December 16, 2022

VIA ELECTRONIC SUBMISSION

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Oregon Substance Use Disorder "Bridge-to-Bridge" Section 1115 Demonstration Amendment

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Oregon's application to amend its "Substance Use Disorder" section 1115 demonstration which is designed to test a strategy to help avert coverage losses and churn once the Families First Coronavirus Response Act continuous enrollment protection for Medicaid ends.

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

As Oregon prepares to implement its Basic Health Program (BHP), *we urge you to approve the state's proposed section 1115 amendment, which seeks to provide Oregon residents with stable health coverage by temporarily extending Medicaid eligibility to enrolled individuals with incomes between 138 and 200 percent of the federal poverty level (*FPL) when the state restarts eligibility redeterminations once the federal continuous enrollment protection is lifted. (In the case of AI/AN populations, we support the state's proposal to extend this coverage on a permanent basis, since AI/AN individuals between 138 and 200 percent FPL will be exempt from mandatory enrollment in CCO-administered BHP.)

Oregon's amendment is part of the state's plan to maximize continuity of coverage once the continuous enrollment protection ends. As your department has found, the coverage losses once the continuous coverage protection ends are expected to be substantial – an estimated 15 million people, or almost 20 percent of current Medicaid and CHIP enrollees, are predicted to lose coverage.[1] Of those estimated to lose coverage due to ineligibility (approximately 8.2 million people), 2.7 million would be eligible for Advanced Premium Tax Credits (APTCs) for plans on the

[1] HHS Assistant Secretary for Planning and Evaluation (ASPE), "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf.

Marketplace.[2] Though most individuals in the amendment's proposed coverage group would be eligible for subsidized coverage through the Marketplace, the state rightfully notes that transitions between Medicaid and the Marketplace are not seamless and can often lead to gaps in coverage, sometimes as a result of procedural denials that occur when paperwork is missing or other administrative barriers prevent individuals who are eligible from being enrolled.

According to recent research from MACPAC, only three percent of all adults and children who were disenrolled from Medicaid or CHIP had enrolled in Marketplace coverage within a year of disenrollment.[3] And in 2015, when parents in Connecticut lost Medicaid eligibility at similar income ranges, only 27 percent were enrolled in a Qualified Health Plan six months later.[4] At a time when the volume of redeterminations is expected to be high, and transfers between Medicaid and Oregon's marketplace may not be seamless, the state's proposal presents an important alternative to help keep low income people who are already enrolled in Medicaid covered pending implementation of the BHP.

Oregon's proposal would likely help reduce "churn" among individuals who, in the absence of the waiver, might qualify for subsidized Marketplace coverage but either do not make a successful transition to that coverage or experience fluctuations in income that would again qualify them for Medicaid, requiring reenrollment, within a short period of time. During the continuous coverage unwinding period, Oregon's proposal will minimize the effects of income volatility that results in churn by retaining eligibility for individuals with incomes between 138 and 200 percent of poverty who are already enrolled in Medicaid, eliminating the need for them to transition to the Marketplace in the first place *or* to have to reenroll in Medicaid if their income drops again. And once the BHP is implemented, individuals would still be enrolled in the same managed care plans that currently serve the state's Medicaid population. This, too, would help reduce disruptions to care by enabling people to retain the same delivery system and providers, even if their source of coverage changes. The back and forth between types of coverage has been found to increase delayed care and hospitalizations, decrease use of prescription medications, and result in periods of uninsurance.[5]

While we support the state's proposed amendment, there are two areas that we recommend CMS clarify as it considers the state's request:

(1) In order to be eligible for the proposed coverage group under the amended demonstration, Oregon residents would have to be enrolled in Medicaid at the time of the initial redetermination after the end of the PHE. The proposal indicates that individuals would meet the criteria for the new eligibility group if they are *determined ineligible* under the current Medicaid limits. However, the state is silent on how the demonstration would work for individuals who lose coverage for non-eligibility reasons (i.e., procedural disenrollments). Procedural disenrollments, also known as administrative churn, are a significant proportion of the disenrollments that occur during redeterminations and a major concern during the unwinding. ASPE predicts that 6.8 million enrollees will lose coverage once the continuous

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[2] *Ibid.*

[3] Medicaid and CHIP Payment and Access Commission (MACPAC), "Transitions Between Medicaid, CHIP, and Exchange Coverage," July 2022, available at https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.

[4] "Potential Consequences of Proposal to Further Reduce Eligibility for HUSKY Insured Parents" Connecticut Health Foundation, April 18, 2016. Available at https://www.cthealth.org/publication/husky-parents-2016/

[5] ASPE, op. cit.

enrollment protection ends.[6] Oregonians who experience procedural disenrollments subsequent to the PHE lifting would meet the requirement of being enrolled in coverage prior to their (uncompleted) redetermination; as such, we encourage CMS to work with the state to clarify that they will be eligible for extended coverage under the demonstration if they reapply for Medicaid before the BHP is implemented. At a minimum, re-application during the reconsideration period should trigger eligibility for extended coverage.

(2) Oregon is also not clear about the enrollment process into the demonstration, and later the BHP, for individuals eligible for the new coverage group. The state notes in its application that staff would be required to determine if an individual has a qualifying income between 138 and 200 percent FPL and was enrolled in Medicaid at the time of redetermination. But there is no discussion of whether individuals would have to fill out any additional paperwork in order to enroll in coverage through the demonstration, or if the process would be automatic, which we would recommend. The state should treat this new Medicaid eligibility group as it would any other eligibility group and enroll qualified individuals automatically and on an *ex parte* basis, if information is available to do so.

In addition, the state does not provide any details about how individuals would be transitioned from the demonstration to BHP coverage. If the state's goal for the demonstration is to minimize coverage loss, we encourage CMS to work with the state to specify standards to ensure that the coverage transition from the demonstration to BHP is as seamless as possible, minimizing administrative burdens for enrollees. CMS should encourage the state to develop and/or clarify these processes to maximize continuity of coverage, even if certain details are reserved until the state launches its BHP.

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Thank you for your willingness to consider our comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

[6] Sarah Sugar, *et al.,* "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," HHS Assistant Secretary for Planning and Evaluation, April 12, 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf.