

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

Note for public comment: Section II Q4 and Section VI are draft responses subject to revision based on ongoing analyses.

**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.*

- 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):

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:

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 period of time and needing to shift from Medicaid Coordinated Care Organizations (CCOs) to qualified health plans in the Marketplace and back in a matter of months is needlessly disruptive.

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.<sup>1</sup>

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 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

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<sup>1</sup> “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>.

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.<sup>2</sup>

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 for this population.<sup>3</sup> 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:

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 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:

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<sup>2</sup> "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>

<sup>3</sup> 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>.

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

5) Include the proposed timeframe for the Demonstration:

This demonstration will begin on the day that the PHE expires. 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 five years.

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.

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

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## **Section II – Demonstration Eligibility**

*This section should include information on the populations that will participate in the Demonstration, including income level.*

- 1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration:

### **Optional State Plan Groups**

<b>Eligibility Group Name</b>	<b>Social Security Act and CFR Citations</b>	<b>Income Level</b>
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 the FPL
Individuals with incomes between 138 - 200% FPL and under age 65 who are AI/AN	1902(a)(10)(A)(ii)(XX), 42 CFR 435.218	138-200% of the FPL

- 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:

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.<sup>4</sup> 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:

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:

**The following is a draft response subject to revision based on ongoing analyses:**

<sup>4</sup> 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.

The State projects that approximately 55,000 people will be covered in the eligibility category created by this amendment. Enrollment in this category will increase over the course of demonstration, with enrollment reaching this projected total approximately 15 months after the expiration of the Public Health Emergency. The estimated total is based on initial estimates of the number of people currently covered in the Oregon Health Plan who would be found to have income in the eligibility range during their first eligibility determination after the PHE expiration. These estimates are based on eligibility system data and will be updated prior to waiver submission.

Estimates of the number of AI/AN enrollees are still being refined. Based on the AI/AN share of statewide enrollment in the ACA-expansion eligibility category, it is likely that approximately 1,000-3,000 of the 55,000 projected enrollees could be AI/AN. The State is in the process of developing a more precise estimate of the number of AI/AN people likely to be determined eligible for this coverage option when the PHE ends.

- 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:

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:

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, or in light of other changes in 2014:

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.*

The benefits provided under the Demonstration do NOT differ from those provided under the Medicaid and/or CHIP State plan.

The cost sharing requirements under the Demonstration do NOT differ from those provided under the Medicaid and/or CHIP State plan.

### **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.*

The delivery system used to provide benefits to Demonstration participants will NOT differ from the Medicaid and/or CHIP State plan:

- 1) 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:

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

- 2) 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:

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

- 3) 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.

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.*

- 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:

Coverage under this demonstration would become effective as of the first day after the PHE ends.

- 2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration:

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:

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.*

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Because individuals covered under this Demonstration could be covered through a Medicaid State Plan Amendment, the State expects that these populations will be treated as “hypothetical” populations for budget neutrality expenditures. As a result, the State will not likely need to prove that federal spending under this waiver would be equal to or less than federal spending in absence of the waiver.

The coverage category under this waiver will be in place after the end of the PHE and until the establishment of a new, permanent Basic Health Program to cover people in the income range targeted by this Demonstration.

The state is still refining its projections of state/federal spending with and without this waiver in place. At a high level, estimated annual spending amounts under the waiver will depend on the specific timing of the end of the federal PHE expiration and the subsequent creation of a Basic Health Program. Currently, the PHE is slated to last until October, 2022. Under this timeline, enrollment in this program would likely begin in February 2023. Additional extensions would delay the State’s implementation of the new eligibility category. The purpose of the Demonstration is to maintain OHP coverage of people identified during the post-PHE redetermination period as having income just above current Medicaid eligibility thresholds. The longer the PHE is extended the longer the State can wait before starting this redetermination process and thus moving people into this eligibility category.

The state is still refining estimates of total spending with and without the waiver.

With the waiver, people will be moved into this coverage category as they are identified during the redetermination process; enrollment will ramp up over time. The State expects to reach “full” enrollment of approximately 55,000 people approximately 15 months after the PHE expires.

Without the waiver, more OHP enrollees would lose OHP coverage during the post-PHE unwinding redetermination process. However, due to fluctuations in income, many of these enrollees could likely return to OHP within a short period of time, which could increase state and federal administrative and other costs associated with people churning in and out of OHP coverage.



## **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.*

- 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.