HB 4035 Report

Unwinding the Federal Public Health Emergency

May 31, 2022

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

This report and other information about the medical assistance redeterminations process is available at www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx.

Information on benefits for individuals can be found at benefits.oregon.gov.

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Executive Summary

When the federal COVID-19 Public Health Emergency (PHE) ends, as expected later this year, hundreds of thousands of Oregonians will be at risk of losing access to health care. A disproportionate number of these people have already experienced health inequities.

The federal Family First Coronavirus Recovery Act provided states an enhanced federal Medicaid match rate of 6.2% and directed that states that accepted the enhanced match rate do not terminate Medicaid members' coverage for the duration of the PHE. Oregon participated and, largely as a result, enrollment in Oregon's Medicaid system – the Oregon Health Plan (OHP) – has risen considerably from about 1 million to about 1.4 million people. Oregon's overall uninsured rate fell from 6.0% to 4.6%, with the largest improvements among priority populations.

When the PHE expires, states will be required to redetermine whether every individual enrolled in Medicaid is eligible. With that, much of the increase in coverage Oregon achieved could be lost. Current estimates are that anywhere from 90,000 to 300,000 members will become ineligible. The PHE is scheduled to expire on July 15, 2022; however, it is likely to be extended until October 15, 2022. States are required to complete the redetermination process within a 14 month window; for operational reason, this means the state will have 9 months to complete work that is normally done over 12 months (that is, annually). Through the redetermination process, Oregon's goal is to ensure as many people as possible retain OHP coverage, and other needed benefits and services, or are transitioned to other affordable health coverage with the least disruption possible.

During the pandemic, Oregon has continued to perform annual redeterminations to keep member contact information and income data as current as possible, but not to determine eligibility. After the PHE expires, regular redetermination processes will restart and members will be disenrolled if they are no longer eligible or fail to respond, per federal requirements.

One key to a successful process will be laying a proper foundation for the work before the expiration of the PHE. That foundation includes planning and implementing operational changes, following a robust communications plan, and working closely with the Community and Partner Work Group.

The Oregon Health Authority (OHA) and Oregon Department of Human Services (ODHS) will use a phased approach for redeterminations for medical benefits based on populations. Populations who are more likely to retain their health coverage should be redetermined early, while those more likely to lose coverage or who are at highest risk if they lose coverage will be redetermined at the end.

Phasing will minimize the risk of disruptions in coverage or care and allow adequate time for outreach to and engagement with members most at risk.

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

- Unknown and shifting timeline for PHE expiration
- Historically high workload and historically inadequate staffing for caseload
- Historically low accuracy of member contact information
- Confusion for members and service providers
- Hard-to-reach populations, due to cultural and linguistic factors and housing insecurity
- Limited agency workforce capacity to perform high volume of renewals
- High volume of tasks to serve current members
- Lengthy call center wait time
- Eligibility workers who lack familiarity with the redeterminations process outside of PHE conditions
- Competing agencies' priorities for programmatic changes to the ONE system
- Unique challenges facing seniors and people with disabilities
- Lack of a state-based health insurance exchange for navigating to marketplace health plans

OHA and ODHS are developing initial mitigation strategies for each known risk – and in many cases, are already implementing those strategies.

The timeline for the redetermination process is organized into three periods, which are applied across policy, operations, communications, external engagement, and coordination with the Community and Partner Work Group. Tentatively assuming the PHE expires on October 15, 2022, those periods are:

- Before PHE expiration: Now to October 15, 2022
- PHE expiration to the beginning of the redetermination period: October 16 to November 1, 2022, with some activities extending before or after
- 14-month redetermination period: November 1, 2022, to January 1, 2024

In HB 4035, the Legislature appropriated to OHA a total of $120 million to support both OHP redeterminations and a Bridge Program. Of the total, $94.4 million is for direct services to support the additional caseload. The remaining $25.6 million will support administration of the program.

The full report and other information about the medical assistance redeterminations process is available at www.oregon.gov/oha/Pages/phe-maintain-coverage.aspx. Information on benefits for individuals can be found at benefits.oregon.gov.

Introduction

When the federal COVID-19 Public Health Emergency (PHE) ends, expected later this year, hundreds of thousands of Oregonians will be at risk of losing access to health care. A disproportionate number of these people have already experienced health inequities.

As guided by the Legislature in HB 4035 (2022), the Oregon Health Authority (OHA), Oregon Department of Human Services (ODHS), and Department of Consumer and Business Services (DCBS) are working to maximize health care coverage as the PHE ends, including maintaining as many eligible individuals as possible on OHP and assisting those who lose eligibility to find other coverage options.

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

> SECTION 2. (3) No later than May 31, 2022, the authority shall submit a report to the interim committees of the Legislative Assembly related to health, the subcommittee of the Joint Interim Committee on Ways and Means related to human services, the President of the Senate, the Speaker of the House of Representatives and the Legislative Fiscal Officer describing:
>
> > (a) The medical assistance program redetermination process;
> >
> > (b) The operational timelines for processing the medical assistance program redeterminations;
> >
> > (c) The risks to successfully implementing the medical assistance program redetermination process; and
> >
> > (d) How the authority will use the authority's appropriations from the Legislative Assembly to complete the redeterminations.

Changes in Medicaid from the Federal COVID-19 Response

In March 2020, at the beginning of the COVID-19 pandemic, Congress passed the Family First Coronavirus Recovery Act (FFCRA). The FFCRA provided states an enhanced federal Medicaid match rate of 6.2% and directed that states that accepted the enhanced match rate do not terminate Medicaid members' coverage for the duration of the PHE. Normally, prior to the FFCRA, members would be disenrolled if an annual redetermination found that their income exceeded the current eligibility threshold (in expansion states, like Oregon, 138% of the Federal Poverty Level) or if they did not respond to requests for information. FFRCA also removed various administrative barriers to enrollment, allowing applicants to attest to most eligibility criteria without providing proof of the reported information and expanding presumptive eligibility; that is, an

individual would be presumed eligible for medical assistance if they applied, rather than needing to prove their eligibility.

In Oregon, Medicaid members receive coverage through the Oregon Health Plan (OHP). During the PHE, in accordance with FFCRA, Oregon has not terminated coverage of members (except in very narrow circumstances identified in FFCRA, such as death, an out-of-state move, or voluntary coverage termination). Oregon has continued to perform annual redeterminations to keep member contact information and income data as current as possible, but not to determine eligibility. The effect is that OHP enrollment has risen considerably, from about 1 million members before the pandemic to about 1.4 million members today (900,000 cases or family groups).

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

Expiration of the Public Health Emergency

Oregon and all other states who participated in FFCRA are now preparing for what the federal Centers for Medicare & Medicaid Services (CMS) refers to as the "PHE unwinding." When the PHE expires, states will again be required to determine whether every member is still eligible. With that, much of the increase in coverage could be lost.

The PHE is currently scheduled to expire on July 15, 2022; however, the expiration date has already been extended multiple times. Each extension of the PHE has lasted for 90 days, and there is generally significant uncertainty as to whether, or for how long, it may be extended again. CMS has indicated to states that they intend to provide at least 60-days advance notice that the PHE will expire. Because no such notice was received by May 15, it is anticipated and very likely that another extension is forthcoming, which could last until October 15. CMS will deliver definitive guidance on or before July 15.

Further extension of the PHE provides several benefits for the redetermination process. Most obviously, it allows more time for Oregon to complete the foundational preparatory work before the actual redeterminations begin. (See Operation Timeline below.) Critically, it allows for a much more in-depth and substantive conversation with the Community and Partner Work Group on how

best to conduct the process. (See Community and Partner Work Group below.) It also means extended coverage and more time to seek alternatives for anyone who likely will be determined not to be eligible.

The Medical Assistance Redetermination Process

The redeterminations conducted during the unwinding of the PHE will be the largest Medicaid redetermination project in the state's history. Financial eligibility for OHP for most populations requires that the member have a reported income of 138% of the federal poverty level (FPL) or less, which for a 1-person household is $17,774 per year. Current estimates are that most OHP members will continue to be eligible for benefits, but anywhere from 90,000 to 300,000 of the current 1.4 million OHP members will become ineligible. Some of the latter may be eligible to enroll in other health plans on the Health Insurance Marketplace. Some will become eligible for Medicare coverage, which generally covers fewer services than OHP. However, many will have no affordable options for health care coverage.

Redeterminations Before the Pandemic

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

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

If passive renewal was not successful, there would be an active renewal, with a state Eligibility Worker directly involved. This could happen because of a technical error while trying to process the passive renewal, such as being unable to use electronic sources to verify information in a timely manner, a case being "in progress," or the individual having an active medical Special Circumstance in the ONE System. In active renewal, a renewal packet was sent to the member 60

days prior to the member's redetermination date. The Eligibility Worker would follow up, and usually an oral interview would be required. If the member provided the information needed to confirm eligibility, their enrollment would be renewed. Again, if the member was requested to provide information demonstrating eligibility and did not respond, they were disenrolled.

Redeterminations During the Pandemic

During the PHE, OHP enrollment was continuous (except in very narrow circumstances identified in FFCRA, such as death, an out-of-state move, or voluntary coverage termination) without the need to re-confirm eligibility. Oregon has continued to perform annual redeterminations to keep member contact information and income data as current as possible, but not to determine eligibility.

Like before, the process started with passive renewal, with the ONE System seeking to confirm the member's information on file against other databases. If passive renewal did not confirm the information, there would be an active renewal, including a renewal packet sent to the member. However, this process would not lead to termination of OHP coverage, even if a member did not respond.

Redeterminations After the Pandemic

When the PHE expires, states will again be required to determine whether each member – all 1.4 million in Oregon – is currently eligible, and to terminate coverage for those whose eligibility cannot be confirmed. Federal guidance requires that states resume the renewal process the month after the date of expiration. It provides a window of 14 months total to complete eligibility redeterminations on all currently enrolled Medicaid members. OHA and ODHS intend to spread out redeterminations across these 14 months.

OHA and ODHS will aim to redetermine eligibility for as many members as possible through passive renewal. This will depend on the ONE System having all the information needed to establish eligibility for various assistance programs or having a valid way to contact members to collect any missing information. In turn, this will require system updates to ensure that information previously verified for other OHA or ODHS assistance programs does not have to be requested again. One of the goals is to minimize the number of coverage terminations for members who remain eligible but merely have not responded to requests for information.

Laying the foundation: One key to the success of the redetermination process will be laying a proper foundation for the work before the expiration of the PHE. The foundation will include planning and implementing policy changes, operational changes, creating and following a communications plan, and working

closely with the Community and Partner Work Group. (See Operational Timeline and Community and Partner Work Group below for more details.)

A phased approach: OHA and ODHS will use a phased approach for redeterminations based on populations. (In contrast, prior to the PHE, the schedule for redeterminations was based simply on the date of each member's original enrollment.) Those populations more likely to retain their health coverage should be redetermined early in the unwind, while those more at risk of losing coverage or who are at the highest risk if they lose coverage will be redetermined at the end of the unwinding period. Phasing redeterminations by population will minimize the risk of disruptions in coverage or care. No additional federal approval is required for this phasing.

The following populations have been identified as possibly at higher risk for losing OHP, at highest health risk if they lose OHP, and/or more likely to experience systemic and oppressive challenges to renewing OHP coverage:

- Pregnant and postpartum people and newborns
- People receiving Long-term Services and Supports
- People residing in Medicaid-funded residential settings
- People receiving Supplemental Security Income (SSI)
- People in the lowest income Medicaid programs
- People receiving or transitioning to Medicare
- People with no permanent address
- Tribal members or those with HNA status
- People eligible for temporary Medicaid program in the 139-200% FPL group (excluding CWM)
- People who require disability verification
- People that have chosen spoken or written language other than English

A detailed renewal timeline based on the phased approach is now being established. Some elements of that timeline will include:

- Beginning of PHE unwind:
    - People who are likely to have passive renewal, such as SSI recipients or people with a recent successful SNAP evaluation
- During Medicare Open Enrollment:

- People who have Medicare and are likely to lose Medicaid
- End of PHE unwinding:
  - People likely to lose eligibility due to income or resources
  - People with the potential need for additional operational support, such as those receiving Long-term Services and Supports or residing in Medicaid-funded residential settings
  - People with the potential need for external supports, such as Refugee, Healthier Oregon Program, unhoused, primary language other than English, and families with mixed immigration status
  - People with chronic health conditions or current health risks

The plan will include flexibility in the ordering of populations even after the unwinding begins to allow for appropriate adjustments if needed.

