Public Notice

Contents

Public comment process

OHA will open a public comment period on the draft 1115 Medicaid Demonstration Renewal application beginning December 7, 2021 through January 7, 2022. During this time, written and verbal comments on the proposed application will be accepted. These comments will be used to inform the final application prior to submission to the Centers for Medicare and Medicaid Services (CMS) in February 2022.

The draft application is available here: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Waiver-Renewal-Application.pdf.

Everyone has a right to know about and use OHA programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written material in other languages
- Braille
- Large print
- Audio and other formats

To receive documents in alternate formats, please contact Michelle Hatfield at 503-551-3881 or 1115Waiver.Renewal@dhsoha.state.or.us

How to submit comments

The public is invited to give written and verbal comments on the draft waiver application from December 7, 2021 through January 7, 2022. **The deadline for comment is January 7, 2022, 11:59 PM, Pacific Time**. The public may provide verbal or written comments. All public comments received by OHA will be posted at Oregon.gov/1115WaiverRenewal.

Beginning December 7, 2021, written comments can be emailed to 1115Waiver.Renewal@dhsoha.state.or.us, submitted through Oregon.gov/1115WaiverRenewal, or sent via physical mail to:

> Health Policy and Analytics Medicaid Waiver Renewal Team
> Attn: Michelle Hatfield
> 500 Summer St. NE, 5th Floor, E65
> Salem, OR 97301

Members of the public may provide verbal comment at any of the following public hearings:

Oregon Health Policy Board
Dec. 7, 2021 | 8:30 a.m. – 12 p.m.
Join Meeting:
https://www.zoomgov.com/j/1602657497?pwd=emhzUnJsK1EzWk5rV0VpYTdjU3VrQT09
One tap mobile: +16692545252,,1602657497#,,,,,,0#,,306554#
If you need help or accommodations, please contact Tara Chetock at 971-304-9917 or tara.a.chetock@dhsoha.state.or.us at least 48 hours before the meeting.

Community Partner meeting (en español)
Dec. 9, 2021 | 3:30 p.m. – 5:30 p.m.
Join meeting: https://us02web.zoom.us/meeting/register/tZwkde6uqTsuGtE7CbrxDUl4WL0f70l18wg5

Health Equity Committee
Dec. 9, 2021 | 12 p.m. – 2 p.m.
Microsoft Teams meeting Click here to join the meeting
Or call in (audio only)
One tap mobile: +1 971-277-2343,,928637902#
Phone Conference ID: 928 637 902#
If you need help or accommodations, please contact Maria Castro at 503-884-4448 or maria.castro@dhsoha.state.or.us at least 48 hours before the meeting.

Medicaid Advisory Committee
Dec. 15, 2021 | 9 a.m. – 12 p.m.
Microsoft Teams meeting Click here to join the meeting
Or call in (audio only)
One tap mobile: +1 971-277-2343,,243372877# Phone Conference ID: 243 372 877#
If you need help or accommodations, please contact Jackie Wetzel at 503-580-5603 or Jackie.Wetzel@dhsoha.state.or.us at least 48 hours before the meeting.

Designing the future of OHP – Workshop 3
Dec. 16, 2021 | 5:30 p.m. – 7:30 p.m.

Register in advance for this meeting: https://www.zoomgov.com/meeting/register/vJIsc--spjoqHteaw5dXCTUmWwDVE_7NgDU

If you need help or accommodations, please contact Michelle Hatfield at 503-551-3881 or michelle.m.hatfield@dhsoha.state.or.us at least 48 hours before the meeting.

Community Partner meeting
Dec. 17, 2021 | 10:30 a.m. – 12:30 p.m.

Join meeting: https://us02web.zoom.us/meeting/register/tZcod-6trD8sEtHdQadI0abTNykZVpihdfFJ

Oregon Health Policy Board
Jan. 4, 2022 | 8:30 a.m. – 12 p.m.

Join ZoomGov Meeting
https://www.zoomgov.com/j/1609166382?pwd=Ulp0eis5bUZPeUNQdWM3VU9aMnZwQT09

Meeting ID: 160 916 6382 Passcode: 912812

One tap mobile +16692545252,,1609166382# ,, 0#,,912812# US (San Jose)

If you need help or accommodations, please contact Tara Chetock at 971-304-9917 or tara.a.chetock@dhsoha.state.or.us at least 48 hours before the meeting.

