Oregon Health Authority
2023-25 Ways and Means

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GB Director's message

I'm pleased to submit the Governor's Budget for the Oregon Health Authority for the 2023-25 biennium. This budget stays true to Governor Kotek's health priorities: it invests in expanded housing, it addresses unmet behavioral health needs and protects and extends health coverage. And this budget demonstrates a clear and consistent commitment to health equity.

At a time when the state's future financial picture is uncertain and resources are tight, Governor Kotek has proposed vital investments to improve the health of Oregonians, especially economically vulnerable families, and people in rural communities. The Governor's Budget (GB) for the Oregon Health Authority (OHA) totals nearly $34.5 billion, which represents a 6.5 percent increase from the current two-year budget cycle.

The state General Fund portion of the budget is $5.4 billion (a 42.3 percent increase from the current budget), which back-fills the post-pandemic loss of federal funds, sustains vital workforce and health coverage investments and meets the state's share of new transformative efforts, such as Oregon's ground-breaking 1115 Medicaid waiver. To deliver on these commitments, the budget supports 5,829 positions in our agency, including a major boost in positions at the Oregon State Hospital (OSH).

These were not easy decisions. I appreciate the Governor's focus on health and health equity and her support for the programs delivered by the Oregon Health Authority and our many partners in communities statewide, as well as our collaborative efforts with Oregon's sovereign tribal nations.

Reducing health disparities and advancing health equity

While health equity runs through all areas of the Governor's health proposals, the GRB provides major investments in health equity priorities.

- The Governor's budget invests $5.0 million General Fund to expand the Equity and Inclusion Division and the Strategic Action Team within OHA to ensure health equity principles are upheld in major new initiatives and to provide additional staff for training, civil rights, and universal accessibility programs, as well as to support community engagement.
- The proposed budget also invests $2.1 million General Fund to add five Regional Health Equity Coalitions to areas of the state not currently covered by one, to channel community-level strengths to tackle disparities and improve health equity.
- The GB provides $12.7 million General Fund to support Race, Ethnicity, Language, Disability (REALD) and Sexual Orientation, Gender Identity (SOGI) demographic data implementation to help the state understand who it serves, reduce disparities, and improve outcomes.

Protecting health coverage and implementing the 1115 Medicaid waiver

More than 1.4 million Oregonians (or 1 in 3 state residents) rely on the Oregon Health Plan for health coverage. The GB includes new investments to protect health coverage for people and families experiencing economic vulnerability and implement the first-in-the-nation benefits to address health-related social needs (such as homelessness and food insecurity) included in the new 1115 Medicaid waiver.

- $128.8 million General Fund investment (matched by $847 million in federal funds) to support Oregon's share of funding to implement the new Medicaid waiver's innovative coverage for temporary housing, food, and benefits to help people adapt to climate change. These funds also provide continuous health coverage eligibility for children up to age 6 and extend health coverage for adults, reducing interruptions in coverage due to administrative barriers. In addition, the GRB's investments support transition services for youth and adult Oregonians returning to the community from institutional settings, as well as enhanced Tribal benefits.
- The Governor dedicates $246.5 million in state funds to prevent the loss of health care coverage statewide for people who are eligible Oregon Health Plan members
- The budget allocates $353.6 million in state funds, to backfill reductions in federal Medicaid dollars after the COVID-19 pandemic federal emergency declaration ends.
- The GB provides funding for Healthier Oregon to open eligibility to all ages as of July 1, 2023 ($500 million General Fund, based on projected utilization), and provide full Oregon Health Plan benefits to all eligible people in Oregon, regardless of immigration status.
- $3 million General Fund to support ongoing development of a Basic Health Program, which would provide health coverage for people in Oregon with incomes of 138%-200% of the federal poverty level. OHA continues to negotiate with the federal government to receive approval to implement a Basic Health Program. Governor Kotek strongly supports extending health coverage to people and families struggling to make ends meet. This investment lays the foundation for a Basic Health Program pending federal and legislative support.

Addressing unmet behavioral health needs and supporting the Oregon State Hospital

Oregonians need a stronger, more accessible behavioral health system that meets peoples' needs and is staffed by a diverse, stable and adequately supported workforce. While Oregon continues to face many challenges – including inadequate treatment capacity in the community, a strained state psychiatric hospital and an influx of dangerous new drugs across the state – prior investments are beginning to show results: hundreds of new supportive housing and residential placements are in the pipeline, workforce investments have helped programs survive the pandemic and local Measure 110 behavioral health resource networks (BHRNs) are delivering services in every county.

The Governor's budget includes major investments that sustain, expand and accelerate progress toward a stronger behavioral health system. These investments include:

- The Governor's budget maintains $1.2 billion invested by the Legislature in 2021 and 2022, to improve services in the behavioral health system.
- The GB will infuse new funding to expand treatment capacity through $100 million in Lottery Bond proceeds to expand acute psychiatric facilities in the community, as well as $15 million in General Fund investments for substance use disorder facilities and recovery centers, and $2.3 million General Fund for additional children's psychiatric residential treatment capacity.
- The GB responds to the substance use crisis by requesting $40 million to support of the harm reduction clearinghouse to reduce preventable deaths associated with opioid use.
- The budget also proposes $14.9 million General Fund for a team at OHA to improve civil commitment services, to expand jail diversion services to counties currently without it, and

to fund enhanced services for patients in the civil commitment process before they are committed.

Governor Kotek's proposed budget stabilizes and supports the Oregon State Hospital, adding more than 300 new positions to the Oregon State Hospital.

Sustaining and expanding Public Health capacity

The Governor's budget makes important investments in public health to reduce preventable deaths and disease, strengthen access to reproductive health care, and increase capacity to respond to emerging health threats.