Bridge Program and Temporary Medical Assistance

As noted above, the phased approach to redeterminations will, among other things, allow more time to connect Oregonians who are determined to not be eligible for OHP with alternative coverage options. HB 4035 establishes two initiatives related to coverage options: the Bridge Program and Temporary Medical Assistance. Work on these, including involvement by the Community and Partner Work Group, is occurring concurrently with work on the redetermination process. Separate reports will be submitted on these initiatives.

Risks to the Redetermination Process

The numbers and potential complications of the redeterminations required during the PHE “unwinding” are unprecedented. Below is a summary of the known risks to successfully implementing the medical assistance program redetermination process, with initial mitigation strategies for each.

Risk: Unknown and Shifting Timeline for PHE Expiration

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

Also, Congress is considering legislation that could affect state options for redeterminations.

In the meantime, OHA must prepare for compliance with the timeframes in current CMS guidance. That guidance still references a July 15, 2022, expiration date. However, as noted above, CMS has indicated to states that they intend to provide at least 60-days advance notice that the PHE will expire. Because no such notice was received by May 15, it is anticipated that another extension is forthcoming, which would last until October 15, 2022

Mitigation strategy: OHA and ODHS are in regular conversation with federal authorities to ensure that Oregon is updated promptly as to the federal plan for ending the PHE. The teams working on these projects are continually adjusting plans to account for shifting timelines. Some of the underlying work can be carried out in the interim. The goal is to complete all tasks that can be completed in advance of the expiration of the PHE, regardless of when that ultimately occurs.

Risk: Historically High Workload and Historically Inadequate Staffing for Caseload

Oregon has seen historic caseload increases since the pandemic began, in Medicaid as well as for SNAP, TANF, and ERDC benefits. Currently almost 1.5 million Oregonians – or about 1/3 of the population of the state – are receiving some sort of ONE program eligibility related to medical, food assistance, cash assistance, or child care. State agencies are needing to process about 70,000 new applications per month, process 130,000 redetermination or SNAP period reviews, and update 100,000 changes noted by individuals per month. This historic caseload has not seen matching staffing provided, with ODHS having the highest staff to case ratio in decades. This is in addition to the need to complete OHP redeterminations within 14 months of the end of the PHE, which means operationally Oregon will need to start and complete all redeterminations across 9 months that would normally spread out across 12 months. Oregon also legislatively increased benefits by expanding TANF benefits, increasing SNAP eligibility, and creating multiple new medical and dental benefits, which is increasing access and caseloads but not with all of the corresponding staffing necessary for this work.

Mitigation strategy: ODHS continues to hire beyond our legislative authority, holding other work and focusing funding on hiring support staff, eligibility workers, leads, and supervisors. OHA and ODHS have contracted with PH Tech to provide additional support for phones and updated contact information. ODHS and OHA have looked at ways to increase operational efficiency in ONE and continue to look at ways to maximize policies to simplify processes for individuals

applying and staff performing this work. With all of this and with increased data from the ONE System that previously was not available, it is clear that additional staffing will be needed. ODHS is working to develop interim workload models to share with the legislature and contracting to develop the first consolidated workload model that is reflective of all programs, including the work within our Virtual Eligibility Center locations (VEC) and our storefront offices, which will inform the legislature on the staffing needs based on caseloads and forecasted changes in caseloads along with current service levels.

Risk: Historically Low Accuracy of Member Contact Information

During the pandemic, OHA and ODHS have noted high rates of returned mail and incorrect contact information relating to OHP members. Inaccurate contact information could lead to members losing coverage due to lack of response even though they remain eligible based on income or other factors. Anticipating the monumental challenge states face in contacting all current Medicaid members, CMS has adjusted its rules to allow for more than one contact attempt within a 12-month period. However, the sensitive nature of updating contact information necessitates time and resource-intensive processes and procedures to protect member privacy and safety. Furthermore, people may have different addresses across the Medicaid system; for example, Coordinated Care Organizations (CCOs) and direct providers may have different addresses than the state has for the same person.

Mitigation strategy: The communication strategy includes encouraging all members to update their contact information prior to the redeterminations starting. Before redeterminations begin, the current 1.4 million OHP members will receive a letter or electronic communication reminding them to update their contact information and instructions how to do so. This will serve as a first pass at identifying out-of-date contact information. If these letters are returned due to incorrect addresses, these members' records will be reviewed to determine if they are associated with a CCO, fee-for-service care coordination entity, or community partner, and information will be sent to that entity as proactive outreach.

Additionally, two processes are being established that will make it easier for members to update their address information with the state:

- New functionality is being added to the ONE System applicant portal that will allow members and community partners to report address changes much more quickly, directly through their applicant dashboard.
- OHA is contracting to support a new process where CCOs can submit address changes on behalf of their members and have those updates reflected in the ONE System and MMIS. This process is based on new

PHE-related authority that allows OHA to accept this information from CCOs.

OHA and ODHS will also explore options to use flexibilities established in HB 4035 to waive limitations on disclosure of member information for the purposes of early outreach and assistance. OHA and ODHS are working with external partners to identify data that may be available to support early outreach and assistance. They will also solicit feedback on similar opportunities from the Community and Partner Work Group. States, including Oregon, and the federal Department of Health and Human Services are also pursuing guidance from the Federal Communications Commission as to whether it is permissible under the Telephone Consumer Protection Act to use text messages and automated pre-recorded telephone calls to individuals' cell phones with reminders to update their contact information, return their renewal forms, and follow up with the Marketplace if their enrollment needs to transition.

