Learned and Best Practices	n
Communications	4
Implementation plan	3

Communications

Three interview respondents believed there were lessons learned and best practices extracted from the communication aspects of the Amendment's implementation. These participants highlighted the need for all state employees to have a solid understanding of new rules and regulations before communicating with the public. Confusion builds when the public receives mixed messages or conflicting information from different state employees. Having a clear message and talking points can alleviate stress and reduce misunderstandings. These interview participants also emphasized the importance of plain-language and understandable messaging.

> "We need to have experts, like communications, that can help take those really kind of high level non plain language things and make it plain language and understandable to the people who we are trying to share the information with." –Interview participant

Implementation plan

Three interview participants agreed that having a strong project plan and implementation plan structure results in optimal outcomes and processes. While one participant focused on the benefits of having a plan for adaptable work environments and flexibility, another participant underscored the importance of having an accounting plan. This participant explained the importance of having a tracking system for waiver and demonstration related work that can be referenced for future waivers and demonstrations. One interview respondent also commented that having more time to implement the changes would have been useful but acknowledged that this request is unrealistic considering the environment in which the Amendment was being implemented (i.e. a public health emergency).

> "Having this structure in place to be able to adapt our working environments quickly so that we can stay active and respond to emergencies rather than try to respond to our personal emergencies,

> I think that that is a pretty significant lesson that came out of…the management of rapid emergency policies while also managing an emergency." –Interview participant
>
> "Some form of accounting…we need to get that team involved from the beginning so we're not scrambling…be more intentional about what our plan is going to be about, what we're going to document, what we're going to do, and be able to more timely provide the report after we completed the demonstration." –Interview participant

Long term impact

Most interview participants could not speak about the long-term impact the Amendment had on CHIP and OHP more generally (n=6). The two respondents who did comment on long-term impacts explained that the state's experience of the PHE and the Amendment accelerated the decision to move from a CHIP-separate state (SCHIP) to a Medicaid-CHIP combined state (MCHIP).

> "It's also worth pointing out that we were [and now] we are no longer a separate CHIP state. [The PHE] was one of the reasons that prompted that change getting made quickly." –Interview participant

Additionally, although Oregon's continuous eligibility policy under the 2022-2027 1115 Medicaid Waiver launched shortly after the unwinding of the FFCRA and the Amendment, interview participants involved in the continuous eligibility program (n=3) explained it was not an outcome of the FFCRA and the Amendment. Continuous eligibility for children 0-6 and two-year continuous eligibility for people over six had been in the works for multiple years and was ultimately authorized by the state's 2022-2027 1115 Medicaid Waiver.

Recommendations

Based on quantitative analyses of enrollment rates, renewal rates, utilization of health care services, and cost of the Amendment, as well as the extensive feedback provided by the eight interview participants, evaluators posit the following recommendations for future waivers and demonstrations.

Recommendation 1: Provide continuous healthcare coverage to reduce churn and increase continuity of care

Analyses of MMIS, ONE System, and REALD data suggest that the demonstration effectively reduced churn and increased CHIP members' continuity of care. Continuous coverage has been shown to increase access to

and usage of necessary healthcare services, as well as improve health outcomes. Moreover, data demonstrate that per-member per-month costs remained steady throughout the Amendment, suggesting that providing continuous coverage does not result in higher healthcare costs. Thus, when drafting OHP and CHIP coverage policies, policy makers should consider the positive impacts associated with continuous coverage.

Recommendation 2: Improve communication channels to provide clear and cohesive messages to staff and public

Across various points in their conversations, interview participants referenced internal and public-facing communications during the PHE and the Amendment period. From an internal perspective, interview participants noted that guidance and rules were in flux and regularly changing, making it difficult to keep track of the most up-to-date information. While this lack of clarity muddled staff's ability to communicate changes to the public, public messaging also suffered from the automated eligibility system status updates and their misleading instructions. For future waivers and demonstrations, leadership should communicate clearly and regularly to the staff, as well as update automated eligibility system notices to remove contradictory language. Moreover, the state should consider the logistical implications of requesting personal information, such as income verification, from benefit program members if that information is not required.

