Oregon
Medicaid Advisory Committee

12-month Continuous Eligibility for Oregon Health Plan Income-eligible Adults

Report and Recommendations

September 2015

Oregon Health Authority

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MEMORANDUM

DATE: September 28th, 2015
TO: Lynne Saxton, Director, Oregon Health Authority
FROM: Medicaid Advisory Committee
RE: Recommendations on 12-Month Continuous Eligibility for Oregon Health Plan Income-eligible Adults

Dear Ms. Saxton,

For nearly two years, the Medicaid Advisory Committee (MAC) has examined the issue of churn, as individuals transition in and out of Medicaid due to changes in income status, family circumstances or administrative issues. While churn is not a new phenomenon, its extent and scope are greater and more complex due to coverage dynamics provided by the Affordable Care Act (ACA). Churn *disproportionately affects* low and moderate income Oregonians, likely resulting in adverse impacts such as disruptions in care, gaps or loss in coverage, and added administrative costs to the state, coordinated care organizations (CCOs) and providers (*see* Attachment A, pgs. 1-5).

In 2014, the Committee submitted a set of comprehensive recommendations to the Oregon Health Policy Board. Among them was a recommendation for the Oregon Health Authority (OHA) to conduct a cost-benefit analysis of adopting 12-month continuous eligibility for Oregon Health Plan (OHP) income-eligible adults, similar to the policy already in place for children. In 2015, the OHA directed the committee to conduct the analysis for the 2017-19 biennium.

Results of the analysis indicate that the continuity of Medicaid coverage would increase during the 17-19 biennium by approximately 15 percent, thus, reducing churn in OHP (*see* Attachment B, pgs. 1-12). Adoption of this policy, however, requires a state investment of $223 million in order to draw down $1.01 billion in additional federal revenue. Approximately $58 million of the state's $223 million investment is a result in a decrease of 2.6 percent in the enhanced federal participation rate for the Medicaid expansion population.[1] Unfortunately, due to insufficient data and limited research on this topic, potential administrative savings and lower per-member per-month costs were not included in the analysis as the information was not available. [2]

[1] ACA provides states with a FMAP of 100% for the period of 2014-2016, and then phases down to 90 percent in 2020 and beyond.

[2] Individuals enrolled in Medicaid for longer periods of time may experience lower monthly costs as these individuals are more likely to receive primary and preventive care as a direct result of enhanced coverage

Recognizing the potential impact this policy would have on the state's budget, the importance of the financial sustainability of OHP, and forecasted budgetary constraints for Oregon's Medicaid program in the 17-19 biennium, the **Committee recommends the following**:

I.	Request policy as part of Oregon's 1115 Waiver renewal: propose to the Centers for Medicare and Medicaid Services (CMS) that 12-month continuous eligibility for OHP income-eligible adults be incorporated into Oregon's 1115 waiver in 2017, including waiving the reduction in FMAP for this policy, reducing the overall state investment to $165 million.
II.	Monitor OHP program performance: implement data collection procedures to monitor changes in the fiscal, quality and health outcomes that result from churn in OHP: a) Adopt transparent OHP eligibility, enrollment and redetermination performance indicators. b) Complete annual assessment of administrative costs that result from churn and potential savings to the Medicaid program, CCOs, and health providers if this policy were adopted.
III.	Conduct longitudinal cost-benefit study: estimate potential financial benefits that could result from changes in health care utilization associated with increases in coverage continuity (i.e. stable Medicaid coverage).

If Oregon's Legislature determines that the financial investment required to implement 12-month continuous eligibility—is not a prudent use of limited state resources—at a minimum, the committee requests OHA support recommendations II and III to ensure Oregon's Medicaid system is achieving the Triple Aim.

In closing, we appreciate the opportunity to propose policy options that minimize churn, and establish a system-wide accountability measurement framework to assess and monitor the operational performance of OHP. It is critical that Oregon's officials monitor and work to ensure access to continuous, quality, affordable care and coverage for OHP members.

Sincerely,

Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee

Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

continuity. See Medicaid Advisory Committee April 2015 brief on 12-month continuous eligibility included as attachment A.

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Attachment A: 12-month Continuous Eligibility for ACA Expansion Adults

Introduction

A key success of Affordable Care Act (ACA) implementation in Oregon is the state's expansion of Medicaid in 2014. Within less than 12 months, approximately 357,500 new individuals enrolled in the Oregon Health Plan (OHP), now covering nearly one in four Oregonians.[3] Equally important to expanding coverage is ensuring that those already insured retain their coverage.

At any point in a calendar year, individuals and families may experience coverage transitions caused by several factors, including income shifts, changes in family circumstances, or administrative enrollment issues, such as difficulties meeting documentation requirements. The phenomenon commonly referred to as "churn" is not new, but its extent and scope have become more complex due to coverage dynamics created by the ACA (e.g. transitions between Medicaid and qualified health plans available on the Marketplace). A key policy issue for states is managing churn in a way that preserves continuity of care and insurance coverage.

This brief provides an introduction to the federal policy of 12-month continuous eligibility for adults in Medicaid. The brief also discusses why several states are considering this option, review current Medicaid eligibility and renewal guidelines in Oregon, and offer an outline for the proposed financial feasibility study for this federal option in Oregon.