Risk: Confusion for Members and Service Providers

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

Mitigation strategy: OHA and ODHS have initiated a Human Centered Design project to update existing notices, based on member and advocate feedback and in partnership with Oregon Department of Justice, to make these notices more readable and informative. A system build to implement these notices in pilot areas has begun, with the first notices sent in May 2022. The pilot involves a consumer survey for feedback and updates prior to statewide implementation. In addition, there must be coordination of messaging to members and providers across agencies and programs, and advance notice to service providers, Tribes, CCOs, fee for service care coordination entities, and district offices of communications that will be going to members.

Risk: Hard-to-Reach Populations, Due to Cultural and Linguistic Factors and Housing Insecurity

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

Mitigation strategy: OHA, ODHS, and partnering agencies will develop strategies for performing outreach to these populations with the Community and Partner Work Group.

Risk: Limited Agency Workforce Capacity to Perform High Volume of Renewals

When member contact information is out-of-date, it increases the level of effort required by state staff to establish eligibility. The scale of culturally and linguistically appropriate outreach now needed is unprecedented, creating substantial state workforce needs within an already strained labor market. Hiring and staffing across all government agencies is a significant challenge right now. Existing staffing shortages exacerbate the challenges associated with increased communication and outreach. These needs will be further intensified by the launch of Healthier Oregon (formerly Cover All People), scheduled for July 1, 2022.

Mitigation strategy: System improvements are in development to allow for maximization of automation and thus minimization of demands on staff. One effort will be to maximize ““passive renewals”” by using as much information as possible to establish eligibility without the need to collect it directly from the member. The use of information previously verified to establish eligibility for other benefits (such as SNAP eligibility) will allow for a greater percentage of passive renewals, as well as avoid the need for a member to provide duplicative information to the agency.

Further, plans are in place to use “reasonable compatibility” when establishing eligibility. This is when electronic sources verify that the member attested income is within 10% of the income that has been verified. This is expected to decrease the time and effort it takes to enroll people in healthcare coverage while also increasing the accuracy of information available through electronic data sources and self-attested information.

Risk: High Volume of Tasks to Serve Current Members

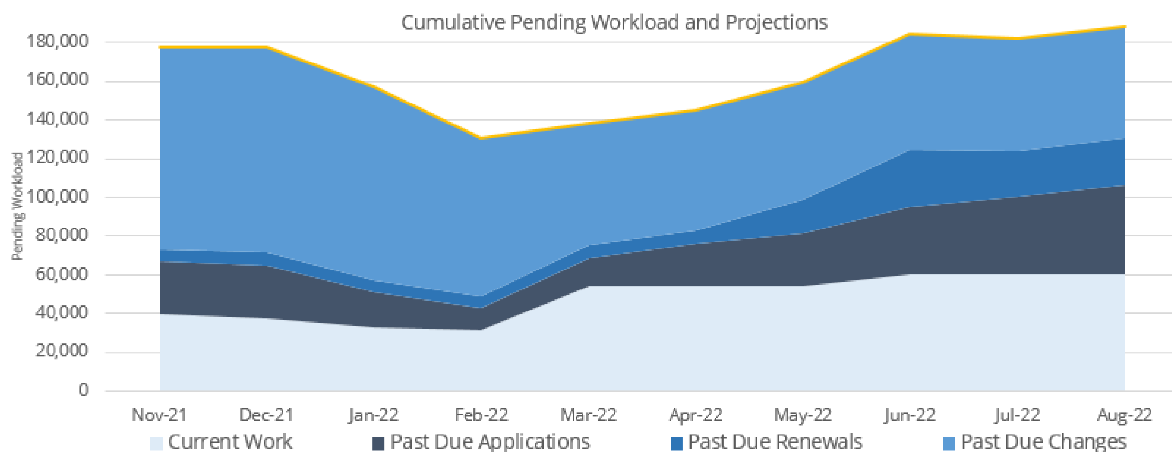
OHP has seen significant growth since the start of the pandemic, adding 321,000 members. There has been limited related staffing increase to serve those

members' existing needs (separate from the staffing needs for the redetermination efforts). The growth in other programs in the ONE System also has been high.

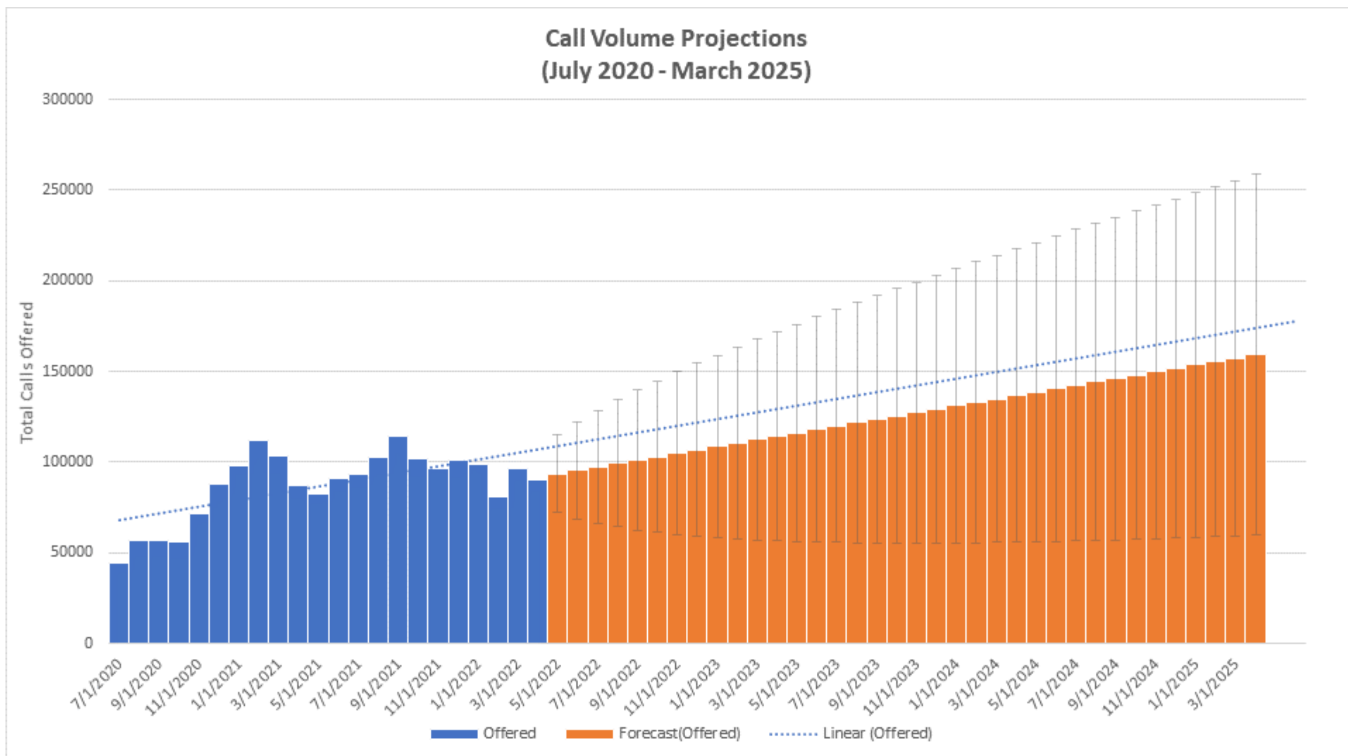
There is an expectation of major impacts on workload and timeliness as Oregon incorporates new programs into the ONE System and begins unwinding the PHE. Projections show the current total pending workload metrics (applications, renewals and changes) and operational metrics (same day/next day service,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

Assuming operational capacity and application demand remain the same, projections show more applications being past due in June/July 2022 than in December 2021.

As workload increases, application processing, call wait times will lengthen



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



Note that the above chart has a forecast (orange) along with upper and lower bounds of those forecasted values, meaning based on forecasting and current call volume trends, there could be increases and variation as much as 100,000 additional calls a month then currently projected. In addition to the forecasts, there is an added trend line.

Mitigation strategy: OHA and ODHS hope to mitigate some of this through plans to balance the workload through system and process changes, by establishing a tiered response plan for supporting people in Oregon based on lessons learned from previous eligibility backlog. The response will include several thresholds and response actions based on considerations such as the volume of new applications, past-due applications, call volume/wait times – all examined over a span of days to indicate potential need for implementing mitigation strategies. These strategies will help mitigate some of the risk, but ODHS is expecting increased call wait times and difficulty processing applications timely while processing this historic caseload and with limited staffing.

This includes a communication plan for people in Oregon and partners, along with operational improvements to reduce worktime such as:

- Shortened “Rights & Responsibilities for All Programs” recording to lessen the time people must spend on the phone.

- Redesigned eligibility notices to people in Oregon to provide clarity and reduce confusion, and thus lessen call volume.

As mentioned above, OHA and ODHS will pursue the use of information previously verified for other benefits, such as SNAP, to establish eligibility to allow for a greater percentage of passive renewals.

Finally, a contract has been executed to help with phone triage, which will allow more availability for government workers to determine eligibility. Contract staff are going into training June 6, 2022 and will be on phones within a week. The contract allows for up to 200 additional contract staff by fall. (See more on the Call Center below.) Also, ODHS is trying to mitigate staffing shortages by continuing to hire above the legislatively authorized amount of ONE staffing, having to make decisions within programs on other work to hold back on or how to utilize budget to cover the costs for this historic workload and demand.

Risk: Existing Call Center Wait Time is a Barrier

CCOs, fee for service care coordination entities, and OHP members rely on the OHP Call Center, which historically has had 2-3 hour wait times. Members struggle to navigate a system that is struggling.

Mitigation strategy: OHA and ODHS have contracted with Performance Health Technology (PH Tech) to provide supplemental customer service for the next two years to help balance the needs of people in Oregon during the unwinding of the PHE, the re-introduction of Oregon Health Plan renewals into ODHS operations, and the continued stabilization of the ONE Customer Service Center. PH Tech will be able to do non-eligibility updates, such as updating contact information, but eligibility work needs to be done by an ODHS.

The contractor's scope of work includes but is not limited to:

- Auxiliary call center support for the ONE Customer Service Center. PH Tech will be the initial level of call triage helping people in Oregon with basic questions, providing access to resources, first stage of application registration, and responding to requests for information based on eligibility determinations from both renewals and new applicants. This will allow the existing ODHS staff to focus on the most complex tasks and calls.
- Outbound campaigns for both OHA and ODHS connected to the PHE unwinding, selected returned mail data collection, and processing updated demographic information.

The timeline of this work is:

- July 1, 2022: Training and deploying a 50-person pilot team for 4 weeks to analyze the training materials and staff resources to further sharpen the courses and tools for the call center staff.
- August 1, 2022 Checkpoint on next hiring phase and desired level of FTE. The desired target of FTE can be adjusted as needed.
- September 1, 2022: Onboarding and training begin for full FTE and is targeted for completion in early in 2023.
- December 31, 2023: Contract expires.

Risk: Eligibility Workers who Lack Familiarity with the Work Outside of PHE Conditions

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

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

Mitigation strategy: Once the end date of the PHE has been determined, ODHS will implement a training plan to provide just-in-time training that reflects the current environment. The trainings are in development.

Risk: Competing Programmatic Changes to the ONE System

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

- The launch of Healthier Oregon in July 2022
- The postpartum eligibility extension that increases the duration of enrollment from two months to twelve months postpartum
- To launch a redesigned eligibility notice, and
- To redesign income verification processes.

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

Mitigation strategy: OHA, ODHS, and the Oregon Early Learning Department have a cross-agency governance structure that approves actions related to changes for the ONE System, evaluating the hours available and change concepts being brought from the agencies with a focus on the outcome for individuals applying and receiving ONE eligibility program benefits in Oregon. This governance body has the primary challenge of balancing the state and federal requirements in an ever-changing landscape.