Background

In 2012, Oregon launched Coordinated Care Organizations (CCOs) through the state's 1115 Medicaid waiver and an accompanying state innovation model grant from the Center for Medicare and Medicaid Innovation (CMMI). CCOs are community-based organizations that deliver care to Medicaid members through a coordinated care model of service delivery designed to address problems inherent in a fragmented health system. CCOs are responsible for physical, behavioral and oral health care services for Medicaid members. They receive a fixed monthly budget from the state to coordinate care with flexibility to address their members' needs outside traditional medical services and financial incentives for improving outcomes and quality.

Oregon will continue the CCO model in the proposed demonstration renewal. As currently implemented, the demonstration renewal will continue to operate statewide and will cover the 1.3 million Oregonians currently receiving benefits through the OHP and proposes changes to the benefits available to existing members. The application also proposes changes to eligibility that would extend coverage to individuals who are not currently eligible to enroll in a CCO. The state seeks to renew this demonstration for the period from July 1, 2022 through June 30, 2027 so Oregon can continue its health system transformation through specific modifications to Medicaid and CHIP programs under the current waiver. These modifications will allow the state to meet its overall goals that are aligned with the triple aim to improve patient experience, improve health, and reduce costs.

Payment via a per member per month rate integrates physical, behavioral and oral health care under one funding stream and provides CCOs with flexibility in how dollars are spent while holding costs to a 3.4% annual growth cap. Further, the CCO model requires community involvement in decision-making. Community Advisory Councils (CACs) for each CCO engage CCO members and other community representatives in guiding some of the spending within the

flexible funds. CACs utilize Community Health Assessments and Community Health Improvement Plans to provide direction and ensure alignment with local hospitals and public health authorities. In 2017, Oregon's renewal expanded this effort by focusing on upstream investment in social determinants of health through the use of health-related services (HRS) that allowed CCOs further flexibility to pay for non-medical services that improve health outcomes.

HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their budgets to address the social determinants of health (SDOH), including the health-related social needs of their members. For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. The goals of HRS are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being.

Following are the elements of the current Section 1115 demonstration that are proposed to continue:

- Contracting with Coordinated Care Organizations (CCOs) to provide physical, behavioral, and oral health services to Medicaid Oregon Health Plan members
- The use of the prioritized list of conditions and treatments, subject to certain exceptions for protected benefits
- The use of Health Related Services
- Restrict coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one
- Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans
- Care Coordination for individuals residing in institutions for mental diseases (IMDs)

Continue Uncompensated Care payments for Tribal Health Facility Program

Purpose, goals, and objectives

The Oregon Health Authority (OHA) will submit an application for renewal of the Oregon Health Plan (OHP) 1115(a) Demonstration Waiver for the July 1, 2022- June 30, 2027 demonstration period. The renewal requests changes to the current demonstration that will:

- Increase access to continuous OHP coverage for some populations by proposing changes to the current enrollment processes and eligibility criteria;
- Define a series of benefit packages of supportive services for individuals experiencing transitions across different systems, across health care settings, and across life stages or due to point-in-time events with the goal of minimizing the disruptions in care that often occur during these transitions;
- Propose changes to the methodology used to set capitation rates that are used to pay CCOs;

- Allow CCOs to spend 3% of their per-member per-month capitation rate on investments to improve health equity and for those investments to be counted as medical expenses during rate development as required by House Bill 3353 from the 2021 Oregon Legislative Session;
- Request federal funding for spending on improving health equity, including investments to build infrastructure to support health equity interventions, to support community-led health equity interventions and statewide initiatives, and grant community-led collaboratives resources to invest in health equity.
- Provide the state with the ability to define preferred drugs for OHP members in an effort to better control the financial impact of rising drug costs;
- Change the process for selecting and operationalizing CCO incentive metrics to focus on reducing health inequities; and
- Expand benefits for American Indian/Alaska Native OHP members to include Tribal-based practices as a covered service, and waive prior authorization criteria for tribal members

The proposed program changes would meet the following goals and objectives:

- Maximize continuous and equitable access to coverage
- Streamline transitions between systems through defined benefit packages of social determinants of health services
- Increase flexibility for Coordinated Care Organizations (CCOs) to invest in community health and health equity
- Improve health through focused equity investments led by communities
- Ensure quality and access through equity-driven performance metrics
- Align with Oregon’s nine Tribal governments’ priorities

Beneficiaries who will be affected by the demonstration

Oregon proposes the following changes for beneficiaries under the demonstration:

