Medicaid Waiver Renewal and Oregon Health Plan Redeterminations in 2022

Jeremy Vandehey, Health Policy and Analytics Director
Dana Hittle, Interim State Medicaid Director

Senate Health Care Committee
January 11, 2022

Oregon Health Authority

What's a waiver?

Medicaid is a federal program administered by states.

Federal law sets Medicaid minimum standards related to eligibility and required benefits.

But states can *waive* certain federal regulations to achieve greater flexibility around eligibility, benefits, delivery systems, etc. than is otherwise allowed under Medicaid rules.

Waivers are approved fully at CMS's discretion, they are a blend of legal, policy, and political dynamics.

2

1115 Medicaid Demonstration Waivers

Different types of waivers describe specific services for specific populations.

An 1115 Demonstration waiver is the broadest type of waiver available under Medicaid.

Under an 1115, states may propose to waive many of the key provisions of the Medicaid statute, including but not limited to:

- ✓ Who is covered
- ✓ What benefits are provided
- ✓ How much individuals may be charged for cost sharing
- ✓ How providers will be paid
- ✓ Must include a formal evaluation of impact.

3

The Oregon Health Plan Waiver is not:

- X Applicable to the Medicaid fee-for-service population
- X For Home and Community Based services for specific populations (those are 1915 waivers)
- X The same as State Plan Amendments (those are for specific services/provider types, and have a different CMS approval process)
- X The only way to transform our health system (State legislation, Administrative Rules, OHA Guidance)

4

Timeline: What's to come

2021

Nov

Final concept papers released

Dec

Public comment

2022

Jan

Incorporate feedback

Feb

Submit formal application

Implementation planning begins

Negotiations with CMS

June

Current waiver ends

2023

July

New waiver accepted

**Contingent on CMS*

Jan

New CCO contract year

Begin implementing changes to contract, rule, and systems

Changes occur through the regular annual restatement process

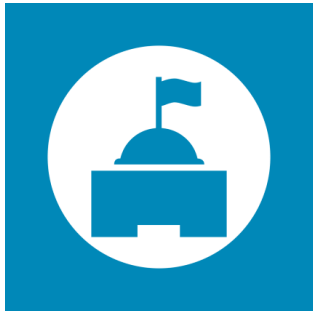
Waiver strategies

Our policy concepts break down the drivers of health inequities into four actionable sub-goals:

Maximizing coverage through the Oregon Health Plan

Improving health outcomes by streamlining transitions

Encouraging smart, flexible spending for health equity



Focused health equity investments

Proposed waiver strategies:

Waive federal OHP *eligibility* rules so that:

1. Kids stay enrolled until their 6th birthday
2. People ages 6+ stay automatically enrolled for two years (instead of one)
3. **When people apply for Supplemental Nutrition Assistance Program (SNAP) benefits, OHA can easily enroll them in OHP if they qualify**

Proposed waiver strategies:

Waive federal *eligibility* rules so that people are allowed to have OHP coverage…

1. When they're in prison, jail or local corrections, juvenile corrections, the Oregon State Hospital, psychiatric residential treatment
2. Up to age 26 for Youth with Special Health Care Needs

Proposed waiver strategies:

Waive federal *covered services* rules…

3. So that OHP members who are experiencing major life transitions can have social supports

Major life transitions include things like	*Social supports include things like*
Becoming homeless	Housing
Getting out of jail or prison	Transportation
Entering or leaving foster care	Food assistance
Leaving the Oregon State Hospital	Employment supports

Proposed waiver strategies:

Waive federal *covered services* rules so that…

4. People with OHP can use more types of providers outside the medical model (like Traditional Health Workers and Peer Support Specialists)

And request federal funding so that…

5. Services are available to support people during disruptive transitions
6. Child Welfare can meet medical necessity for psychiatric residential treatment services for children in custody of the state by ensuring beds are available

Proposed waiver strategies:

Waive federal rules about *rate setting methodology* so that

1. CCOs are encouraged to spend more money on health-related care for members
2. CCOs' budgets are simpler and predictable

Waive what rules Oregon can make about *how drugs are covered* so that

3. The cost of prescription medications can be better controlled

Proposed waiver strategies:

Change the way the *Quality Incentive Program* is described in the waiver so that:

1. The program can be split into two parts: Upstream and downstream metrics
2. More decision-making power can be given to communities
3. **The program can be redesigned better advances health equity**

Proposed waiver strategies:

State and federal investment toward community-driven initiatives that help eliminate health inequities.