ODHS and OHA entered into an interagency agreement to assist with funding additional change hours. ODHS is negotiating an update to the system integrator contract for ONE, updating its special procurement, and engaging federal partners for approval of the updates to allow for the greatest flexibility to meet the needs of programs and the State through this shifting environment and historic demand.

Adjusting the schedule for system changes to ONE and/or MMIS will not cause any Oregonians to stop receiving any of the actual services associated with these systems. However, it may affect compliance with federal and/or state regulations which could result in budget implications.

Risk: Unique Challenges Facing Seniors and People with Disabilities

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

Additionally, some individuals who should have enrolled in Medicare when they first became eligible, but delayed enrollment because of the better coverage under OHP, need to enroll in Medicare prior to the PHE ending. If they do not enroll, they will face penalties and wait times to Medicare benefits.

APD has identified the risk to older adults and people with disabilities that are now over income or assets but are currently receiving long term services and supports. These individuals could lose not only their services but, if they are living in licensed care facilities such as an assisted living facility or adult foster home, they could lose their housing as well.

Lastly, there are children who have been eligible based on parental income who are being served through the Office of Developmental Disabilities. If, through redetermination, the family is no longer eligible, the child will need to be determined eligible based on their disability. They could either be determined independently through their SSA determination and MAGI eligibility, or will need to go through the presumptive eligibility determination process (PMDDT) which could take additional time and create a gap in coverage.

Mitigation strategy: Senior Health Insurance Benefits Assistance (SHIBA) joined ODHS Aging & People with Disabilities in 2021. SHIBA provides people in Oregon with access to certified Medicare counselors with answers to questions about Medicare. SHIBA also offers presentations to help Medicare beneficiaries understand the Medicare program. Counselors are available via phone and/or in-person in some areas or virtually.

A collaborative response plan is being put into place in partnership with SHIBA to prepare their counselors and ODHS and OHA staff to support people who will experience Medicaid benefit reductions or terminations but remain eligible for Medicare. The plan will include community partnership outreach about appropriate referrals to SHIBA as well as education for agency staff and community partners. OHA has provided some additional funding. However, it is important to note that without further funds, SHIBA volunteers and staff, currently at less than 200 individuals statewide, will not be able to assist a significant increase in demand.

OHA and ODHS are working to develop a list of individuals who normally would have enrolled in Medicare during the PHE, but instead enrolled in OHP. APD and AAA staff will be reaching out to those individuals to assist in enrolling them in Medicare. Additionally, APD intends to do a specific mailing to these individuals to stress the importance of enrolling prior to October 2022.

For those receiving long term services and supports but are now over income or resources, a list will be developed to allow case managers to contact these consumers early. The goal of this contact is to explain income and asset criteria. For those over asset limitations, the conversation could be as simple as explaining to the individual that they can spend their savings on themselves and do not need to save the funds. For individuals over income, it will be more complicated to determine the best strategy for the individual. A few may be able

to privately pay for services while others will need to transition to other living settings. Choice counseling will be critical for these individuals.

Reports and coordination with ODDS and APD is critical to ensuring that local and county case management services can coordinate with families and help identify individuals who will no longer be eligible so they can determine appropriate next steps or assist with them providing necessary documentation to complete or correct eligibility determinations.

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

The state's ability to facilitate migration of people no longer eligible for OHP to the Marketplace is hindered by Oregon's continued use of the federally facilitated exchange. Because Oregon does not have a state-based marketplace eligibility and enrollment technology, it relies on HealthCare.gov, which presents significant limitations and forces migration to the Marketplace to be a manual process. Once a member's information is sent to HealthCare.gov, state agencies no longer have access to the member's progress and are unable to assist in any communication, enrollment assistance, and outreach to help the member.

Mitigation strategy: For members who are not remaining in Medicaid, the strategy is to conduct extensive outreach and offer manual enrollment assistance over the phone or in person. OHA and ODHS will utilize OHP member claims data to match a member's usage to the networks contracted with private insurers in their residential area to ensure they are able to keep those providers in network with their private carrier. Another aspect of this strategy will be to include private plans that offer the lowest monthly premiums in the member's area, so they can see a range of options.

Operational Timeline

The planning for the PHE unwinding is organized into three periods of activity across operations, communications, external engagement, and coordination with the Community and Partner Work Group. Tentatively assuming the PHE expires on October 15, 2022, the three periods are:

- Before PHE expiration: Now to October 15, 2022
- PHE expiration to the beginning of the redetermination period: October 16 to November 1, 2022, with some activities extending before or after those dates

- The 14-month redetermination period: November 1, 2022, to December 31, 2023

	Period 1 Pre-PHE Expiration	**Period 2** PHE Expiration, Beginning of Redetermination Period	**Period 3** 14-Month Redetermination Period
PHE Key Activities	Medicaid eligibility redeterminations suspended during PHE. HHS will provide notice to states that the PHE will expire 60 days prior to the date of expiration.	Once the PHE expires, states will have 14 months to complete the redetermination process. The 14-month window begins on the month following the expiration.	States must have distributed all renewal notices to members, and completed the review of responses, within 14 months after the PHE expires. Members and recipients are given 60 days to respond to notices before a case is closed.

Operations			
Operations	Planning and implementing operational changes needed to: • Process redeterminations in phased approach • Align SNAP and medical redeterminations • Manage redetermination backlogs during unwinding • Train staff and partners to process medical renewals • Shift members and recipients to "passive renewal" • Provide choice counseling to LTSS consumers • Assist those who have gained Medicare eligibility to enroll while still in Medicaid Begin scoping and designing any system changes that must be in place to implement the temporary medical assistance eligibility category and Bridge Program. Execute contract with supplemental call center to perform early outreach and divert call volume from eligibility workers.	ONE System begins to schedule renewals based on phased approach to populations. Training of staff and partners and implementation of new workflow processes that reflect system changes.	Renewals commence and regular business operations resume. Current status of renewals and regular progress reporting is published to external-facing website. Renewals related to the PHE completed within 14 months.