Background

The underlying issue is that low and moderate-income parents and childless adults experience substantial income volatility throughout the year, which affects eligibility and can cause churning on and off Medicaid. Prior to implementation of the ACA, several studies[4] estimated that nationally, adults under age 65 with income below 138 percent of the federal poverty level (FPL) (i.e. expansion population) would transition on-and-off coverage, at significant rates. For example, one study estimated that 23 percent of adults would have incomes above 138 percent FPL four months later. Of these adults, a third (34 percent) would fall back below 138 percent FPL by their regular annual redetermination.[5] In other words, although income eligibility for adults has increased to 138%, and there are new coverage options available through the ACA, individual and families will continue to transition, or churn in-and-out of Medicaid coverage.

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[3] OHP Enrollment Report (2015, January).

[4] Sommers, B. & Rosenbaum, S. (2011).Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges. *Health Affairs*. 30 (2): 228-236.

[5] Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

In 2013, Oregon received a federal waiver to grant Medicaid and OHP eligibility to adults who already qualified for other state issued benefit programs (such as SNAP).[6] This process, referred to as "fast track," resulted in approximately 140,000 eligible adult Oregonians being enrolled in OHP as part of Medicaid expansion. This policy significantly increased the number of income-eligible adults enrolled in OHP, resulting in an historic and unprecedented number of Oregonians in OHP.

Recognizing the success of Oregon's Medicaid expansion and the importance of monitoring churn, OHA tasked the Medicaid Advisory Committee (MAC) to explore policy options intended to promote continuity of coverage in OHP.

Committee's 2014 churn report

In 2013, the MAC started examining the issue of churn and considered policy options intended to promote continuity of coverage for individuals and families enrolled in OHP and qualified health plans (QHP) in the Marketplace. In August 2014, the committee submitted a comprehensive report and set of recommendations to reduce, avoid, and mitigate future churn between these two programs. One of the committee's recommendations was to conduct a study of the costs and benefits of adopting 12-month continuous eligibility for OHP income-eligible adults, similar to the policy already in place for children in OHP.[7]

Why states are considering the12-month option?

For almost two decades, states have had the option to provide 12-months of continuous eligibility for children in Medicaid and CHIP. As of 2013, CMS reported that 32 states had adopted 12-month continuous eligibility for children through their Medicaid and/or CHIP programs.[8] States have opted to implement this federal option for children in an effort to minimize disruption in coverage (i.e. churn) resulting from a temporary change in eligibility status or administrative related churn, such as complex renewal processes with burdensome verification requirements.

States that implement 12-month continuous eligibility can reduce month-to-month disenrollment in state Medicaid programs, as demonstrated by states that previously adopted this option for children.[9]

Rationale for 12-month continuous eligibility

- Promotes coverage continuity for eligible individuals, despite fluctuations in family income or other eligibility criteria (i.e. potentially prevents avoidable breaks in coverage).

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[6] Fastrack enrollment as of October 2013. http://www.oregon.gov/oha/OHP2014/OHP%20Fast%20Track%20Fact%20Sheet.pdf

[7] OAR 410-200-0115

[8] See CMS.

[9] See Ku, L. and Steinmetz, E. Bridging the Gap: Continuity and Quality of Coverage in Medicaid. George Washington University. Sept. 2013. http://ccf.georgetown.edu/wp-content/uploads/2013/09/GW-Continuity-Report-9-10-13.pdf

- Increases access to timely and necessary preventive and ongoing health care, ensuring continuity in services, including medications, that Medicaid eligible individuals need.
- Reduces hospitalizations for chronic health conditions that occur as a result of the lack of consistent care.
- Helps states to serve the greatest number of eligible individuals possible and to keep them enrolled for appropriate eligibility periods.
- Promotes the triple aim by supporting consistent, comprehensive coverage for low-income families.

Research indicates individuals who experience more stable coverage have better met health needs and require less costly services over time.[10] Thus, states may also realize potential savings from enhancing continuity of coverage through 12-month continuous eligibility. For example, by decreasing the number of renewals, there may be reduced administrative costs, and thus, potentially program savings. Another potential type of savings for states to assess is that individuals enrolled in Medicaid for longer periods of time experience lower monthly costs. These individuals are more likely to receive primary and preventive care as a direct result of enhanced coverage continuity, in addition to reducing the potential for expensive specialty care or avoidable utilization of the emergency department (ED).[11]

Federal Policy on Medicaid Eligibility and Renewal

Federal law requires states to cover a number of mandatory population groups (e.g. pregnant women, children, people with disabilities, and seniors and medically needy individuals). States also have the option to cover additional population groups (e.g. low-income adults who do not meet current criteria). For optional eligibility groups, states have the flexibility in determining Medicaid eligibility by setting income eligibility criteria as long as they adhere to federal minimum eligibility standards.[12]

CMS requires that states must re-determine the eligibility of Medicaid recipients, with respect to eligibility-related circumstances that may change, *at least* every 12-months. States have the flexibility to implement more frequent renewals (e.g. every 6 months).[13] Upon being determined eligible, individuals or households receive a 6-12-month *certification* period.[14] States are also required by federal law to review eligibility within the 12-month period if it receives information about a change in the beneficiary's that may affect eligibility.[15]

[10] See Ku, L (2013).
[11] Ibid.
[12] There are also federal residency requirements (citizenship and immigration status, etc.) that can either qualify or disqualify an individual from being eligible.
[13] 42 C.F.R. §435.916.
[14] Kaiser Brief (2012, Dec.). Medicaid Eligibility, Enrollment Simplification, and Coordination under the ACA: A Summary of CMS's March 23, 2012 Final Rule.
[15] Kaiser Brief (2012, Dec.). p. 12.