Population	Criteria	Changes proposed
Youth with Special Health Care Needs	*Adolescents and young adults with a behavioral, developmental, emotional, and/or physical condition ages 17 up to 26 years and have service or Medicaid eligibility through Aged and Peoples with Disabilities (APD), Oregon Developmental Disability Services (ODDS); or, be identified through the Pediatric Medical Complexity Algorithm (PMCA); or be identified through the following indicators: Intellectual or Developmental Disability (IDD), or Medically Fragile or Medically Involved indicators*	The changes requested would extend this coverage through age 26 and would qualify them for services designed to support employment, life skills development, and other benefits designed to aid in the transition to adult benefits.
American Indian / Alaska Native OHP Members	*OHP members who are enrolled as American Indian or Alaska Native*	Services provided to these members would have prior authorization criteria waived for all services offered to tribal members under OHP. Additionally, the proposal requests that defined Tribal-based Practices be included as covered services for tribal members.
Youth in custody of Juvenile Corrections (Oregon Youth Authority)	*Youth in custody (pre- and post-adjudication) of Juvenile Corrections who either enter with current OHP enrollment or become enrolled while in custody*	Youth in custody would maintain continuous OHP enrollment for the entire duration of their time in custody, allowing them to access a defined package of support services to aid in the transition at time of release. This differs from the current demonstration which does not allow the enrollment of individuals in custody until they have been released.

Population	Criteria	Changes proposed
Adults who are incarcerated or in the custody of the Department of Corrections	*Individuals in custody of Department of Corrections planned for release within in 90 days or less and meet Medicaid income requirements*	Individuals would be eligible to enroll in OHP beginning 90 days prior to their date of release, allowing them to access a defined package of support services to aid in the transition. This differs from the current demonstration, which does not allow the enrollment of individuals in custody until they have been released.
Adults in the custody of local correction facilities	*Individuals in custody (pre- and post- adjudication) of county jails or local correction facilities who either enter with current OHP enrollment or become enrolled while in custody.*	Individuals who are enrolled in OHP at the time they are held in the custody of county jails or local correction facilities would not be disenrolled from OHP. This differs from the current demonstration, which suspends enrollment at the time of arrest even if the charges are not sustained.
Individuals residing in the Oregon State Hospital	*Individuals who are in the care of the Oregon State Hospital (OSH) who meet Medicaid income eligibility who are planned for discharge within 90 days or less.*	Individuals in the care or custody of the Oregon State Hospital would be eligible to enroll in OHP beginning 90 days prior to the date of discharge. This differs from the current demonstration, which suspends enrollment at the time of intake.
Individuals residing in Psychiatric Residential Facilities (IMD)	*Individuals who are in the care of an Institute of Mental Disease (IMD) who meet Medicaid income eligibility who are planned for discharge within 90 days or less.*	Individuals who are in the care of a Psychiatric Residential Treatment Facility would be eligible to enroll in OHP beginning 90 days prior to their date of discharge. This differs from the current demonstration, which suspends enrollment when an individual enters this type of facility.

Population	Criteria	Changes proposed
Youth transitioning out of Foster Care	*Currently enrolled OHP youth who are involved or at risk of involvement with the child welfare system, transitioning in and out of foster care homes, including those aging out of the system*	Individuals would be qualified for supportive services such as housing, life skills training, employment assistance, or transportation, including peer supports or navigation when changing foster homes aging out of foster care, or returning to the natural home. These services are not currently provided under the demonstration.
Members transitioning from Medicaid-only coverage to Medicare-Medicaid Coverage	*Existing OHP members who are dually eligible for Medicare and Medicaid per OHP eligibility determinations*	Individuals who are dually eligible may be qualified to receive additional support to assist in transitioning onto Medicare, accessing benefits they are newly eligible for and to support continuity of providers. These services are not currently provided under the demonstration.
Individuals vulnerable to extreme climate events	*Individuals who are enrolled in OHP located in an area affected by a declared state of emergency due to climate change.*	Individuals who are enrolled in OHP and who are located in an area affected by a declared state of emergency such as wildfires, extreme heat events, flooding, or other climate events would qualify to receive additional services designed to mitigate the negative impact to a person's health and well-being. These services are not currently provided under the demonstration.
Children under the age of 6	*Individuals who meet Medicaid income eligibility and are between the ages of 0 and 6 years*	Children under the age of 6 would not be required to undergo the annual eligibility redetermination process until age 6 and would experience continuous enrollment in OHP. This differs from the current demonstration, which requires eligibility redetermination once a year.

Population	Criteria	Changes proposed
People age 6 and up	*Currently enrolled OHP members who meet Medicaid income eligibility and are age 6 and older*	Individuals enrolled in OHP would undergo eligibility redetermination every 24 months instead of every 12 months under the current demonstration.
All other OHP members	*Any individual currently receiving OHP benefits*	Individuals who receive prescription drugs under the Oregon Health Plan may see changes to what medications are preferred by their plan
SNAP-eligible individuals who are not currently enrolled in OHP	*Individuals who meet Medicaid income eligibility and who are currently enrolled in SNAP benefits*	Individuals who are eligible for the Supplemental Nutrition Assistance Program would be screened for OHP eligibility and offered streamlined enrollment using income criteria already established during SNAP enrollment. This differs from the current demonstration which reviews an individual's eligibility for OHP and for SNAP separately.

