April 13, 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 Health Plan Extension Application

Dear Secretary Becerra,

As organizations dedicated to promoting the health of our nation's children and pregnant women, the undersigned organizations appreciate the opportunity to comment on Oregon's renewal application for the "Oregon Health Plan" section 1115 demonstration. We strongly support the state's request to provide multiple years of continuous eligibility for young children, as well as two years for older children, parents, and other adults. Continuous coverage and uninterrupted access to care is vital for children's healthy development and future success. We commend the state for its visionary proposal.

We are also pleased that Oregon has recognized that their waiver of retroactive eligibility for all eligibility groups including pregnant women and children was no longer experimental and indeed contrary to their stated goals of maximizing coverage and achieving health equity. We believe the state's decision to drop its request to continue waiving the benefit is wise and urge other states to follow suit.

We applaud the state's proposal to extend child eligibility levels for children with special healthcare needs through age 26 and provide enhanced transition benefits as they move to adult care, aligning coverage with the American Academy of Pediatrics' Bright Futures guidance.[1]

While we were very encouraged by the state's decision to drop its request for a waiver of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, we have significant concerns about the state's description of how it will administer the benefit going forward. The continued use of the prioritized list of services in any fashion is fundamentally incompatible with the EPSDT benefit's guarantee of access to all medically necessary services. Finally, we are opposed to the state's request to exclude certain prescription drugs from coverage. These provisions would prevent children and families from accessing needed care.

Multi-year continuous eligibility for young children will provide stability of coverage and support early childhood development.

Currently, Oregon provides 12 months of continuous eligibility for children enrolled in Medicaid or the Children's Health Insurance Program (CHIP), shielding them from gaps in coverage that can occur because of annual fluctuations in income. In this proposal, the state seeks to maximize

[1] Joseph F. Hagen, Judith S. Shaw, and Paula M. Duncan, eds., "Promoting Health for Children and Youth with Special Health Care Needs," in *Bright Futures Guidelines* [Pocket Guide], 4th ed., American Academy of Pediatrics, February 2017, https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_CYSHCNHealth.pdf.

coverage and limit administrative burdens by providing continuous eligibility for young children until the age of six. We believe that extending the continuous eligibility period will reduce gaps in coverage, promote access to care, and support healthy development during the critical early years of life. This proposal will promote the objectives of Medicaid and is the type of request for which 1115 demonstrations should be used. *We strongly urge CMS to approve Oregon's request to provide continuous eligibility to young children through the age of six.* A robust evaluation of such a groundbreaking policy will help advance knowledge about the ways to ensure that children--especially those of color--are best supported to grow and thrive.

Between 2016 and 2019, the uninsured rate for young children under the age of six in Oregon rose 1.4 percentage points from 2.3 to 3.7 percent.[2] Unfortunately, this figure likely underestimates the share of children who experienced gaps in coverage at any point during the year as they moved off and on coverage, or "churned."[3] Recent research shows that nationally children are among the eligibility groups most likely to experience churn, and that Asian, Black, and Hispanic children are more likely to be uninsured for part or all of the year than non-Hispanic white children.[4] Ensuring that children do not lose coverage because they face red tape barriers or fluctuations in family income could help reverse this concerning trend and ameliorate racial disparities in coverage.

Stability in coverage would also support connection to a medical home and foster a trusted relationship between provider and family, promoting optimal care.[5] Even if a child does not become uninsured, when their family frequently switches coverage they must navigate different provider networks and prior authorization requirements, which can lead to gaps in care.[6]

Continual access to care during early years is critical for healthy development in childhood and beyond. The American Academy of Pediatrics recommends that children receive at least 15 well-child visits in their first six years of life.[7] These visits provide an opportunity to perform preventative screenings, administer life-saving vaccines, and address conditions such as asthma, hearing impairment, and nutritional deficiencies before they have lasting impacts on a child's

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[2] Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey data, Table S2701.

[3] Aubrianna Osorio and Joan Alker, "Gaps in Coverage: A Look at Child Health Insurance Trends," Georgetown University Center for Children and Families, November 22, 2021, https://ccf.georgetown.edu/2021/11/22/gaps-in-coverage-a-look-at-child-health-insurance-trends/.

[4] Bradley Corallo *et al.*, "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies," Kaiser Family Foundation, December 14, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/; Aubrianna Osorio and Joan Alker, Op. cit.

[5] American Academy of Pediatrics, "Overview of Data Related to Pediatric Medical Home," September 29, 2017, https://medicalhomeinfo.aap.org/Documents/Overview%20of%20Data%20Related%20to%20the%20Pediatric%20Medical%20Home%20NCMHI%20Update%209.29.17.pdf.

[6] Sarah Sugar *et al.*, "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," Assistant Secretary for Planning and Evaluation Office of Health Policy, April 12, 2021, https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

[7] American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," March 2021, https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

growth and functioning.[8] Early visits also include developmental screenings and counseling for families on how to best support the social-emotional health of their child.[9]

Extending continuous coverage for young children is likely to have long-term benefits. There is a growing body of literature on the critical importance of the early years of life in brain development and future learning.[10] Childhood access to Medicaid and CHIP coverage is associated with numerous long-term benefits including educational achievement and financial security.[11] We commend the state for its innovative kindergarten readiness metric which recognizes this cross-sector impact and incentivizes building an integrated early childhood health and learning infrastructure.

Two-year continuous eligibility for older children and adults is likely to promote health equity, improve access to care for families, and strengthen program efficiency.

In addition to maximizing coverage for young children through multi-year continuous eligibility, Oregon seeks to provide two-years of continuous eligibility to children ages six and over and all other beneficiaries. We believe that this two-year continuous eligibility period serves the objective of Medicaid and performs a valid experimental purpose. *We strongly urge CMS to approve the state's request to extend continuous eligibility.*

Oregon's proposed demonstration is centered around the laudable goal of achieving health equity by 2030, and ensuring stable access to coverage for everyone is a critical first step. While Black, Hispanic, and American Indian/Alaska Native Oregonians are still more likely to be uninsured than their white peers, the continuous coverage period associated with the COVID-19 pandemic showed promising results: the coverage disparity between Black Oregonians and white Oregonians narrowed between 2019 and 2021 as Black Oregonians saw the largest percentage point decline in their uninsured rate of any race/ethnicity.[12]

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[8] Delaney Gracy *et al.*, "Health Barriers to Learning: The Prevalence and Educational Consequences in Disadvantaged Children: A Review of the Literature," Children's Health Fund, January 2017, https://www-childrenshealthfund.b-cdn.net/wp-content/uploads/2017/02/HBL-Literature-Review-2-2-2017.pdf.

[9] Joseph F. Hagen, Judith S. Shaw, and Paula M. Duncan, eds., "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents [Pocket Guide]," 4th ed., American Academy of Pediatrics, February 2017, https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_POCKETGUIDE.pdf.

[10] National Scientific Council on the Developing Child, "Early Childhood Development: Closing the Gap Between What We Know and What We Do," Harvard Center on the Developing Child, January 2007, https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/Science_Early_Childhood_Development.pdf.

[11] Edwin Park, Joan Alker, and Alexandra Corcoran, "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm," The Commonwealth Fund, December 8, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm; National Scientific Council on the Developing Child, "Connecting the Brain to the Rest of the Body: Early Childhood Development and Lifelong Health are Deeply Intertwined," Harvard Center on the Developing Child, June 2020, https://developingchild.harvard.edu/resources/connecting-the-brain-to-the-rest-of-the-body-early-childhood-development-and-lifelong-health-are-deeply-intertwined/.

[12] Jeremy Vandehey and Dave Baden, "Oregon Health Plan Post-Public Health Emergency Eligibility Redeterminations Planning," Presentation to House Rules Committee, February 17, 2022, https://www.oregon.gov/oha/HPA/HP-MAC/MACmeetings/2.0%20Oregon%20Redeterminations%20Briefing%20House%20Rules%202-17-22%20FINAL.pdf#page=4; Oregon Health Authority, "Types of Uninsurance," January 2022, https://visual-

Continual access to care will support families by boosting school attendance rates, lessening worries of medical debt, and improving parental health. Both child and parental health are predictors of "chronic absenteeism" as children stay home due to uncontrolled conditions such as asthma, diabetes, and dental pain or take on family responsibilities while a parent is ill.[13] Chronic absenteeism, in turn, is associated with poor health and economic outcomes as an adult.[14] Access to regular physical and mental health care for the whole family are key to keeping children in school.[15] And, stable access to coverage for children and parents protects against the medical debt that can accrue during gaps in coverage and disproportionately impacts families of color.[16] Improved financial security, in turn, leads to lower levels of toxic stress in the home.[17] Finally, better parental mental health is key for healthy parental-child interaction, which nurtures early brain development.[18]

Extending continuous eligibility also has the potential to improve program performance and efficiency. In New York, implementing a one-year continuous eligibility period for adult beneficiaries led to declines in inpatient hospital admissions and overall per-member per-month costs.[19] And, after adopting one year of continuous eligibility for adults, Montana state officials reported administrative savings and fewer staff hours needed to process individuals moving off and on the program.[20] Oregon's proposal to test a two-year continuous eligibility period leads to promising programmatic hypotheses including increased access to preventive care, reduced health care costs in the long term, and lower administrative burden.

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data.dhsoha.state.or.us/t/OHA/views/OregonUninsuranceRates/Uninsurance?%3Aiid=2&%3AisGuestRedirectFromVizportal=y&%3Aembed=y.

[13] Mandy Allison *et al.*, "The Link Between School Attendance and Good Health," *Pediatrics* 143, no. 2, February 2019, https://publications.aap.org/pediatrics/article/143/2/e20183648/37326/The-Link-Between-School-Attendance-and-Good-Health.

[14] Ibid.

[15] Shreya Roy *et al.*, "The Link Between Medicaid Expansion and School Absenteeism: Evidence from the Southern United States," *Journal of School Health* 92, no. 2, November 2021, https://onlinelibrary.wiley.com/doi/10.1111/josh.13111;

[16] Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey," The Commonwealth Fund, August 2020, https://www.commonwealthfund.org/sites/default/files/2020-08/PDF_Collins_looming_crisis_affordability_biennial_2020_exhibits.pdf#page=6; Matthew Rae *et al.*, "The Burden of Medical Debt in the United States," Kaiser Family Foundation, March 10, 2022, https://www.kff.org/health-costs/issue-brief/the-burden-of-medical-debt-in-the-united-states/; Jack P. Shonkoff, Natalie Slopen, David R. Williams, "Early Childhood Adversity, Toxic Stress, and the Impacts of Racism on the Foundations of Health," *Annual Review of Public Health* 42, no. 1, April 2021, https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-090419-101940.

[17] Daniel Brisson, "A Systematic Review of the Association between Poverty and Biomarkers of Toxic Stress," *Journal of Evidence-Based Social Work* 17, no. 6, July 12, 2020, https://www.tandfonline.com/doi/abs/10.1080/26408066.2020.1769786.

[18] National Scientific Council on the Developing Child, "Young Children Develop in an Environment of Relationships," Harvard Center on the Developing Child, January 2004, https://developingchild.harvard.edu/resources/wp1/.

[19] Harry H. Liu *et al.*, "New York State 1115 Demonstration Independent Evaluation: Interim Report," Rand Corporation, 2021, https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2021-08-03_1115_demo_eval.pdf#page=110.

[20] Niranjana Kowlessar *et al.*, "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Summative Evaluation Report," Social & Scientific Systems and Urban Institute, November 30, 2020, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-montana-2020.pdf.

Dropping the EPSDT waiver is a critical step in the right direction, but the demonstration continues to raise serious concerns and questions about access to EPSDT services going forward.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is the cornerstone of children's coverage in Medicaid which guarantees that children and young adults under age 21 receive the full scope of services necessary for their healthy growth and development. Oregon has waived the EPSDT benefit for children since the inception of its demonstration in 1994, allowing the state to limit children's services to those included on a "prioritized list" determined by the governor-appointed Health Evidence Review Commission (HERC). As of August 2021, there were over 460,000 children subject to this waiver.[21]

In its application, the state proposes to phase-out its waiver of EPSDT, ending no later than January 1, 2024. The state suggests that during this wind down period the HERC will undertake a review of services not currently covered and revise the list such that all medically necessary pediatric services are "above the line" (covered). Once the revision is complete, the state promises that any service indicated by an EPSDT screen which is not included on the list will receive an individualized medical necessity review. *While we applaud the state's decision to drop its request for a formal waiver of EPSDT, we have significant concerns about the state's proposal to continue using the prioritized list and questions about the implementation plans.* It should be noted that it is difficult to comment on the state's proposal given the lack of detail.

The continued use of an extraneous list is incompatible with the basic purpose and design of EPSDT and does not promote the objectives of Medicaid. The EPSDT benefit guarantees children access to all medically necessary services, even if they are not covered by the state plan.[22] The state's proposal to revise the prioritized list such that "all medically necessary EPSDT services for the population of children and adolescents are covered" glosses over the fact that medical necessity is an individual (as opposed to a population) standard. The state acknowledges this erroneous reasoning insofar as they concede there must be a process for children to access medically necessary services not included on the list. The HERC may place *common* pediatric services on the list, however there is no way to fully capture what providers will deem necessary for individual children. This would be particularly harmful for children with special health care needs. The list is simply an arbitrary subset of EPSDT services that will be a barrier to care.

We also have significant concerns about the implementation of this policy, based on the details we can garner from the application. First, the state proposes a "transition period" to phase out its waiver by January 1, 2024, yet there is no justification for this long delay. It is also unclear what policy applies during and after the transition period. Will children still be subject to the prioritized list? Will there be an appeals process through the state agency? How will the proper provision of services be monitored across CCOs? How will the state ensure that there is a strong public outreach process which meets the standard of section 1902(a)(43) of the Social Security Act? If CMS allows this lengthy phase-down process, it should require the state to adopt mitigation and

[21] "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data," Centers for Medicaid and Medicare Services, March 28, 2022, https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data.

[22] Title XIX of the Social Security Act, §1905(r).

monitoring strategies including communication strategies and grievance/appeal reviews. No child should have reduced access to services during the transition period.

The application includes no explanation of the individualized medical necessity review process, although the state does admit that "these processes can be lengthy and burdensome to providers and families." Nor does the application include information about outreach or education to ensure that providers and families are informed of their right to such a review. In reality, the continued use of a list for children, even with an exceptions process, alongside the use of an *exclusionary* list for adults will cause confusion for enrollees and providers. The state also does not detail how such restrictions on and confusion around EPSDT services will impact children of color. As recognized by the Biden Administration, administrative burden has a disproportionate impact on families of color.[23] *Imposing additional burdens on families, especially families of children with special health care needs and families of color, is contrary to the demonstration's stated goal of achieving health equity and CMS's strategic vision promising to link new initiatives to progress on reducing health disparities.*[24]

Our recommendation is that CMS deny the continued use of any extra list for children, regardless of the exceptions process. However, if, contrary to our suggestion, CMS allows the continued use of a list, it is imperative that CMS require the state to publicly explain and implement a strong outreach and exceptions process plan.

Conclusion

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for consideration of our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Leo Cuello (lc247@georgetown.edu).

Sincerely,

American Academy of Pediatrics
First Focus on Children
Georgetown University Center for Children and Families
National Association of Pediatric Nurse Practitioners

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[23] Office of Management and Budget, "Study to Identify Methods to Assess Equity: Report to the President," July 20, 2021, https://www.whitehouse.gov/wp-content/uploads/2021/08/OMB-Report-on-E013985-Implementation_508-Compliant-Secure-v1.1.pdf#page=21.

[24] Chiquita Brooks-LaSure and Daniel Tsai, "A Strategic Vision for Medicaid and the Children's Health Insurance Program (CHIP)," *Health Affairs Blog,* November 16, 2021, https://www.healthaffairs.org/do/10.1377/forefront.20211115.537685/full/.