Federal Guidance on 12-month Continuous Eligibility

In guidance provided by CMS on May 17, 2013, states were given the option of applying for a federal waiver to adopt a 12-month continuous eligibility policy for parents and other adults.[16] Guidance stated that CMS would work with states interested in this strategy on ways to apply the appropriate federal medical assistance percentage (FMAP) to the extent that individuals remain enrolled despite not meeting the requirements for newly eligible FMAP.

After issuing the 2013 guidance, CMS reviewed the analysis of health policy researchers at George Washington University. The researchers studied the impact of continuous eligibility on enrollment continuity for children, after the enactment of the CHIPRA of 2009, when seven states adopted this policy for children.[17] Based on the information from the GW analysis, in 2014 CMS released additional guidance, in which interested states learned that they would not receive the full enhanced match rate for their Medicaid expansion population under 12-month continuous eligibility. According to CMS, 97.4% of the member months could be matched at the enhanced rate, and 2.6% of the member months would be matched at the regular FMAP. This was to account for the proportion of member months that beneficiaries would have been dis-enrolled due to excess income in the absence of continuous eligibility.

For states interested in this policy, their matching rate for continuous eligibility depends on its regular Medicaid rate and on the enhanced matching rate for newly-eligible adults, which remains at 100 percent through the end of 2016, but then declines modestly in 2017 and future years until it reaches 90 percent in 2020 and thereafter. No state, except for New York has yet adopted 12-month continuous eligibility for their new ACA expansion population, largely due to financing barriers.[18,19]

In May 2014, Manatt released a brief that included state-specific data on the estimated federal matching rate for newly-eligible adults that states would likely receive. Their analysis indicated a matching rate s between 98.7 percent and 99.3 percent for the new ACA expansion population in 2014. [20,21] For state Medicaid programs, although continuous eligibility will likely increase enrollment continuity and coverage, it also creates additional costs for a state.

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[16] CMS Letter to State Medicaid Directors, 13-003 (May 17, 2013). Facilitating Medicaid and CHIP Enrollment and Renewal in 2014.

[17] Ku, L. (2013).

[18] New York CMS Section 1115 Waiver (2015, March 31st).

[19] Guyer, J., & Schwartz, T. (2014, May 14). Manatt on Medicaid: New strategy for financing 12 months of continuous coverage for newly eligible adults.

[20] Guyer, J. & Schwartz, T. (2014).

[21] Manatt (2014, May 14). State-specific chart.

Oregon Medicaid Policy

Oregon's July 2012 section 1115 Demonstration Waiver from CMS allows the State to enroll all OHP populations for Medicaid for 6-12-months. In compliance with federal regulations, Oregon Administrative Rule (OAR 410-200-0235) requires that OHP beneficiaries report changes in circumstance affecting eligibility within 30 calendar days of their occurrence.

Changes in circumstances that affect income eligibility and that must be reported are:

- A change in source of income
- Change in employment status (e.g. new job or job loss)
- Change in earned income of more than $100 or unearned income of more than $50

Circumstances affecting eligibility not related to income include but are not limited to:

- Receipt or loss of health coverage
- Change in pregnancy status of a household member
- Change in household group membership (e.g. marriage)

Currently, individuals determined eligible are enrolled in OHP for a 12-month *certification* period. However, when an individual experiences a change in circumstance, they are required to report the change and will be redetermined for Medicaid eligibility. If the 12-months elapse and an individual does not experience a change in circumstances, federal law requires states to re-determine their eligibility at the end of the certification period in order to renew their Medicaid coverage.

A key distinction between 12-month *certification* and 12-month *continuous* enrollment is that with 12-month *continuous* eligibility, children and adults are able to keep coverage during the 12-month period *even if* an individual becomes employed, has a raise in pay, or receives new income or assets, and it is reported.

Oregon feasibility study

Committee staff is working to prepare an analysis of the policy and implementation considerations, the potential effect related to increases in estimated expenditures in OHP for the 2017-19 biennium, if 12-month eligibility were to be adopted, and potential cost savings. The analysis will provide estimates, where available, for additional member months for income-eligible adults in OHP, forecast of federal funds that reflect reduced FMAP for the ACA expansion population for 17-19 biennium, and required state matching funds. A preliminary analysis will be available by mid-June for the committee's review.

Conclusion

There are a number of important considerations around 12-month continuous eligibility for states working to promote coverage continuity and reduce churn. To develop and submit a recommendation for OHA by July 2015, the committee will consider a range of factors related to the federal option of 12-month continuous eligibility for OHP income-eligible adults for future consideration by state policy makers.

Attachment B: Cost Estimates for 12-Month Continuous Eligibility in Oregon for Medicaid Adults: 2017-19 Biennium

Executive Summary

In 2013, the Oregon Health Authority (OHA) tasked the Medicaid Advisory Committee (MAC) with preparing a financial analysis of adopting 12-month continuous eligibility for Oregon Health Plan (OHP) income-eligible adults for the 2017-19 biennium. This federal policy promotes coverage continuity for eligible individuals, despite fluctuations in income or other eligibility criteria.