Recommendation 3: Rely on implementation plans and policy tracking systems

Interview participants' comments emphasized the importance of strong implementation plans and processes. Interview participants repeatedly mentioned that the Amendment coincided with the pre-planned roll out of the state's integrated benefit eligibility system known as the ONE Eligibility System. These interview participants noted that the roll out of such a large system during "normal" times would have been challenging and these challenges were exacerbated by the public health emergency. These comments suggest the importance of adaptability so existing projects are not derailed when unexpected events occur and waivers are needed. Moving forward, state officials should continue to develop and rely upon detailed implementation plans and expand existing waiver policy tracking systems to be used in future emergencies.

Recommendation 4: Foster a collaborative workplace that encourages teamwork

Multiple interview respondents applauded state staff's ability to work collaboratively during the public health emergency and cited this collaboration as a key factor in the successful implementation of the demonstration. United under the common goal of improving the health and well-being of Oregonians, state officials found a way to extend continuous eligibility to all Medicaid and CHIP beneficiaries and avoid the potential fallout that may have occurred if some Oregon children lost their coverage. When planning and administering future waivers and demonstrations, state officials should continue to foster a collaborative and cooperative work environment.

Limitations

This evaluation included comprehensive quantitative analyses of enrollment and renewal rates during the Amendment period, utilization of health care services by members impacted by the Amendment, and cost of the Amendment, as well robust feedback from state staff involved in the administration of the Amendment. However, the limitations of these findings must be considered when planning programmatic changes.

- **Demographic Group Size and Data Availability –** Due to the detailed and granular nature of REALD data, some subgroups of interest were small enough to warrant data suppression or warnings about unreliability. Using small groups as denominators can produce exaggerated or otherwise unreliable results. Incomplete data can also affect the reliability of results. Complete demographic information was not available for all members due to missing, unknown, or declined responses, especially for disability and primary race/ethnicity data.
- **Coverage Gap Data –** Gaps represent periods between Medicaid enrollments and may not reflect true gaps in coverage, particularly for very long gaps. For example, members who temporarily switched to employer-provided insurance or moved out of state may be counted as having lengthy gaps in coverage when they may have had health care coverage from a different source.
- **Impact on Health Outcomes is Unknown –** This evaluation sought to understand how the Amendment impacted health care coverage and access during the COVID-19 PHE and was not designed to assess its effects on patient health outcomes. Although results suggest the demonstration was associated with fewer gaps in coverage and higher

utilization of health services, the impact on health outcomes is unknown.

- **COVID-19 PHE Impacts –** Changing policies and circumstances throughout the COVID-19 PHE limit the ability to draw causal inferences regarding the impact of the Amendment, even when comparing against a historical comparison period. For example, trends in health needs and health care utilization may have been partially driven by shifts in COVID-19 trends, public health guidance, and health care system capacity during the PHE.
- **Recall Bias –** Qualitative data collection was limited by interview participants' ability to recollect and describe events and activities from several years ago. However, evaluators found that the eight interview participants were highly engaged and responded in detail to the interview questions despite the passage of time. More than one interview participant thanked the evaluators for the opportunity to talk about their experiences, albeit several years later.
- **Interview Sample Size –** The evaluation design called for 10-15 interviews with key OHA and partnering agency staff involved in the implementation and administration of the benefit, however the evaluation team was only able to identify ten potential interview participants, eight of whom participated in an interview. The participant pool was limited to those who were agency staff at the time of the interviews and employed during the demonstration more than six years ago.
- **Perspectives Represented in Qualitative Data –** The evaluation was designed to assess how the Amendment was implemented via qualitative data collected from interviews with agency staff. Our understanding of processes used, barriers faced, and successes achieved during the demonstration is therefore limited to the perspectives of the eight staff members who agreed to be interviewed. The qualitative findings do not include the direct perspectives of beneficiaries, families, providers, or community partners.

Conclusions

In March 2020, the Families First Coronavirus Response Act (FFCRA) required states to ensure that Medicaid recipients did not lose coverage during the COVID-19 Public Health Emergency. Oregon applied this requirement to all OHP recipients but later learned that the legislation did not cover Oregon's CHIP members, since CHIP was separated from Medicaid. This separation of

programs existed in multiple states, so the federal government offered a waiver allowing states to include CHIP recipients in the continuous coverage provision.

In August 2023, Oregon received approval for the COVID-19 Public Health Emergency CHIP Waiver. The CHIP Waiver was applied retroactively beginning March 1, 2020, to align with the effective date of the FFCRA's continuous coverage provision. It lasted until December 31, 2023, when Oregon folded the CHIP program into Medicaid.

The Amendment provided continuous health care coverage to 253,097 CHIP members who would have otherwise lost coverage during the public health emergency. In total, their CHIP coverage throughout the demonstration cost $1,154,220,808.94. While PMPM spending remained stable, total expenditures may have increased due to more individuals having coverage. Under the Amendment, CHIP renewals more than doubled (from 33.4 to 65.0 renewals per 1,000 mm), and fewer CHIP members experienced gaps in coverage (from 29.4% of CHIP members during the historical period to 13.2% during the demonstration). Health care utilization among CHIP members increased under the Amendment for all categories studied: behavioral health appointments, emergency department visits, inpatient visits, and preventive/routine services.

Conversations with eight state staff involved in the administration of the Amendment revealed that the Amendment was generally considered a success and that the state would likely have faced large obstacles if continuous coverage had not extended to CHIP members. State staff explained that implementation of the Amendment did not impact their workload; instead, staff argued that workload and system changes would have been further complicated if the waiver had not been approved. Staff applauded the Amendment’s ability to provide continuous coverage to all CHIP and Medicaid members during a turbulent public health period and reflected on the negative implications not providing coverage to Oregon children may have had on the state.

Moving forward, state officials should learn from the experiences of the demonstration, strengthen communication lines, rely on detailed project plans, and foster collaborative teams when administering new waivers and demonstrations.

Appendix

Additional tables: Results by subgroup of interest

Table 7: CHIP enrollments or renewals during the demonstration, by demographic subgroup of interest

Demographic category and subgroup	Number of CHIP members who enrolled or renewed	Number of CHIP enrollments or renewals per 1,000 mm
Age: <1 year	5,169	177.6
Age: 1-5 years	64,775	73.8
Age: 6-18 years	147,014	74.2
Age: 19+ years	217	2.2
Sex: Female	99,062	72.4
Sex: Male	102,811	74.8
Primary race/ethnicity: American Indian and Alaska Native	7,173	74.0
Primary race/ethnicity: Asian	9,345	75.9
Primary race/ethnicity: Black/African American	8,702	72.4
Primary race/ethnicity: Hispanic or Latino/a/x/e	54,972	69.3
Primary race/ethnicity: Middle Eastern/North African	1,051	69.9
Primary race/ethnicity: Multiracial	12	69.7
Primary race/ethnicity: Native Hawaiian and Pacific Islander	3,159	74.0
Primary race/ethnicity: Other race not listed	2,686	74.4
Primary race/ethnicity: White	83,557	76.0

Demographic category and subgroup	Number of CHIP members who enrolled or renewed	Number of CHIP enrollments or renewals per 1,000 mm
Primary race/ethnicity: Declined	12,104	78.6
Primary race/ethnicity: Missing	19,106	72.9
Primary race/ethnicity: Unknown	****	49.5
Language: Another language only	1,136	72.3
Language: Arabic (any) only	85	62.8
Language: Chinese (any) only	462	71.7
Language: English + other	2,268	70.1
Language: English only	150,930	75.1
Language: Other (excluding sign language)	78	45.5
Language: Other (including sign language)	32	78.5
Language: Russian and/or Ukrainian only	744	67.0
Language: Somali only	33	66.5
Language: Spanish & English + other	7,981	70.7
Language: Spanish only	20,793	66.4
Language: Vietnamese only	555	71.3
Language: Missing	16,776	72.9
Disability: 2+ disabilities	3,140	72.1
Disability: Cognitive only	3,327	73.7
Disability: Communication only	432	70.4
Disability: Hearing only	1,049	69.8

Demographic category and subgroup	Number of CHIP members who enrolled or renewed	Number of CHIP enrollments or renewals per 1,000 mm
Disability: Independent living/self-care	521	72.7
Disability: Learning only	7,053	72.3
Disability: Mental health only	695	74.9
Disability: Mobility only	146	70.5
Disability: Non-disabled	149,176	72.6
Disability: Vision only	786	72.2
Disability: Declined	1,049	76.0
Disability: Missing	33,310	77.7
Disability: Unknown	1,789	73.6
Region: 1	79,684	74.0
Region: 2	46,454	72.4
Region: 3	26,537	73.8
Region: 5	17,640	73.7
Region: 6	3,433	73.8
Region: 7	18,874	75.3
Region: 9	10,678	71.9
Region: Out of state	***	73.5
Region: Missing	**	83.3

Note: Some members are represented in more than one age category.
*May be statistically unreliable due to small numbers; interpret with caution.
** Indicates number <5.1 (inclusive of 0). Estimate suppressed due to small numbers; statistically unreliable.
*** Value suppressed to prevent backward calculation of other suppressed value(s).
**** Suppressed due to CMS Cell Size Policy. Value is between 1-10.