How will the investments be community-driven?

New Community Investment Collaboratives (CICs) will decide where to spend money in the community to solve inequities.

Where will the money come from?

Some of the money would come directly from the state to CICs.

CCOs would also be required to spend a certain amount of their budget to support CICs.

What do we need to ask for in the waiver?

To implement this strategy, we need permission from the federal government to spend state money in new ways.

We also plan to ask the federal government to provide additional money toward this effort.

Parts of our current waiver that we plan to renew, *unchanged….*

Prioritized List of Health Services and Health Evidence Review Commission - A ranked list, based on clinical effectiveness, of what types of treatment are covered by OHP

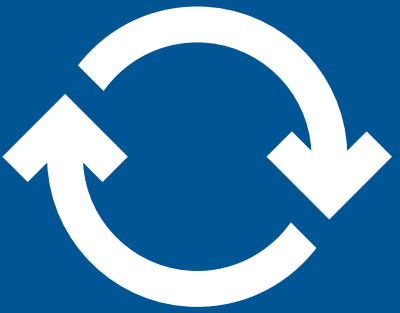
The Coordinated Care Model and physical, behavioral, and oral health integration

Value-based payment methodologies

Commitments to care quality and access

Community Advisory Councils

Tribal Engagement and Collaboration Protocol for CCOs and OHA



Oregon Health Plan Redeterminations in 2022

The federal government declared a public health emergency (PHE) effective March 18, 2020.

In response to the Families First Coronavirus Relief Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Oregon implemented emergency policies:

- OHP recipients eligible on March 18, 2020, and those enrolled after, will maintain coverage through the end of the PHE.
  Exceptions: death, confirmed out-of-state residency, incarceration, and voluntary request.
- Applicant attestation of most eligibility criteria is accepted for initial and ongoing eligibility determinations (redeterminations).
  Oregonians are not required to provide proof of reported information, except for their citizenship/immigration status.

Current federal guidance

- The Centers for Medicare & Medicaid Services (CMS) has committed to providing states with 60 days advance notice of the PHE end date.
- CMS expects states to review eligibility for all recipients within 12 months following the PHE end-date. States are required to perform a full renewal and consider all programs before ending coverage.
- Passage of the federal Build Back Better Bill may affect timelines and processes.
- CMS will release additional guidance.

Easing the transition- work has begun to plan and prepare

- When PHE end date is confirmed, OHA will start updating the ONE eligibility system to end the PHE-related rules.
- OHA will ‘balance’ the OHP caseload over the 12 months following the PHE, avoiding large surges and lags in renewal volume.
- OHA will conduct robust outreach and communication to let OHP members know what to expect, and to get members’ current contact information to avoid coverage loss among eligible individuals.
- Coordination with the health insurance Marketplace to support individuals transitioning from OHP to a Marketplace Qualified Health Plan.

When post-PHE renewals begin

- OHA will begin redetermining OHP member eligibility once the PHE ends.
- OHA will process renewals via existing methods:
    - Automated Renewal (OHA confirms/verifies eligibility criteria without requiring action from the member) will be attempted.
    - If coverage cannot be automatically renewed, members receive a pre-populated renewal notice that they must sign and return.
- Renewals will be performed in monthly batches with each batch started ~90 days prior to the renewal deadline. OHA will begin to see the results of those renewal batches ~3 months after the PHE ends.
- Renewals will be spread out over 12 months. OHA will share reports of cases being included in each batch ahead of time so that CCOs can reach out to their members.
- Any member who is found ineligible for coverage will receive a notice of action and fair hearing rights.

Outstanding Planning Issues

- **Timing of Disenrollment**: Confirm the timing and process for redeterminations and disenrollment both locally and with CMS
- **Resource Needs:** Determine the internal and external resources needed for outreach and enrollment efforts
- **Outreach & Engagement:** Engage with members and partners to provide assistance and support
- **Federal Marketplace Platform:** Address the challenges and limitations with the federal Marketplace platform
- **Ensure alignment for continuity of care:** Consider a Basic Health Plan, public option, or other Marketplace plan changes
- **Next Step:** Conversations with partners and community about the Marketplace and transitioning coverage

Thank You

Oregon Health Authority