Several adult Medicaid populations (19-64 years of age) were considered for the analysis, and were selected based on whether income was the primary requisite for Medicaid eligibility. Income volatility is strongly associated with churn. The populations most likely impacted by the policy of 12-month continuous eligibility were:

- Medicaid expansion (up to 138 percent FPL)
- Aid to the Blind (AB) and Aid to the Disabled (AD)
- Parent/Caretaker Relative (i.e. Temporary Assistance to Needy Families (TANF))

To assess the potential impact of 12-month continuous eligibility, this analysis adopted an approach developed by national researchers. The continuity ratio measures the average length of enrollment during a year and thus provides a measure of continuity of Medicaid coverage. For this analysis, two sets of continuity ratios were developed for the three different Medicaid adult populations: (1) ratios for the "current policy" (i.e. no 12-month continuous eligibility), and (2) ratios for the new policy (i.e. adoption of 12-month continuous eligibility).

Based on the projected cost estimates, if Oregon chose to adopt 12-month continuous eligibility for income eligible adults in Medicaid, the continuity of Medicaid coverage would increase considerably during the 17-19 biennium (~15%), and thus, reduce churning on and off of OHP. The policy is estimated to generate approximately $1.01 billion in additional federal revenue, but cost the state $223 million in state share dollars. Potential cost and administrative savings and additional benefits were not included in the analysis as discussed, but could be incorporated into a future more comprehensive financial assessment if Oregon were to consider implementing this policy.

Table 1: Estimated Cost for OHP Adult Populations, 2017-19 Biennium

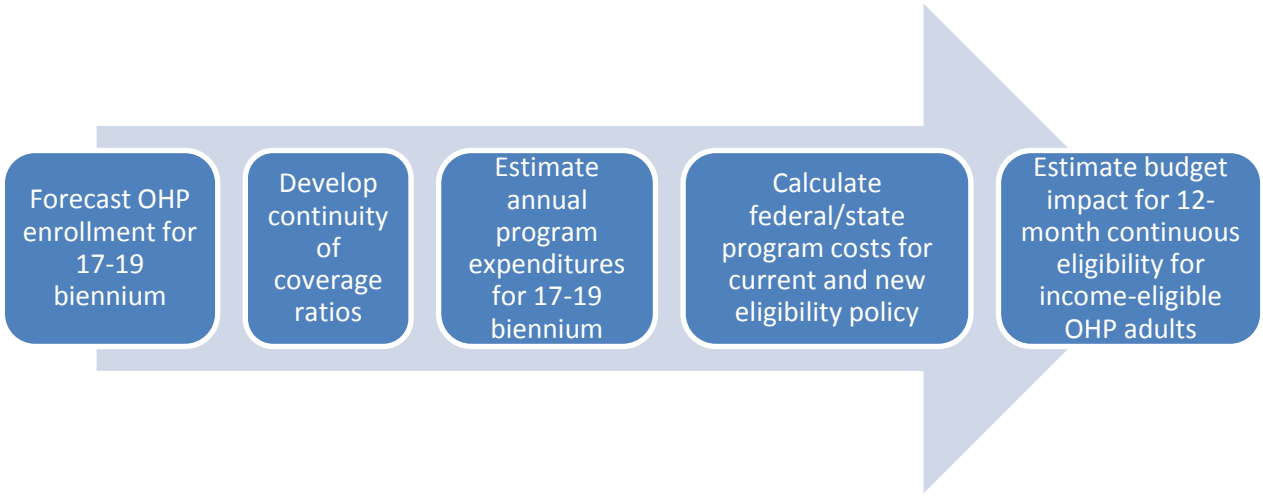
	Current Policy	New Policy	Change 17-19 Biennium
Total Member Months of Coverage	11,860,675	13,595,021	**1,734,346**
Program Expenditures (PMPM)	$770	$759	**N/A**
Federal Share FMAP	$7,649 million 83.81%	$8,664 million 83.58%	**$1,015 million** -0.22%
State Share	$1,479 million	$1,702 million	**$223 million**
Total Program Cost 2017-19 Biennium	$9,128 million	$10,366 million	**$1,238 million**

Background

In 2013, the Oregon Health Authority (OHA) tasked the Medicaid Advisory Committee (MAC) with submitting a comprehensive report and set of recommendations to reduce, avoid and mitigate churn between Medicaid and qualified health plans (QHPs) offered in the commercial Marketplace. One of the committee's recommendations was to conduct a financial analysis of adopting 12-month continuous eligibility for Oregon Health Plan (OHP) income-eligible adults, similar to the policy already in place for children in OHP.[22] This federal policy has been an option for Medicaid adults since 2013, and promotes coverage continuity for eligible individuals, despite fluctuations in income or other eligibility criteria. Additional background information on 12-month continuous eligibility and Oregon's current Medicaid eligibility policy, see the committee's April 2015 brief.[23,24]

In 2015, the committee is examining 12-month continuous eligibility for OHP adults for the 2017-19 biennium.[25] This report describes the methodology used to estimate costs for the policy if Oregon were to adopt and implement in 2017 (see Figure 1).

Figure 1. Method for Determining Costs of 12-Month Continuous Eligibility in OHP, 2017-19 Biennium



[22] OAR 410-200-0115

[23] Oregon Medicaid Advisory Committee (2015, April). Brief: 12-month continuous eligibility for ACA expansion adults. Available at: http://www.oregon.gov/oha/OHPR/MAC/MeetingDocs/April%2022,%202015%20Materials.pdf

[24] "Continuous eligibility" also called "12-month continuous eligibility" is different from a "12-month certification period" or "12-month renewal." The latter terms both imply that families are required to proactively report changes income during the 12-month period. Only 12-month continuous eligibility guarantees 12 months of coverage regardless of changes in income.