Table 8: Gaps in coverage experienced by CHIP members during the demonstration (in days and as a percentage of all Medicaid members' days without coverage), by demographic subgroup of interest

Demographic category and subgroup	Days without coverage among by CHIP members	% Medicaid gaps (in days) experienced by CHIP members	% Medicaid members enrolled in CHIP
Age: <1 year	11,782	28.1%	17.0%
Age: 1-5 years	2,446,734	45.1%	47.5%
Age: 6-18 years	10,601,639	44.4%	47.0%
Age: 19+ years	1,824,265	1.6%	1.8%
Sex: Female	7,857,599	11.5%	15.2%
Sex: Male	7,026,821	9.7%	16.9%
Primary race/ethnicity: American Indian and Alaska Native	674,680	9.7%	14.1%
Primary race/ethnicity: Asian	736,214	11.9%	15.7%
Primary race/ethnicity: Black/African American	706,590	10.1%	16.2%
Primary race/ethnicity: Hispanic or Latino/a/x/e	3,989,671	13.8%	26.6%
Primary race/ethnicity: Middle Eastern/North African	54,891	7.1%	13.9%
Primary race/ethnicity: Multiracial	2,359	10.8%	14.6%
Primary race/ethnicity: Native Hawaiian and Pacific Islander	327,136	15.0%	19.7%

Demographic category and subgroup	Days without coverage among by CHIP members	% Medicaid gaps (in days) experienced by CHIP members	% Medicaid members enrolled in CHIP
Primary race/ethnicity: Other race not listed	132,657	11.1%	18.2%
Primary race/ethnicity: White	6,801,804	9.0%	12.5%
Primary race/ethnicity: Declined	936,542	13.6%	16.5%
Primary race/ethnicity: Missing	521,193	11.1%	16.3%
Primary race/ethnicity: Unknown	683	6.5%	11.4%
Language: Another language only	42,820	11.4%	14.3%
Language: Arabic (any) only	3,228	9.3%	10.9%
Language: Chinese (any) only	21,479	8.2%	11.7%
Language: English + other	175,265	8.8%	15.5%
Language: English only	12,287,960	10.2%	14.0%
Language: Other (excluding sign language)	10,776	13.9%	9.1%
Language: Other (including sign language)	612	1.4%	6.2%
Language: Russian and/or Ukrainian only	14,286	5.4%	12.5%
Language: Somali only	430	1.3%	7.5%
Language: Spanish & English + other	808,923	15.1%	28.0%
Language: Spanish only	1,296,665	11.8%	30.1%
Language: Vietnamese only	30,974	9.6%	13.1%
Language: Missing	191,002	25.8%	26.7%

Demographic category and subgroup	Days without coverage among by CHIP members	% Medicaid gaps (in days) experienced by CHIP members	% Medicaid members enrolled in CHIP
Disability: 2+ disabilities	316,673	5.4%	8.7%
Disability: Cognitive only	346,051	8.8%	12.8%
Disability: Communication only	35,708	13.3%	24.7%
Disability: Hearing only	46,145	4.0%	6.8%
Disability: Independent living/self-care	604,364	2.9%	3.2%
Disability: Learning only	61,208	15.3%	22.7%
Disability: Mental health only	59,772	5.3%	7.9%
Disability: Mobility only	15,930	0.7%	1.0%
Disability: Non-disabled	11,668,607	12.6%	21.1%
Disability: Vision only	93,733	6.4%	9.3%
Disability: Declined	46,311	7.8%	16.1%
Disability: Missing	1,494,407	15.9%	17.3%
Disability: Unknown	95,511	14.9%	20.9%
Region: 1	5,837,500	10.5%	15.4%
Region: 2	3,326,344	11.9%	18.7%
Region: 3	1,939,322	9.4%	13.6%
Region: 5	1,175,259	9.4%	15.0%
Region: 6	258,446	11.7%	18.9%
Region: 7	1,347,269	10.7%	16.5%
Region: 9	889,918	11.8%	17.6%

Demographic category and subgroup	Days without coverage among by CHIP members	% Medicaid gaps (in days) experienced by CHIP members	% Medicaid members enrolled in CHIP
Region: Out of state	110,362	8.0%	10.7%

Note: Some members are represented in more than one age category.

Table 9: CHIP members with at least one claim during the demonstration (and claims per 1,000 member months), by demographic subgroup of interest

Demographic category and subgroup	All claims	BH	ED	Inpatient	Preventive
Age: <1 year	7,446 (4,233.2)	192 (17.0)	3,366 (338.4)	5,361 (154.1)	6,960 (1,120.8)
Age: 1-5 years	65,658 (1,442.8)	12,931 (147.7)	35,643 (108.7)	16,914 (13.1)	62,496 (302.3)
Age: 6-18 years	173,530 (1,609.3)	60,127 (392.7)	66,409 (59.3)	4,395 (1.5)	158,504 (223.4)
Age: 19+ years	28,935 (13,908.2)	9,059 (2,094.8)	13,560 (640.6)	8,948 (110.9)	18,412 (557.9)
Sex: Female	140,852 (1,943.9)	41,663 (363.0)	60,659 (89.0)	21,976 (9.3)	124,439 (259.8)
Sex: Male	134,717 (1,656.2)	40,646 (349.0)	58,319 (79.7)	13,642 (5.8)	121,933 (252.3)
Primary race/ethnicity: American Indian and Alaska Native	10,081 (2,062.4)	3,602 (476.8)	4,970 (106.4)	1,146 (7.6)	8,939 (249.7)
Primary race/ethnicity: Asian	12,029 (1,479.9)	2,645 (244.4)	3,688 (52.7)	1,392 (6.5)	10,637 (237.7)
Primary race/ethnicity: Black/African American	13,111 (2,105.0)	3,714 (396.1)	6,378 (132.0)	1,703 (9.5)	11,709 (285.3)
Primary race/ethnicity: Hispanic or Latino/a/x/e	83,463 (1,853.4)	21,183 (257.1)	39,226 (98.2)	14,181 (10.2)	74,592 (295.8)
Primary race/ethnicity: Middle Eastern/North African	1,628 (2,433.4)	408 (390.5)	715 (118.1)	237 (10.3)	1,427 (310.4)
Primary race/ethnicity: Multiracial	29 (2,675.6)	11* (399.5)	14 (126.0)	**	26 (343.2)

Demographic category and subgroup	All claims	BH	ED	Inpatient	Preventive
Primary race/ethnicity: Native Hawaiian and Pacific Islander	4,486 (1,559.2)	881 (264.7)	1,934 (100.7)	689 (10.9)	3,811 (238.1)
Primary race/ethnicity: Other race not listed	3,433 (1,380.0)	945 (268.1)	1,369 (60.4)	610 (8.3)	3,046 (215.2)
Primary race/ethnicity: White	109,321 (1,943.8)	38,084 (461.7)	46,234 (83.8)	11,915 (6.5)	97,923 (248.2)
Primary race/ethnicity: Declined	14,481 (1,505.9)	4,411 (357.5)	5,381 (60.3)	1,459 (5.3)	12,753 (215.4)
Primary race/ethnicity: Missing	23,493 (1,309.1)	6,419 (256.4)	9,062 (52.5)	2,281 (4.5)	21,496 (206.5)
Primary race/ethnicity: Unknown	14 (2,871.3)	****	****	**	13 (331.7)
Language: Another language only	1,556 (1,444.2)	343 (228.4)	525 (49.8)	118 (3.7)	1,350 (203.4)
Language: Arabic (any) only	152 (3,091.8)	32 (248.6)	78 (164.0)	19 (10.3)	134 (347.7)
Language: Chinese (any) only	624 (1,293.6)	64 (166.3)	159 (43.1)	64 (4.7)	541 (225.0)
Language: English + other	3,503 (1,702.2)	512 (170.3)	1,285 (81.1)	334 (7.2)	3,047 (264.2)
Language: English only	194,047 (1,765.5)	67,855 (419.4)	81,160 (76.0)	9,554 (3.0)	173,280 (226.2)
Language: Other (excluding sign language)	228 (2,713.5)	*** (107.3)	123 (143.2)	103 (39.2)	141 (219.0)
Language: Other (including sign language)	48 (5,112.9)	27 (1,198.3)	19 (144.6)	** (11.0)	41 (362.3)