	Period 1 Pre-PHE Expiration	**Period 2** PHE Expiration, Beginning of Redetermination Period	**Period 3** 14-Month Redetermination Period
	Planning for managing redetermination backlogs during PHE unwinding.		
Communications Strategies	Encourage members to update their contact information so their coverage can be renewed. Establish audience profiles and key messaging. Provide draft communications plan to Community and Partner Work Group for feedback and revision (June). Develop and launch external web sites, internal change management plan, and provider and partner tool kits.	Help people in Oregon prepare for upcoming changes. Communicate with community partners, CCOs, insurers, brokers, navigators, pharmacies and providers so they can help those they serve navigate the changes. Provide CCOs, providers, CBOs, Ombuds program, member services, eligibility staff, and AAAs the tools and information to help OHP members prepare for upcoming changes before communicating with members or launching paid campaigns.	Communicate actions needed for people in Oregon to navigate the changes to retain coverage or secure new coverage. Coordinate with the Marketplace to ensure that members who lose OHP are supported in their transition to a private plan. Coordinate with and promote Bridge Plan as an option for those who do not qualify for OHP and cannot access Marketplace plans.

Community and Partner Work Group	Review initial planning and approach to obtaining and updating contact info, outreach and communication, maximizing awareness and use of navigational assistance, and the use of community-based organizations. Feedback and recommendations provided to OHA and ODHS regarding: • Changes to process and deadlines • Flexibilities for phasing populations once renewals begin • Waiving data sharing restrictions while maintaining consumer protections • Other ways to minimize loss of coverage: automatic renewals, post-eligibility verification Incorporate feedback into planning documents and ongoing operational planning.	Revised plans implemented for outreach and communication with enrollees, providers, community partners and other organizations based on work group feedback.	Maximize awareness and utilization of navigation and assistance. Increase the use of assisters. Partner with CBOs and other contractors for navigation.

	Period 1 Pre-PHE Expiration	**Period 2** PHE Expiration, Beginning of Redetermination Period	**Period 3** 14-Month Redetermination Period
External Engagement	Establish informational needs of external partners and appropriate platforms for information sharing and collaboration. Create escalation paths for issues to be raised as renewals begin and as plans are drafted to incorporate into ongoing planning. Provide draft engagement plans to Community and Partner Work Group for feedback and revision (June). Incorporate recommendations from Community and Partner Work Group into ongoing engagement planning.	Implement revised engagement plans and continue to connect to external partners through established channels.	Continue to coordinate with external partners as issues are identified.

Community and Partner Work Group

As established in HB 4035, the Community and Partner Workgroup (CPWG) advises OHA, ODHS, and DCBS on the development of outreach and enrollment assistance and communications strategies to communicate and assist medical assistance program members in navigating the redetermination process and any transitions to coverage through the health insurance exchange. This work has the dual goals of:

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

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

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

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

Current CPWG members are:

- Natalia Anand, Community member
- Shelia Anders, AllCare CCO
- Gladys Boutwell, HIMAC member
- Thomas Brown, Rise Partnership/SEIU
- Stephanie Castano, Oregon Primary Care Association
- Anji Djubenski, Deschutes County Behavioral Health
- Beth Englander, Oregon Law Center
- Erin Fair Taylor, Pacific Source CCO
- Elizabeth Fox, Providence Health System
- Jake Gariepy, Member
- Lavinia Goto, Medicaid Advisory Committee
- Tara Gray, Community member
- Kalyna Korok, IRCO
- Jackie Leung, Micronesian Islander Community
- Rosetta Minthorn, Tribal representative
- Lourdes Reyna Alcala, GOBHI

OHA recognizes and values the extensive community input that it has previously received through various community forums including those related to the Medicaid Advisory Community (MAC), ODHS Ombuds Program, OHA Ombuds Program, OHA Civil Rights Office, the OHA Community Partner Outreach Program (CPOP) team monthly meetings, the state health improvement plan, and the 1115 Waiver process. OHA will compile, categorize, and incorporate previous input to inform initial redetermination plans and strategies related to the redetermination work. These outputs will then be used to engage the CPWG for advice and recommendations.

Additionally, OHA will continue to engage the MAC and CPOP monthly enrollment workgroup for further input, as well as seek ways to solicit input from all the CPWG applicants even if they are not appointed to the CPWG.

The CPWG will have a public facing webpage that includes:

- Charter
- Meeting notes

- PowerPoints and presentations made to the group
- Documents and background information shared with the CPWG
- Membership roster
- Point of contact for providing feedback on posted content

The first meeting of the CPWG occurred May 26, 2022. Recommendations from the work group will be incorporated into operational planning and future updates to the legislature.

The likely extension of the PHE emergency to October 2022 allows for a much more in-depth and substantive conversation with the Community and Partner Work Group on how best to conduct the process, prior to beginning implementation, than would have been possible if the PHE expired in July 2022.

The current schedule of CPWG activities is:

May	June	July	Later
Recruitment, selection, and onboarding. Kickoff meeting on May 26.	Review and provide feedback on plans for obtaining and updating contact information. Review and provide feedback on plans for outreach and communication.	Review plans to maximize navigation assistance and use of community-based organizations to provide navigational assistance. Review of strategies to minimize loss of members' medical assistance coverage.	*August – September 2022:* Review of actions taken by state to incorporate CPWG advice and recommendations into redetermination process, timelines, and strategies *October 2022 – March 2023:* Continued recommendations and planning coordination, review and draft update to legislature

Public Engagement and Communications

Oregon's goal throughout the redetermination process is to ensure as many people as possible retain affordable health coverage and other needed benefits and services. Navigating the numerous benefits and services offered by multiple agencies is complex and made even more difficult when language, transportation, unstable housing and other barriers are present. In cases where the benefit is ending and cannot be retained, communications should connect

people to other local, state and federal supports. Clear, consistent and coordinated communication will be critical to people taking the necessary actions to retain coverage for themselves and those they love and to adjust to other changes that will result from the unwinding of the PHE.

Objectives within the engagement and communications planning include:

- Center equity in outreach and communications activities by working closely with community-based organizations (CBOs) and creating culturally relevant communications materials.
- Ensure program participants have the information they need throughout the PHE to take action to retain services or find alternatives for programs that are ending.
- Ensure all CCOs, CBOs, providers and partners have the information and tools they need throughout redetermination to help members and clients retain care or find alternatives.
- Set realistic expectations about customer service so that Oregonians are not surprised by long wait times during peak activity.
- Ensure feedback from members, clients, CCOs, providers and partners is woven throughout communications messages, strategies and tactics throughout the PHE unwinding.
- Establish structures and processes to foster multiagency collaboration that prioritizes aligning efforts and sharing resources and opportunities to benefit the people served.

Delivery System Partners: Navigators, Assisters, Advocates, and SHIBA Volunteers

OHA and ODHS plan on keeping all navigators, assisters, community partners, local insurance agents, and all other interested and active groups up to date on all decisions and options as they move forward. They also plan to solicit feedback on potential paths forward, and on program, policy, and operational options from as many interested groups as possible, via engagement sessions and communications requesting feedback.

Data Dashboards and Reporting

OHA and ODHS will develop a dashboard to tell the story of the current experience through data. This will include information on same day/next day processing, average call wait time, and the average processing time for applications per program.

The dashboard should also illustrate the current workload through information such as numbers for weekly tasks, appointments, and calls. Additionally, the data should show where there are successes and gaps when it comes to serving Oregonians. This can be done through providing information on the number of outstanding tasks and applications, number of abandoned calls, the number of applications received online, and the number of applications and redeterminations supported by community partners.

Additional data will be available as a result of federal requirements. Where appropriate and meaningful these measures will be incorporated into regularly updated dashboards. These will include measurements demonstrating progress towards restoring timely application processing, initiating and completing all renewals for Medicaid and the Childrens Health Insurance Program (CHIP), and processing fair hearings. This progress will be demonstrated by reporting applications pended during the PHE, total beneficiaries due for renewal disaggregated by those retained in Medicaid, those determined ineligible, and those terminated for procedural reasons. Reports will also clearly communicate appeals to adverse benefits determinations by demonstrating the number of Medicaid fair hearings pending more than 90 days.

Input will be sought from the CPWG, CPOP, and other partners as appropriate to ensure that measurements published in dashboards will be meaningful.

Member and Recipient Resources

Communications and outreach will be informed by the CPWG, which will advise the state on outreach and enrollment assistance and communication strategies to assist OHP members in navigating the renewal process or transitioning to other health coverage. The CPWG will also provide recommendations on strategies to assist OHA in achieving its overall goal to maximize continuity of insurance coverage for as many people in Oregon as possible and reduce health inequities.

Communications and outreach will begin well in advance of the PHE expiration to allow for multiple touchpoints and provider and member action before the PHE ends and the redetermination period begins. Communication topics will reinforce the importance of updating beneficiary contact information, keeping benefits, applying for OHP if uninsured, notice about Marketplace letters and redetermination eligibility letters, and the current status of the PHE.

Tactics will include community-specific communications for priority populations, such as resources to receive mail if beneficiaries are houseless, translated materials, directions on how to gather renewal documents, and more. OHA will provide direct outreach specific to members who fall into the criteria of possible extension (based on FPL). Channels such as word of mouth, social media, and

outdoor advertising will be utilized. OHA will also provide tools to CBOs, CCOs and others who interact with beneficiaries to help them navigate the changes.

ODHS and OHA are working with Deloitte Consulting to redesign ONE System notices, including the medical notice of eligibility, passive renewal, active renewal, and request for information. The goal is to improve readability and calls to action using a human centered design approach. A pilot effort is being prepared and will include surveying to collect feedback from people receiving the redesigned notices.

OHA will develop resources specifically to help members find the tools and support they need. Primary tools will include:

- Website for beneficiaries with updated information and calls to action
- Direct outreach through letters, emails, phone calls and tools provided to community partners
- Indirect outreach through social media and news releases
- Phased advertising campaign including the following channels: social media, outdoor, radio, digital video, digital display and print

OHA will also develop resources specifically for partners and providers including:

- Communications toolkits, including a holding statement, FAQ, email template, social posts, newsletter article samples, web banners, and flyers
- Website for resources and updated information

Provider and Partner Resources

OHA has established channels with OHP providers including via OHP Provider Matters, OHA's website, the CPOP provider outreach team, and provider communications and relationships through CCOs.

OHP Provider Matters is a monthly email communication geared towards OHP providers. Supporting information will be provided to the OHA Provider Team to help them answer any questions they receive directly from providers.

OHA communicates with CCOs in multiple forums including MEOC, CCO Operations, QHOQ, and through Innovator Agents who work directly with CCOs. Engaging with CCOs for targeted communications to support members will be done through MEOC.

For community partners who are also providers (and who often serve OHP members disproportionally affected by health inequities), CPOP provides targeted communications and updates.

CCOs work directly with their provider networks and can elevate communication shared in Provider Matters.

OHP will use established CPOP communications channels with provider and non-provider community partners including CP Update newsletter, Groupsite, webinar trainings, and regional collaborative meetings to communicate changes.

Long-term care providers and community partners who provide services to individuals on Medicaid also need to be aware. This includes CDDPs, Brokerages, Nursing Facilities, Assisted Living and Residential Care Facilities, Foster Homes, and home care and personal support workers. Organizations such as SEIU, independent foster home association, Oregon Health Care Association, AFSCME, Leading Age, and other organizations should be coordinated with.

Medical programs authorized through Child Welfare need to be considered for any rules and adjustments and communicated with regarding changes for medical benefits.

HB 4035 Appropriations

In HB 4035, the Legislature appropriated to OHA a total of $120 million to support both OHP redeterminations and the Bridge Program. Of the total, $94.4 million will go to direct services to support the additional caseload.

The remaining $25.6 million will support administration of the program. This portion includes:

- $3 million for 26 positions, including both permanent and limited duration positions, working on OHP redeterminations and the Bridge Program
- $3.2 million for communications with OHP members
- $3.2 for ongoing outreach to target populations and collaboration with community partners
- $14 million to the Call Centers to support OHP members and help them transition to the Marketplace or Bridge Program, and
- $2 million for additional project management and consulting to support this work.

(Totals do not match up due to rounding.)