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Oregon 1115 Waiver Approval Overview

Date: September 28, 2022

Executive Summary

On September 28, CMS approved Oregon's new Section 1115 demonstration waiver application titled, "Oregon Health Plan (OHP)." The demonstration will transform the state's Medicaid program to better serve members by building on the state's previous health care transformation success and creating a more equitable system through initiatives related to addressing health inequities, continuous eligibility, coverage expansion, and health related social needs. The approval is effective as of October 1, 2022, through September 30, 2027. Oregon will receive $1.1 billion in federal funds over the five-year waiver period to innovate and expand coverage for its 1.4 million beneficiaries.[i]

The following outlines five key objectives within the OHP demonstration[ii]:

1. Extended health coverage for children, special needs youth and adults:
    - Prevent gaps in coverage by allowing the state to keep children enrolled in Medicaid up to six years old, regardless of changes in circumstances that would otherwise cause a loss of eligibility. Oregon is the first state in the country to receive federal approval for continuous health coverage for children under the age of six.
    - Provides two years of continuous OHP enrollment for all OHP beneficiaries six years and older, regardless of changes in circumstances that would otherwise cause a loss of eligibility, establishing longer continuous coverage periods.
    - Effective January 1, 2023, covers all EPSDT services for children up to age 21 and for youth with special health care needs up to the age of 26.
    - Expands eligibility and benefits for youth with special needs health care up to the age of 26 with income levels at or below 300% FPL.
2. Expansion of health-related social needs (HRSN) coverage for food assistance, housing supports, and other interventions:
    - Provides up to six months of food and housing supports, including rental assistance, for marginalized groups such as youth in foster care, the homeless population, and low-income older adults.
    - Provides devices such as air conditioners, air filters, or generators, to individuals with high-risk clinical needs who reside in regions with extreme weather events.
    - Authorizes significant federal matching funds for Designated State Health Programs (DSHP), totaling $1.1 billion ($535 million in FFP) over the five-year waiver period to address HRSN, increase health coverage, improve quality, and improve health outcomes.
        - Matchable DSHP expenditures cannot exceed 1.5% of the state's total Medicaid spend during the demonstration period. The state must contribute state funds for expenditures under the DSHP-supported demonstration initiatives and submit a sustainability plan which describes the scope and the strategy to

secure resources to maintain DSHP-supported initiatives beyond the current demonstration approval period. This sets precedent for other states to consider use of DSHP in their waiver financing methodology.

3. Modifications to Oregon's Quality Incentive Program which has paid bonuses to coordinated care organizations (CCOs) since 2013 for performing well on certain health metrics for OHP members:
    - Increases committee seats/input from OHP members, community members, individuals with experience of health inequities, and health equity professionals.
    - Splits the metric system into upstream and downstream where upstream metrics address health equity and downstream metrics will include standard health metrics used by other Medicaid programs.

4. Provider rate increases:
    - Requires Oregon to increase and sustain Medicaid fee-for-service (FFS) provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care if the state's Medicaid to Medicare provider rate ratio is below 80% in any of those categories.
    - Makes DHSP and HRSN expenditure authority contingent upon this ratio being maintained.

5. Changes in budget neutrality:
    - Provides Oregon expanded budget and flexibility in implementing programs as noted in greater detail below.

Withdrawn Waiver Requests:

Oregon withdrew the following waiver requests from its application or determined that the state will address through Oregon's state plan (or other mechanisms)[iii]:

- Several rate setting flexibilities for CCOs.
- Pharmacy requests.
- Coverage of peer-delivered behavioral health services without a plan of care from a physician/licensed practitioner.
- Expedited Medicaid enrollment via SNAP.

Waiver Request Not Currently Approved:

Oregon and CMS will continue to discuss[iv]:

- The new community-led health equity interventions, managed by Community Investment Collaboratives (CIC) composed of community-based organizations and health care providers throughout the state.
- OHP benefit coverage for the duration of incarceration for youth in juvenile correction facilities and adults in jails or other local/tribal correctional facilities.
- 90-day transitional pre-release coverage for adults in prison or Institutions for Mental Disease (IMDs).
- The removal of prior authorization requirements for American Indians/Alaska Natives on OHP.

- Conversion of the Special Diabetes Program for Indians into a Medicaid benefit.
- Reimbursement of tribal-based practices and the extended coverage of new HRSN services to tribal members not enrolled in a CCO.

Financial Components

The updated Oregon 1115 waiver also includes the following financial-specific factors:

1. Medicaid to Medicare Provider Rate Ratio

As a condition of approval, Oregon must increase and (at least) maintain Medicaid FFS provider base rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care if the state's Medicaid to Medicare provider rate ratio is below 80% in any of these categories. Of note, only primary care provider payment levels are below 80% of Medicare rates and must be increased.

2. Changes to Federal Matching funds for Designated State Health Program (DHSP) funding
    - CMS is moving away from its 2017 DSHP policy to provide states with expanded 1115 waiver flexibility to use DSHP "freed up" state funding on a time-limited basis to implement new innovations and initiatives that support the objectives of the Medicaid program.
    - CMS is making changes to give states greater access to funding while maintaining fiscal integrity.
    - Oregon must also contribute non-DSHP funds as the non-federal share of the identified initiatives on an annual basis.

3. Evaluation of HRSN Initiatives
    - The evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. CMS has also updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration.

4. Changes to the Budget Neutrality Approach
    - CMS is moving away from its 2018 budget neutrality policy to provide states with expanded flexibilities and budgets to implement innovative programs with a focus on advancing health equity and addressing disproportionate HRSNs.
    - CMS signaled that it will consistently apply the approach to Massachusetts budget neutrality to all similarly situated states going forward.[v]
    - CMS is making several changes to give states greater access to funding while maintaining fiscal integrity. *See these changes in the table on the following page.*[vi]

Area of Focus	2018 SMD Guidance	Changes approved through OR waiver	Anticipated Impact
Without Waiver (WOW) Baseline	Adjusted WOW per-member-per-month (PMPM) cost estimates to reflect only the recent actual PMPM costs	Uses a weighted average of OR's historical WOW PMPM baseline and its actual PMPM costs	Expected to result in a slightly higher WOW baseline
Trend rate for Expected Expenditures	Used the lower of the state's historical trend rate or the President's Budget trend rate	Projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period	Increases budget room and aligns the demonstration trend rate with federal budgeting principles and assumptions
Demonstration "Savings" Rollover	CMS explained that it expected to permit states to roll over "savings" to a demonstration extension from only the most recent five years of prior approvals, and that there would be a transitional phase-down of accrued "savings"	The "savings" amount available for the extension approval period has been limited to the lower of: (1) The "savings" available in the current extension approval period plus net savings from up to 10 years of the immediately prior demonstration approval period(s); or (2) 15% of the state's projected total Medicaid expenditures in aggregate for the demonstration extension period	With less narrow limitations on savings rollover, states can access more "savings" from prior approval periods to fund program innovations
"Hypothetical" Expenditures for HRSN Infrastructure and Services	No explicit categorization of HRSN expenditures as hypothetical expenditures	CMS is treating certain HRSN expenditures as "hypothetical" expenditures. There is an additional sub-cap to HRSN infrastructure expenditures, referring to these expenditures as "capped hypothetical expenditures" in the Special Terms and Conditions (STCs) Unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year	States do not have to find demonstration "savings" to offset hypothetical expenditures, thereby freeing up funds/adding flexibility

Evaluation

The approved waiver STCs require the state's waiver evaluation design to include the following:

- In General
    - Must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography).
- HRSN
    - Evaluation hypotheses for the HRSN initiatives must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries.

- Must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes.
- Must include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.
- Must also assess the effectiveness of the infrastructure investments authorized through the OHP demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing and nutrition supports change over time in concert with new Medicaid funding toward those HRSN services.
- Must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services.

- Continuous Eligibility
  - Must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility
  - Must evaluate the effectiveness of the continuous eligibility authority
  - May conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

- DSHPs
  - Assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations.
  - Must address CCO's efforts to integrate behavioral, oral, and physical health, Oregon Health Plan Demonstration Approval Period: October 1, 2022 through September 30, 2027 Page 86 promote value-based care, and support cost-effective, quality health care to beneficiaries, and must further focus on the impact of passively enrolling FFS-eligible beneficiaries in CCOs.
  - Must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs.

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[i] CMS approves Oregon's Medicaid waiver, state will receive funds to address food and housing initiatives - State of Reform | State of Reform;

[ii] Federal Government approves Oregon Medicaid waiver - Elkhorn Media Group; 2022-2027-1115-Demonstration-Approval.pdf (oregon.gov); Oregon Health Authority : What's Changing in the 2022 – 2027 1115 Demonstration Waiver : Medicaid Policy : State of Oregon

[iii] Oregon's 2022-2027 1115 Medicaid Waiver

[iv] Federal Government approves Oregon Medicaid waiver - Elkhorn Media Group

[v] Ibid.

[vi] Oregon 1115 Waiver approval (Medicaid.gov)