No other changes to eligibility criteria are being requested.

Delivery system and eligibility requirements

Oregon proposes to keep the Coordinated Care Organization (CCO) model of service delivery. CCOs will still be contracted to provide physical, behavioral, and oral health services for eligible members. Eligibility requirements will remain the same outside of those changes described above.

Changes to benefits and coverage

The benefits for OHP members that are defined in the State Plan will not change. Additional benefits will be available to individuals who qualify under the eligibility changes described above, and include:

Changes proposed	Current program
Coverage of a defined set of services to support members experiencing transitions in care between systems, between settings, and during live events	Some services in this proposal are available from CCOs as health-related services, but are not considered a covered service
Availability of some peer-delivered services expanded to include coverage of services before a treatment plan is developed and after a treatment plan has been completed	Peer-delivered services are considered covered services when they are performed under the supervision of a certified provider and are included in a member's treatment plan
Flexibility to exclude drugs with limited or inadequate clinical efficacy, with a pathway for coverage for non-preferred drugs	The state does not have the ability to exclude coverage of approved drugs

No other changes to benefits are being requested.

Cost sharing requirements

No changes to cost sharing requirements are being requested. OHP does not require cost sharing.

Estimate of expected change in annual enrollment and annual expenditures

Historical data (current waiver period)					
	SFY18	SFY19	SFY20	SFY21	SFY22
Total enrollment	856,262	857,297	879,157	1,005,122	1,131,501
Total expenditure	$6,258,934,391	$6,597,659,631	$7,073,711,147	$7,784,273,070	$9,555,087,914

Demonstration renewal period					
	SFY23	SFY24	SFY25	SFY26	SFY27
Total projected enrollment	1,019,073	1,123,740	1,132,032	1,134,884	1,115,832
Total projected expenditure	$10,007,172,653	$11,620,080,436	$12,088,770,684	$12,537,125,292	$12,556,399,420

Hypotheses and evaluation parameters

The state is proposing changes to what will be evaluated with this extension that are similar to what is being evaluated under the current demonstration. The changes are described below:

Q1. Will the 1115 waiver renewal proposed interventions decrease health inequities by race and ethnicity?

Hypothesis #1:

Redistributing power and resources to individuals and communities most harmed by historical and contemporary racism will result in improvements in health inequities and self-reported measures of autonomy, health status and quality of life.

Hypothesis #2:

Using the new decision-making structure to select and operationalize CCO incentive metrics will result in greater improvements in health inequities by race/ethnicity than occurred under the decision-making structure in place during the 2012-2017 waiver.

Q2. Will continuous coverage improve health outcomes?

Hypothesis #3:

Earlier OHP enrollment with fewer gaps in coverage for vulnerable populations will result in more members receiving care in the right settings, and improved health status and quality of life.

Hypothesis #4:

Offering packages of SDOH support services to individuals experiencing transitions is more effective at improving integration for successful transition than offering individual services alone.

Q3. Does the new rate development methodology for a value-based budget increase CCO spending in community investments to reduce health inequities?

Hypothesis #5:

Offering a predictable budget, based on a streamlined method with predictable cost growth, allows for greater clarity around available funds for CCO reinvestment in local community and increases community investments.

Hypothesis #6:

Offering a predictable budget, based on a streamlined method with predictable cost growth, allows community partners to more effectively partner with CCOs to meet members' needs for SDOH support services.

Waiver and expenditure authorities requested for the demonstration

Oregon is requesting to continue the following waiver and expenditure authorities used under the current demonstration:

Waiver authority	Use for waiver
Section 1115 (a)	Continuation of the state's Tribal Uncompensated Care Program (UCCP)
42 CFR § 438.56	• Permitting enrollees dually eligible through Medicare and Medicaid to disenroll from CCOs without cause at any time • Contract with managed care entities and insurers that operate locally • Offer benefits consistent with a prioritized list of conditions and treatments, subject to certain exceptions for protected benefits • Restrict coverage for treatment services identified during Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to those services that are consistent with the prioritized list of health services for individuals above age one • Define types of insurers and mandatorily enroll and auto-enroll individuals in managed care plans • Not pay disproportionate share hospitals payments for managed care enrollees • In general, to permit coordinated care organizations to limit periods during which enrollees may disenroll • Provide coverage for certain chemical dependency services for targeted beneficiaries • Receive federal financial participation for certain state-funded health care programs