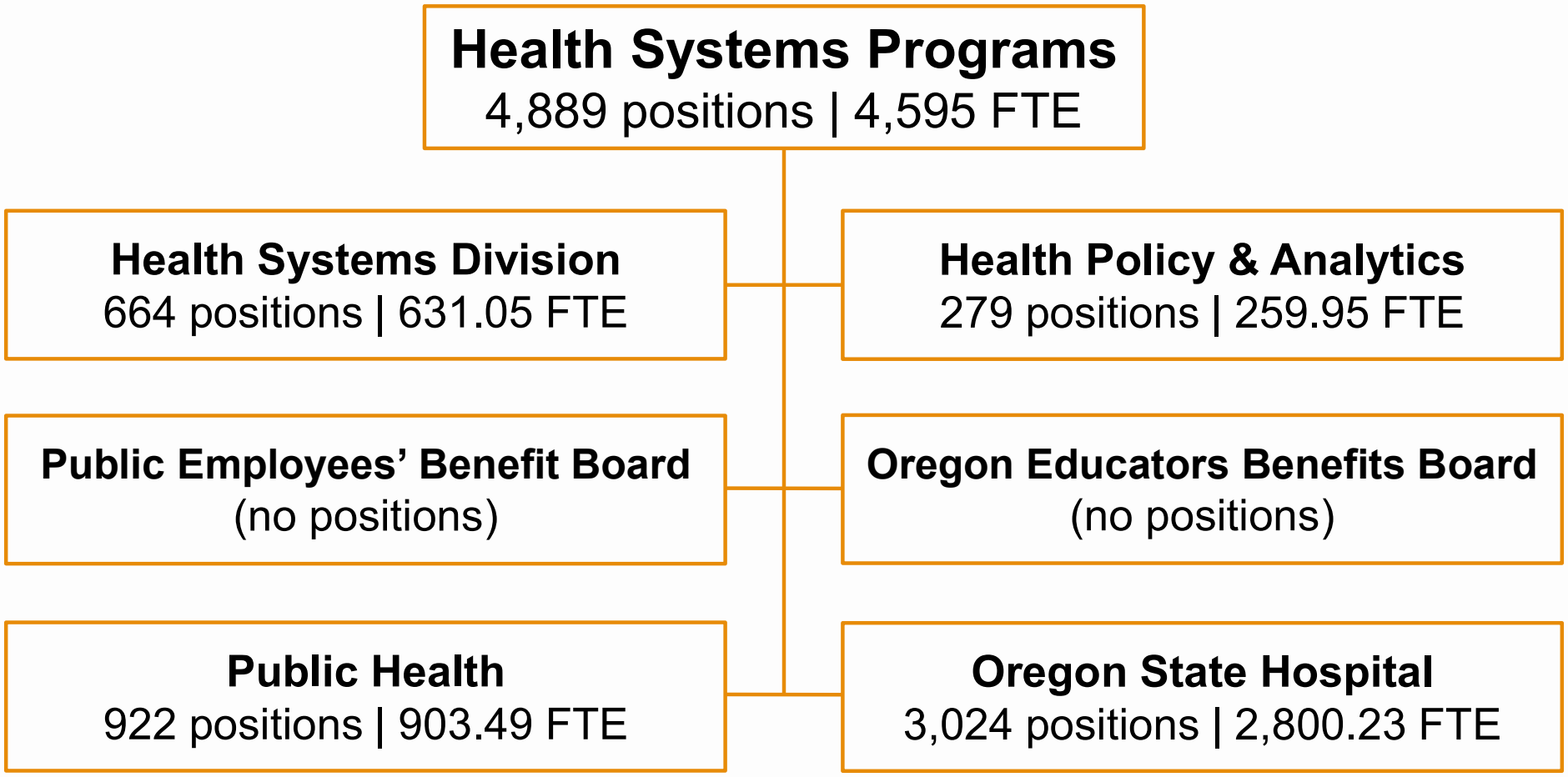
- The budget provides $50.0 million General Fund to sustain public health capacity to respond to emerging needs for local public health authorities, tribal governments, reproductive health providers, and community-based organizations, all to help modernize the state's public health system. This investment includes $3.4 million to support enhanced access to reproductive health care across the state by increasing opportunities to support the health care workforce, reducing administrative barriers to participation in public programs, and improving and standardizing reproductive health reimbursement rates across OHA programs. This investment also funds the development of a statewide public health system plan to maximize upstream investments to address disparities in communities of color and for rural Oregonians.
- The GB includes $5.9 million General Fund for the full statewide expansion of the Universally Offered Home Visiting program for families with newborns to support healthy families.
- The proposed budget includes $3.0 million General Fund to address drinking water contamination in the lower Umatilla basin, paying for outreach, coordination, domestic well testing, and water treatment systems for affected households. It also provides funding for statewide infrastructure for the drinking water safety program at OHA.
- The Governor's proposal provides $1.0 million General Fund to support OHA's Personal Protective Equipment (PPE) Stockpile of personal protective equipment, vaccines and vaccine kits, tests and testing supplies, and other medical equipment for use in response to a major disaster or public health emergency.
- The GB also includes $6.6 million from Other Funds revenues to provide program development, regulatory oversight, and consumer protection related to the use of psilocybin.

Governor Kotek's proposed budget represents an important investment in the health and well-being of Oregonians. I look forward to collaborating with partners across the state to address the significant health challenges facing our communities and implementing Governor Kotek's health priorities.

