DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

February 13, 2024

Vivian Levy
Interim Medicaid Director
Oregon Health Authority
500 Summer Street NE E35
Salem, OR 97301

Dear Director Levy:

The Centers for Medicare & Medicaid Services (CMS) is approving Oregon's (the state) application for a five-year section 1115(a) demonstration, titled "Oregon Project Independence–Medicaid" ("OPI–M" or the "demonstration") (Project Number 11-W-00380/10), effective February 13, 2024, through January 31, 2029. Approval of this demonstration will enable the state to receive federal financial participation (FFP) to provide a limited set of home and community-based services (HCBS) to qualifying individuals ages 18 or older, who are older adults or adults with disabilities, to avoid or delay entry into Medicaid through an institutional level of care. This demonstration is likely to assist in promoting the objectives of title XIX of the Social Security Act (Act) as further specified in this approval letter.

CMS' approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authority, waiver authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this demonstration project. The state may deviate from the Medicaid state plan requirements only to the extent that those requirements have been specifically identified as not applicable under the demonstration.

The OPI–M demonstration will enable beneficiaries to coordinate with case managers to create a limited service plan to maintain a beneficiary's level of independence and quality of life in their home. The demonstration also provides supports to beneficiaries' unpaid caregivers, to meet the beneficiaries' health needs while also sustaining the needs of their caregiver. The goals of the demonstration are to:

- Provide limited HCBS for older adults and adults with disabilities at risk of needing Medicaid long-term services and supports (LTSS),
- Expand HCBS to individuals who need assistance with activities of daily living but do not meet the current Medicaid nursing facility level of care, and
- Provide support to unpaid family caregivers who care for demonstration beneficiaries.

The OPI–M demonstration will permit individuals who are otherwise eligible for Oregon's Medicaid state plan, but meet the demonstration eligibility requirements, to "opt into" the demonstration to receive the targeted benefit package through OPI-–M. Beneficiaries who are otherwise eligible for Oregon's Medicaid state plan will have access to the mandatory state plan

medical services provided, however, they will not have access to Medicaid optional state plan services, LTSS under the Medicaid state plan or any of Oregon's other Medicaid waivers (other than Medicare buy-in benefits), unless they choose to disenroll from the demonstration to access Medicaid LTSS.

Subject to certain exceptions specified in the STCs, this demonstration also permits the state to provide continuous eligibility for beneficiaries enrolled in the demonstration for up to 24 months, regardless of certain changes in circumstances that would otherwise cause a loss of eligibility. CMS is authorizing this continuous eligibility to align this demonstration with the Oregon Health Plan and Oregon Contraceptive Care demonstrations,[1,2] and to support consistent coverage and continuity of care by keeping beneficiaries enrolled for 24 months, regardless of income fluctuations or other similar changes that otherwise would affect eligibility, except for such circumstances specifically excepted, which would result in the individual's eligibility being redetermined or terminated, as specified in the STCs (for example, the individual ceasing to be a resident of the state).

CMS has determined that this demonstration is likely to assist in promoting the objectives of Medicaid under title XIX of the Act because it will expand Medicaid services to individuals at risk of needing Medicaid LTSS and provide supports to unpaid family caregivers who care for demonstration beneficiaries. Continuous eligibility is also likely to assist in promoting the objectives of Medicaid as it is expected to minimize coverage gaps and help maintain continuity of access to program benefits, thereby helping improve health outcomes of beneficiaries.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration.

In requiring demonstrations to be budget neutral, CMS strives to achieve a balance between its interests in preserving the fiscal integrity of the Medicaid program and facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" (WOW) costs).

In this new demonstration, CMS is including STCs, as applicable, that reflect these efforts to achieve the aforementioned balance between fiscal integrity and state innovation. Specifically,

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[1] Oregon Health Plan section 1115 demonstration approval. https://www.medicaid.gov/sites/default/files/2023-02/or-health-plan-ca-10282022.pdf

[2] Oregon Contraceptive Care section 1115 demonstration approval. https://www.medicaid.gov/sites/default/files/2023-12/or-contraceptive-care-appvl-12072023.pdf

CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to midcourse corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on (1) actual expenditure data to accommodate circumstances that are out of the state's control (e.g., expensive new drugs enter the market and the state is required to cover them); and/or (2) the effect is not a condition or consequence of the demonstration (e.g., unexpected costs due to a public health emergency); or (3) the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (e.g., a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with CMS requirements for section 1115 demonstrations (*see, e.g.*, 42 CFR 431.424 and 42 CFR 431.428), and as outlined in the demonstration's STCs, the state is required to conduct systematic monitoring and robust evaluation of the demonstration in accordance with the STCs. The demonstration's monitoring activities must support tracking the state's progress toward meeting the demonstration goals. The state must report on metrics that relate to the demonstration's continuous eligibility and benefits provisions and must cover categories including but not limited to: enrollment and renewal, including the percent of renewals completed *ex-parte* (administratively); access to providers; utilization of services; grievances and appeals; and quality of care and health outcomes. The state's selection of the quality of care and health outcomes metrics must be aligned with the demonstration's policy composition and objectives, to be reported for all demonstration populations. As appropriate, the state must leverage measures from the HCBS Quality Measure Set[3] and CMS' draft Disparities Sensitive Measure Set.

Furthermore, in accordance with the STCs, Oregon must develop for the demonstration period a rigorous evaluation design using robust data sources and sound analytic approaches that support a comprehensive independent evaluation of the demonstration to assess whether the demonstration initiatives are effective in producing the desired outcomes for beneficiaries and the state's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, including the continuous eligibility policy, that support understanding the demonstration's impact on beneficiary coverage, access to and quality of care, and health outcomes, as well as the demonstration's effectiveness achieving the policy goals and objectives.

[3] The HCBS Quality Measure Set can be accessed on Medicaid.gov at the following link: https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.

Specifically, evaluation hypotheses must focus on the impact of the demonstration in helping eligible beneficiaries access HCBS, coordinate with case managers, and pursue support for unpaid family caregivers. The evaluation must also examine beneficiary and caregiver perspectives on the usefulness of the services and supports received. Hypotheses must include, but not be limited to, outcomes such as beneficiaries' quality of life at home and their increased independence. In addition, the evaluation must assess how the demonstration helps to prevent or delay escalation of beneficiary health outcomes, disability, and need for institutional levels of care, and thereby may support any cost savings in the long run. For the continuous eligibility policy, the state must evaluate how the policy affects coverage, enrollment, and churn (i.e., temporary loss of coverage during which beneficiaries are disenrolled but re-enroll within 12 months), as well as appropriate measures of HCBS utilization and health outcomes. In addition, the state must conduct a demonstration cost assessment.

The state is strongly encouraged to conduct an implementation evaluation and undertake a well-designed beneficiary survey, both of which will significantly strengthen the demonstration's evaluation. Finally, to the extent feasible, the state must collect data to support its monitoring and evaluation efforts stratified by key subpopulations of interest (*e.g.*, by sex, age, race, ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing shortcomings or disparities in access to and quality of care and health outcomes, as well as help inform how the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(l) and (2) of the Social Security Act (the Act) direct the Secretary of Health and Human Services (HHS) to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act further specifies that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute does not impose additional requirements on the states or the Secretary to provide individualized responses to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations at 42 CFR part 431, subpart G, specifically 42 CFR 431.416(d)(2) provide that CMS will review and consider all comments received by the deadline, but will not provide individualized written responses to public comments.

The federal comment period was open from November 16, 2021 through December 16, 2021. CMS received 19 comments during the federal comment period. Two comments were unrelated to the demonstration request, and two comments misunderstood the intent of the demonstration request because commenters thought the demonstration would impact beneficiaries who are

disabled and currently receiving Medicaid state plan benefits. Overall, the comments indicated strong support for the demonstration.

Several commenters expressed support for expanding coverage for older adults, and praised supporting family members who assume care taking responsibilities for individuals in need. Commenters emphasized that the demonstration will provide services beyond what the state-funded program can offer due to limited funding. Lastly, commenters asserted that the demonstration will help prolong qualifying individuals' independence by delivering care that can be received in-home rather than in an institutional setting.

Other Information

CMS' approval of this demonstration project is contingent upon the state's compliance with the enclosed expenditure authority, waiver authority, and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

The project officer for this demonstration is Ms. Valisha Andrus. She is available to answer any questions concerning your section 1115 demonstration. Ms. Andrus's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: valisha.andrus@cms.hhs.gov

We appreciate your state's commitment to improving the health of people in Oregon, and we look forward to partnering with you on the OPI-M 1115(a) demonstration. If you have questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410)786-9686.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

cc: Nikki Lemmon, State Monitoring Lead, Medicaid, and CHIP Operations Group