In addition to Oregon's existing waiver authority, the state will work with CMS to determine whether the state needs additional waiver authority to allow for:

Waiver authority	Use for waiver	Reason for waiver request
42 C.F.R. 435.916	Expenditure authority to permit the State to implement continuous enrollment.	This allows the state to request federal financial participation for the continuous enrollment of children without regard to whether a child's income exceeds eligibility limits and provide continuous OHP enrollment for children until their sixth birthday (age 0-5)
42 C.F.R. 435.916	Expenditure authority to permit the State to implement continuous enrollment.	This allows the state to waive the annual redetermination requirements with respect to income eligibility and establish two-year continuous OHP enrollment for people ages six and up
42 CFR 438.8 and 42 CFR 438.74 45 CFR 158.150 or 45 CFR 158.151	Allow Health Related Services to be counted in the numerator of the MLR.	This allows the state to count health-related services that meet the requirements in the numerator of the Medical Loss Ratio when evaluating CCO financial reporting
	Expenditure authority to permit the State use SNAP eligibility information as the basis for determining Medicaid enrollment.	This allows the state to provide an expedited enrollment path for people who apply and are eligible for Supplemental Nutrition Assistance Program (SNAP) benefits.

Waiver authority	Use for waiver	Reason for waiver request
	Expenditure authority for state-funded health-related initiatives.	This allows the state to request a new federal investment focused on improving health equity, including investments to build infrastructure to support health equity interventions; support community-led health equity interventions and statewide initiatives; grant community-led collaboratives resources to invest in health equity.
	Expenditure authority to fund payments to provider and community-based organizations for infrastructure and capacity building	This allows the state to request federal investment for Community Investment Collaboratives to support implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building.
	Expenditure authority to fund health-related services for individuals during certain life transitions.	This allows the state to request additional funding for a defined set of SDOH transition services to support members in need during transition in coverage periods and life transitions.
	Expenditure authority for Medicaid services rendered to institutionalized individuals	This would waive the federal rule preventing Medicaid coverage for a person in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities, and allows the state to request federal fund participation for the enrollment of individuals in custody.
	Expenditure authority for Medicaid services rendered to institutionalized individuals.	This allows the state to cover through Medicaid certain costs of medical services for a member in custody, including justice-involved populations and those in the Oregon State Hospital and psychiatric residential facilities

Waiver authority	Use for waiver	Reason for waiver request
sections 1902(a)(10) and 1902(a)(17).	Waiver of comparability to permit the State to offer additional benefits to YSCHN up to age 26.	This allows the state to retain child eligibility levels and benefit package for Youth with Special Health Care Needs (YSHCN) up to age 26.
sections 1902(a)(10) and 1902(a)(17)	Expenditure authority to cover YSCHN up to age 26 up to **305** % of the federal poverty level, who would not otherwise be eligible for Medicaid.	This allows the state to request federal fund participation for Youth with Special Health Care Needs (YSHCN) up to age 26.
	Expenditure authority for services delivered by Traditional Health Workers, including community health workers, personal health navigators, peer wellness and support specialist and doulas.	This allows the state to expand and fund the services provided by Traditional Health Workers outside of the currently approved settings
42 C.F.R. 438.5	Expenditure authority to pay for capitation rates that are built with specified deviations from the rate development standards outlined in 42 C.F.R. 438.5	This allows the state to request changes to the methodology used to develop per-member per-month capitation rates paid to CCOs for providing care to members.
§1902(a)(54); Section 1927(d)(1)(B; §1902(a)(14); Section 1916 and 1916A; §1902(a)(23)(A)	Waiver of the permissible coverage restriction requirements for outpatient drugs, specifically §1902(a)(54) insofar as it incorporates Section 1927(d)(1)(B; §1902(a)(14) insofar as it incorporates Section 1916 and 1916A; §1902(a)(23)(A)	This allows the state to define a list of preferred drugs and exclude unproven or low-value drugs based on clinical efficacy.

Waiver authority	Use for waiver	Reason for waiver request
	Expenditure authority to fund health-related services for members experiencing certain life transitions.	This allows the state to obtain federal match for Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions
42 C.F.R. 438.5.	Expenditure authority to pay for capitation rates that are built with specified deviations from the rate development standards outlined in 42 C.F.R. 438.5.	This allows the state the authority to count CCO investments in health equity required by HB 3353 as medical claims or quality improvement spending for purposes of CCO rate setting.

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Community Partner Outreach Program at community.outreach@dhsoha.state.or.us or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.