**** Suppressed due to CMS Cell Size Policy. Value is between 1-10.

Demographic category and subgroup	All claims	BH	ED	Inpatient	Preventive
Language: Russian and/or Ukrainian only	1,119 (1,066.2)	79 (83.4)	355 (51.6)	72 (4.8)	997 (215.5)
Language: Somali only	60 (3,459.2)	** (262.8)	38 (355.0)	** (9.1)	53 (500.0)
Language: Spanish & English + other	11,664 (2,005.5)	3,500 (299.2)	5,557 (108.0)	1,285 (7.2)	10,475 (281.0)
Language: Spanish only	33,683 (1,752.9)	7,149 (182.7)	14,850 (82.6)	5,736 (9.8)	29,122 (276.1)
Language: Vietnamese only	738 (1,181.9)	100 (111.5)	151 (25.7)	59 (3.8)	662 (214.0)
Language: Missing	28,147 (2,294.1)	2,624 (62.6)	14,678 (180.6)	18,263 (57.5)	26,529 (565.0)
Disability: 2+ disabilities	4,668 (5,112.5)	3,533 (2,048.3)	2,611 (169.6)	350 (6.6)	4,206 (305.4)
Disability: Cognitive only	4,748 (4,051.1)	3,417 (1,538.9)	2,468 (129.7)	306 (4.8)	4,184 (252.2)
Disability: Communication only	663 (2,920.7)	417 (1,005.7)	361 (140.4)	49 (5.2)	617 (363.2)
Disability: Hearing only	792 (2,888.5)	316 (463.4)	418 (134.9)	121 (13.5)	709 (312.0)
Disability: Independent living/self-care	10,729 (6,274.1)	7,244 (2,125.5)	5,713 (185.4)	1,434 (15.4)	9,391 (297.2)
Disability: Learning only	1,005 (3,327.1)	617 (1,095.3)	515 (127.4)	47 (3.2)	920 (297.6)
Disability: Mental health only	676 (5,149.6)	539 (2,062.3)	387 (203.1)	77 (10.0)	542 (214.3)
Disability: Mobility only	229 (4,258.2)	99 (491.4)	125 (195.0)	39 (14.1)	197 (242.1)

Demographic category and subgroup	All claims	BH	ED	Inpatient	Preventive
Disability: Non-disabled	210,972 (1,678.5)	55,978 (260.7)	92,839 (89.0)	29,725 (8.4)	189,304 (274.3)
Disability: Vision only	1,220 (2,671.3)	456 (373.2)	609 (124.7)	144 (9.0)	1,082 (326.8)
Disability: Declined	1,258 (1,213.8)	330 (213.1)	491 (60.6)	120 (4.7)	1,094 (194.9)
Disability: Missing	36,330 (1,030.8)	8,843 (185.8)	11,516 (36.5)	2,764 (3.1)	32,073 (174.3)
Disability: Unknown	2,279 (1,383.2)	520 (196.0)	925 (67.6)	442 (10.2)	2,053 (241.7)
Region: 1	105,796 (1,674.7)	29,737 (318.0)	43,910 (84.0)	13,545 (7.4)	93,754 (235.7)
Region: 2	64,015 (1,839.3)	18,768 (346.7)	28,167 (87.4)	8,469 (7.6)	57,633 (274.0)
Region: 3	35,964 (1,965.9)	12,318 (441.3)	15,841 (89.9)	4,421 (7.3)	32,262 (262.3)
Region: 5	23,853 (1,858.1)	7,097 (404.7)	10,126 (83.9)	3,128 (7.5)	21,414 (272.0)
Region: 6	4,613 (1,630.2)	1,418 (301.8)	2,044 (62.6)	571 (6.9)	4,226 (249.2)
Region: 7	24,547 (1,876.7)	8,484 (423.1)	10,613 (68.0)	3,107 (7.1)	22,144 (248.7)
Region: 9	15,463 (1,888.1)	4,169 (272.5)	7,859 (91.4)	2,216 (8.8)	13,838 (289.9)
Region: Out of state	1,318 (6,711.7)	318 (1,407.4)	418 (330.7)	161 (39.2)	1,101 (930.0)

Note: BH = behavioral health; ED = emergency department.
*May be statistically unreliable due to small numbers; interpret with caution.
** Indicates number <5.1 (inclusive of 0). Estimate suppressed due to small numbers; statistically unreliable.
*** Value suppressed to prevent backward calculation of other suppressed value(s).
**** Suppressed due to CMS Cell Size Policy. Value is between 1-10.

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