[25] Oregon 2017-19 Biennium: July 1, 2017 – June 30, 2019

Methods, Assumptions and Data Sources

The estimates developed for the 2017-19 biennium are based on several data sources: (1) historical caseload in OHP to estimate projected OHP enrollment, (2) estimates of continuity ratios developed to model policy impact on coverage continuity (i.e. enrollment), (3) projected annual per-member per-month (PMPM) Medicaid expenditure costs, and (4) federal financial participation rates to determine the federal and state share of overall program costs.

Eligibility and Enrollment

The populations considered for this analysis were selected based on whether income was the primary requisite for Medicaid eligibility, i.e. income-eligible. Income volatility is strongly associated with churn.[26] As such, these populations would be most impacted by the policy of 12-month continuous eligibility. The Medicaid adult (19-64 years of age) eligibility groups included in the analysis were:

- Medicaid expansion (up to 138 percent FPL)
- Aid to the Blind (AB) and Aid to the Disabled (AD)[27]
- Parent/Caretaker Relative (i.e. Temporary Assistance to Needy Families (TANF))

There are a number of additional eligibility categories in Medicaid, including pregnant women and the breast and cervical cancer treatment program. However, eligibility for the adult populations included in the analysis are partially or fully based on defined income eligibility criteria, compared to program-based eligibility criteria (i.e. breast and cervical cancer) not directly connected with income eligibility.

Enrollment estimates for the three adult populations were provided by Oregon's Office of Forecasting, Research and Analysis (OFRA). This office issues forecasts semiannually in the spring and fall. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and expert consensus. It is important to note that implementation of the Affordable Care Act (ACA) in Oregon in combination with the number of deferred redeterminations in OHP in 2014 has affected the data quality.[28]

Table 1 shows the forecasted enrollment for each population group during the 2017-19 biennium, with Oregon's current policy (i.e. no 12-month continuous eligibility), and the total member months of coverage over the biennium for each group, which are used to calculate annual program expenditures. A member month is defined as a member being

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[26] Sommers, B. and Sara Rosenbaum, S. (2011). Issues in Health Reform: How Changes in Eligibility may Move Millions Back and Forth Between Medicaid and Insurance Exchange. *Health Affairs*, 30, 2, 228-236.

[27] Modified Adjusted Gross Income (MAGI) is used to calculate an individual's household size and income, using federal income tax rules and a tax filer's family size to determine eligibility for Medicaid.

[28] Implementation of ACA created an array of changes that impacted the quality of data and disrupted the time series critical for forecasting. In general, the forecast is built using three main components: exits, transfers, and new clients. For each given month, the caseload is calculated as the previous month caseload, plus new clients, plus transfers in from other caseloads, minus exits, and minus transfers out. ACA implementation severely impacted the time series for all three of these components. For more information, see OHA/DHS Office of Forecasting, Research and Analysis, Spring 2015 Forecast (pg. 35).

enrolled for one month in OHP. For example, an individual who is a member of OHP for a full year generates 12 member months and a family of five enrolled for six months generates 30 member months (5 x 6=30).

Table 1. Estimated Coverage for OHP Adults (19-64 Years) with Current Policy (i.e. no 12-Month Continuous Eligibility), 2017-19 Biennium

Eligibility Categories	Estimated Enrollment	Total Member Months of Coverage
Medicaid Expansion Adults	375,944	9,022,646
Aid to the Blind and Aid to the Disabled (AB/AD)	73,847	1,772,076
Parent/Caretaker Relative	44,270	1,065,953
Total	**494,061**	**11,860,675**

Source: OHA/DHS Office of Forecasting, Research and Analysis, Spring 2015 **Forecast**

Medicaid Enrollment Continuity Ratio

Offering 12-month continuous eligibility in Medicaid reduces insurance gaps among low-income individuals and families by improving the continuity of coverage in Medicaid. To assess the potential impact of 12-month continuous eligibility, this analysis applied a similar approach developed by researchers at George Washington University (GWU) in 2009.[29] Their method, the Medicaid "continuity ratio"[30] uses state Medicaid administrative enrollment data to measure the average length of enrollment in Medicaid for beneficiaries during a year. The continuity ratio is computed by dividing the average monthly number of Medicaid enrollees in each eligibility category by the total number of unduplicated enrollees in that Medicaid eligibility category at any time over the year. The ratio essentially measures the average length of enrollment during a year and thus provides a measure of continuity of Medicaid coverage. An important limitation is

> ***Explaining Continuity Ratios***: A state with a score of 100 percent continuity ratio is perfect; meaning the average monthly enrollment and total annual unduplicated enrollment are the same, indicating that everyone was enrolled for the entire year. In contrast, a score of 8.3 percent means that there was a 100 percent turnover in enrollees each month (so the total unduplicated number enrolled over the year is 12 times the number enrolled in any month). In other words, the lower the ratio, the lower the level of enrollment continuity.
>
> *- Ku & Steinmetz (2013).*

[29] Ku L., MacTaggart, P., Pervez, F., Rosenbaum, S. "Improving Medicaid's continuity and quality of care." Washington, DC: Association for Community Affiliated Plans. July 2009. (pg. 27).
[30] Ku, L. and Steinmetz, E. "The Continuity of Medicaid Coverage: An Update." George Washington University. April 19, 2013.

that it does not address the extent to which beneficiaries had other coverage or were uninsured for the rest of the year.[31]

For this analysis, two sets of continuity ratios were developed for the three different Medicaid adult populations: (1) ratios for the "current policy" (i.e. no 12-month continuous eligibility), and (2) ratios for the new policy (i.e. adoption of 12-month continuous eligibility).

Baseline Continuity Ratios: "Current Policy"

Continuity ratios are used to compare the impact of the proposed policy on enrollment for each Medicaid population group. For two of the population groups, Aid to the Blind and Aid to the Disabled (AB/AD) and Parent/Caretaker Relative adults, historical enrollment data was used to calculate ratios based on a five-year averages of continuity ratios from 2008-2012. During this time, both groups were subject to redetermination at least once every 12 months.[32] The third group, the Medicaid expansion group, did not exist prior to 2014. Consequently, there is no historical enrollment data available to develop a baseline ratio. A potential proxy group, OHP Standard (adults with incomes ≤100 percent FPL) was considered but ultimately not used to calculate a baseline ratio for the Medicaid expansion population. This was due to notable policy changes affecting enrollment in OHP Standard during the identified timeframe (2008-2012). An alternate approach to calculating a baseline ratio for the expansion group was used by drawing on continuity ratios from George Washington's analysis of Oregon specific enrollment data from the Medicaid Statistical Information System Datamart for years 2006-2011 for non-elderly adults.[33] This approach, however, presents a considerable limitation to the financial analysis for the Medicaid expansion population.

Oregon's Experience: In 2009, Oregon implemented 12-month continuous eligibility for its Medicaid/CHIP children. After adopting this policy, the continuity ratio for children increased by 10 percent, reaching 81 percent in 2013.

Projected Continuity Ratios: "New Policy"

To calculate ratios for the three different groups if the policy were implemented (referred to as "new policy"), the analysis used OHP enrollment data from 2014 as a proxy. The rationale is that the majority of OHP beneficiaries remained enrolled throughout the 2014 calendar year due to delayed redeterminations and technological issues experienced with the transition of Oregon's Medicaid eligibility system from Cover Oregon to OHA. These temporary changes simulate continuous eligibility in 2014.[34] The continuity ratios calculated for the analysis are found in Table 2.

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[31] It is also worth noting that continuity ratios are often higher for those who are blind and disabled, the aged and children are the next highest, and non-elderly, non-disabled adults is the lowest. The majority of adults in the last group are those now covered through Medicaid expansion.

[32] Upon being determined eligible, individuals or households receive a 12-month *certification* period.

[33] See Ku, L., & Steinmetz E. (April 2013).

[34] Oregon Office of Forecasting, Research and Analysis, Spring 2015 DHS/ OHA Caseload Forecast (pg. 34). Available from: http://www.oregon.gov/dhs/ofra/ofradocuments/Spring%202015%20Caseload%20Forecast.pdf

Table 2. Continuity Ratios, 2017-19 Biennium

Eligibility Categories	Current Policy (%)	New Policy (%)	Difference
Medicaid Expansion Adults	68.2	78.7	+10.5
Aid to the Blind and Aid to the Disabled (AB/AD)	83.8	87.3	+3.5
Parent/Caretaker Relative	61.9	77.7	+15.8
Sources: George Washington's analysis of Medicaid Statistical Information System Datamart for FY 2006-11; DHS/OHA Integrated Client Services data warehouse, 2008-2012			

Estimated Program Expenditures

To estimate program expenditures for both the "current policy" and the "new policy," the analysis relied upon per-member-per-month (PMPM) estimates. These estimates are average cost projections based on high-level OHP caseload and expenditure projections, variables that can cause considerable changes to the estimates. The PMPM estimates in Table 3 assume coverage of OHP benefits remain constant and applies a fixed annual rate of growth of 3.4 percent. This is the maximum rate of growth allowed as part of Oregon's current 1115 Demonstration waiver approved by CMS that runs through June 30, 2017.

Table 3. Projected Program Expenditures, 2017-19 Biennium (PMPM)

Eligibility Categories	SFY 2018	SFY 2019	17-19 Biennium
Medicaid Expansion Adults	$673	$696	$685
Aid to the Blind and Aid to the Disabled (AB/AD)	$1,207	$1,248	$1,227
Parent/Caretaker Relative	$716	$740	$728

Federal Financial Participation

States receive varying levels of federal financial assistance for Medicaid based on each state's per capita income. The amount of federal assistance also varies, to some extent, by eligibility group. To calculate the federal financial share for the financial analysis, we developed estimates for each population group. In Oregon, the federal medical assistance percentage (FMAP) for the AB/AD and Parent/Caretaker Relative adult groups for the 2017-19 biennium is estimated at 62.47 percent.[35]

For the Medicaid expansion population, in 2014 the Centers for Medicare and Medicaid Services (CMS) released guidance to states that they would not receive the full-enhanced match rate for their Medicaid expansion population under 12-month continuous eligibility. Based on analysis from George Washington University[36], CMS concluded that 97.4% of the member months would be matched at the enhanced rate, and 2.6% of the member months

[35] Projected from Federal Funds Information for States (FFIS) (2015, March 26): FY 2017 FMAP Projections. Retrieved from: http://www.ffis.org/node/3691

[36] Ku, L. and Steinmetz, E. (2013, September). Bridging the Gap: Continuity and Quality of Coverage in Medicaid. George Washington University. September 10, 2013.

would be matched at the regular FMAP. This was to account for the proportion of the year that beneficiaries would have otherwise been dis-enrolled, in the absence of continuous eligibility, due to excess income. OHA calculated the FMAP for the Medicaid expansion population based on CMS' guidance, shown in table 4. Based on available federal guidance, the analysis did not adjust the FMAP rates for the AB/AD or Parent/Caretaker Relative populations.

Table 4. Federal Participation for Oregon's Medicaid Expansion Population with New Policy (i.e. 12-Month Continuous Eligibility), 2017-19 Biennium

SFY Year	Estimated ACA Enhanced FMAP	12-Month CE FMAP for Adults	FMAP Reduction 17-19 Biennium
2018	94.50%	93.68%	-0.82%
2019	93.50%	92.68%	

Results

Based on the financial analysis, there are several key findings if a 12-month continuous eligibility policy were implemented for OHP adults for 17-19 biennium:

- **Coverage Continuity:** estimated to increase total member months of coverage by nearly 15% over the biennium, resulting in 1,734,346 additional member months of coverage.
  - Continuity ratios are estimated to increase on average by nearly 10 percent for the three OHP adult populations.
- **Program Costs:** estimated to increase total program spending by $1.23 billion
  - Additional federal revenue of $1.01 billion
  - Additional state spending of $223 million

See tables 5-8 for the fiscal impact of implementing 12-month continuous eligibility by individual eligibility group and then combined.

Table 5. Estimated Cost for ACA Expansion Adults, 2017-19 Biennium

	Current Policy	New Policy	Change 17-19 Biennium
Total Member Months of Coverage	9,022,646	10,410,903	**1,388,257**
Continuity Ratio	68.2%	78.7%	**+10.5%**
PMPM Cost	$685	$685	**N/A**
Federal Share (FMAP)	$5,806 million 94.00%	$6,641 million 93.18%	**$835 million** -0.80%
State Share	$371 million	$486 million	**$115 million**
Total Program Cost, 2017-19 Biennium	**$6,177 million**	**$7,127 million**	**$950 million**

Table 6. Estimated Cost for AB/AD Adults, 2017-19 Biennium

	Current Policy	New Policy	Change 17-19 Biennium
Total Member Months of Coverage	1,772,076	1,845,516	**73,440**
Continuity Ratio	83.8%	87.3%	**+3.5%**
PMPM Cost	$1,227	$1,227	**N/A**
Federal Share (FMAP 62.47%)	$1,358 million	$1,415 million	**$57 million**
State Share	$817 million	$850 million	**$33 million**
Total Program Cost, 2017-19 Biennium	**$2,175 million**	**$2,265 million**	**$90 million**

Table 7. Estimated Cost for Parent/ Caretaker Relative Adults, 2017-19 Biennium

	Current Policy	New Policy	Change 17-19 Biennium
Total Member Months of Coverage	1,065,953	1,338,602	**272,649**
Continuity Ratio	61.9%	77.7%	**+15.8%**
PMPM Cost	$728	$728	**N/A**
Federal Share (FMAP 62.47%)	$485 million	$608 million	**$123 million**
State Share	$291 million	$366 million	**$75 million**
Total Program Cost, 2017-19 Biennium	**$776 million**	**$974 million**	**$198 million**

Table 8. Combined Estimated Cost for OHP Adult Populations, 2017-19 Biennium

	Current Policy	New Policy	Change 17-19 Biennium
Total Member Months of Coverage	11,860,675	13,595,021	**1,734,346**
PMPM Cost	$770	$759	**N/A**
Federal Share FMAP	$7,649 million 83.81%	$8,664 million 83.58%	**$1,015 million** -0.22%
State Share	$1,479 million	$1,702 million	**$223 million**
Total Program Cost 2017-19 Biennium†	$9,128 million	$10,366 million	**$1,238 million**

†The change in combined program expenditure from "current policy" to "new policy" reflects a change in the ratio of clients due to changes in the continuity ratio for the respective adult populations resulting from the implementation of 12-month continuous eligibility. Because each eligibility group has a different program expenditure (PMPM), the combined weighted average PMPM is different when the ratio of member months changes.

Limitations

This analysis relies on several recent and unique experiences in Oregon's Medicaid program. First, is an unprecedented enrollment in OHP in 2014, compared to previous years, as this was an atypical enrollment year due to the "fast track" enrollment process.[37] Second, as previously mentioned, due to technology issues with the state's Medicaid eligibility system, beginning in the fall of 2013, Oregon's Medicaid population experienced temporary delays in regularly scheduled redeterminations, which continued for the majority of OHP enrollees throughout 2014. While this limited our ability to use 2013 and 2014 enrollment data for our baseline continuity measures, conversely, for the same reason, this allowed us to use Oregon's 2014 enrollment experience as a proxy for 12-month continuous eligibility.

Another limitation was the inability to estimate potential administrative cost savings likely to result from reducing the number of renewals, annually. At this time, it is not possible to estimate the information technology costs needed to modify the IT systems used in client management and redeterminations.

Discussion

The original intent of the analysis was to complete a comprehensive cost-benefit, which at this time is not feasible due to insufficient data and limited research on this topic. Since 2009, the policy of 12-month continuous eligibility has been in place for children covered in OHP. Interestingly, even with this policy in place, there is paucity of data on the actual impact of this policy in terms of savings demonstrated from changes in health care utilization patterns or lower program administration costs in Oregon and elsewhere. In general, the literature indicate that individuals who experience more stable coverage have better met health needs and require less costly services over time.[38] These individuals are also more likely to receive primary and preventive care as a direct result of enhanced coverage continuity, utilize less expensive specialty care, and avoid use of non-urgent emergency department services (ED).[39] Analysis of 2010 MEPS data by researchers from GWU found that the average monthly Medicaid cost for the care of an adult falls by 22% when the length of enrollment increases from six months of the year to 12 months.[40]

As of 2015, New York is the only state that has adopted this policy for its Medicaid adult populations. Subsequently, we were unable to develop any estimates for potential savings resulting from the implementation of 12-month continuous eligibility in Oregon.

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[37] Fastrack enrollment as of October 2013. http://www.oregon.gov/oha/OHP2014/OHP%20Fast%20Track%20Fact%20Sheet.pdf

[38] See Bindman, A. Chattopadhyay, A., & Auerback, G. (2008). Interruptions in Medicaid coverage and risk for hospitalization for ambulatory care-sensitive conditions. *Annals of Internal Medicine,* 149, 12, 854-860. See Banerjee, R., Ziegenfuss, J., & Shah, N. (2010). Impact of discontinuity in health insurance on resource utilization. *BMC Health Services Research,* 10, 195.

[39] Ibid.

[40] Ibid.

Nonetheless, it is worth mentioning as an important future consideration to identify types of potential program savings, including but not limited to:[41,42]

- Prevent avoidable disruptions in care and non-urgent use of the emergency department;
- Reduced coverage transitions: decreases in disenrollments, reenrollments, and redeterminations;
- Administrative savings for states, health plans and providers; and
- Greater potential return on investments in prevention and care management.

Also of interest is that incremental, nominal increases in the continuity ratio could result in considerable impact to the number of enrolled members, annually. We estimate that for every single percentage point increase in the ratio for the Medicaid expansion population there would be an approximate 90,000 additional member months of coverage for the 2017-19 biennium, costing approximately $62 million. Similarly, for the parent/caretaker population, a single percentage point increase in the ratio would result in approximately 11,000 additional member months of coverage for the biennium, costing about $8 million. We did not calculate a similar figure the Aid to the Blind (AB) and Aid to the Disabled population as their continuity of coverage in Medicaid is relatively high already and has remained relatively constant over the last decade based on Oregon's current policy.

Effect of 12-Month Continuous Eligibility in Oregon

Based on the projected cost estimates, if Oregon chose to adopt 12-month continuous eligibility for income eligible adults in Medicaid, the continuity of Medicaid coverage would increase considerably during the 17-19 biennium (~15%), and thus, reduce churning on and off of OHP. The policy is estimated to generate approximately $1.01 billion in additional federal revenue, but cost the state $223 million in state share dollars. Potential cost savings and additional benefits were not included in the analysis as discussed, but could be incorporated into a future more comprehensive financial assessment if Oregon were to consider implementing this policy.

[41] See Irvin, Peikes, Trenholm, & Khan (2001). Discontinuous coverage in Medicaid and the implications of 12-month continuous coverage for children. Mathematica, DC. Lewin Group. (1999, May). Continuous eligibility for children under Medi-Cal: cost estimates for six-month and twelve-month coverage extension options. Medi-Cal Policy Institute.

Appendix A. Adjusted FMAP for Oregon's Medicaid Expansion Population Under 12-Month Continuous Eligibility

SFY Year	Enhanced FMAP	% Member Months at Enhanced FMAP	=	Regular FMAP	% Member Months at Regular FMAP	=	12-Month CE FMAP for Adults
2018	94.50%	97.40%	92.04%	63.07%	2.60%	1.64%	**93.68%**
2019	93.50%	97.40%	91.07%	61.87%	2.60%	1.61%	**92.68%**
2017-19 Biennium	94.00%	97.40%	91.56%	62.47%	2.60%	1.62%	**93.18%**

Appendix B. Estimated Program Cost for OHP Adult Populations, 2017-19 Biennium

	Medicaid Expansion			AB/AD Adults			Parent/Caretaker Relative		
	Current Policy	**New Policy**	**Change 2017-19**	**Current Policy**	**New Policy**	**Change 2017-19**	**Current Policy**	**New Policy**	**Change 2017-19**
Total Member Months of Coverage	9,022,646	10,410,903	**1,388,257**	1,772,076	1,845,516	**73,440**	1,065,953	1,338,602	**272,649**
Continuity Ratio	68.2%	78.7%	**+10.5%**	83.8%	87.3%	**+3.5%**	61.9%	77.7%	**+15.8%**
PMPM Cost	$685		**N/A**	$1,227		**N/A**	$728		**N/A**
Federal Share *	$5,806 million	$6,641 million	**$835 million**	$1,358 million	$1,415 million	**$57 million**	$485 million	$608 million	**$123 million**
State Share	$371 million	$486 million	**$115 million**	$817 million	$850 million	**$33 million**	$291 million	$366 million	**$75 million**
Total Program Cost	**$6,177 million**	**$7,127 million**	**$950 million**	**$2,175 million**	**$2,265 million**	**$90 million**	**$776 million**	**$974 million**	**$198 million**

*FMAP for the AB/AD and Parent/Caretaker Relative adult groups for the 2017-19 is estimated at 62.47 percent. FMAP for the expansion population reflects an adjustment based on May 2013 guidance from CMS, 94% in with current policy and 93.18% with the new policy due to a decrease of .8%.in the federal participation rate.