Sincerely,

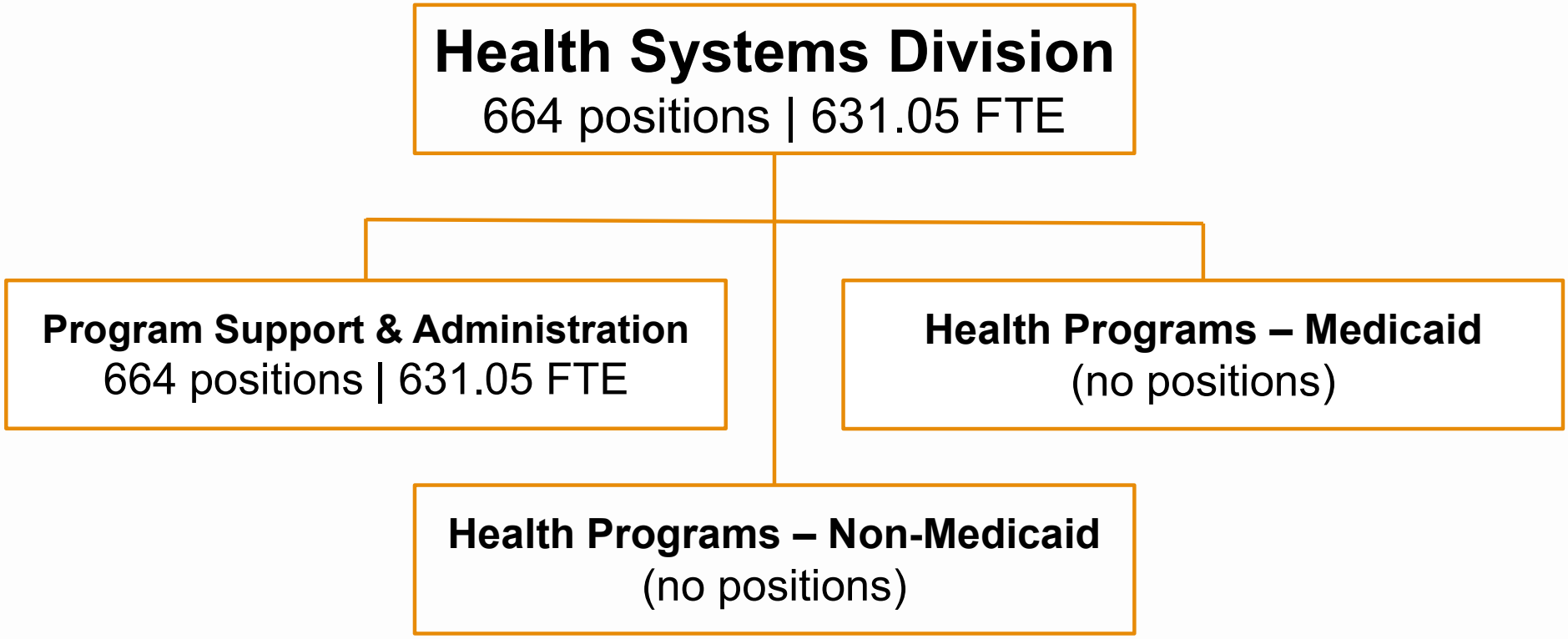
James Schroeder
Interim Director

2023-25
Governor's Budget



Oregon Health Authority

2023-25
Governor's Budget



Oregon Health Authority

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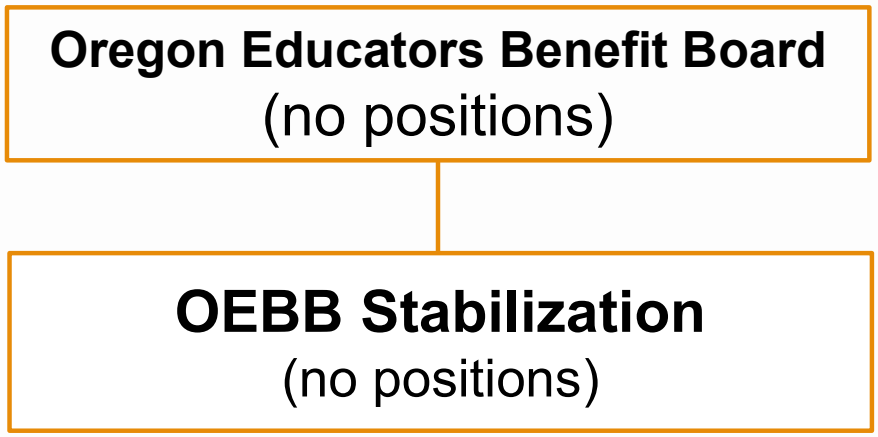


Oregon Health Authority

2023-25
Governor's Budget

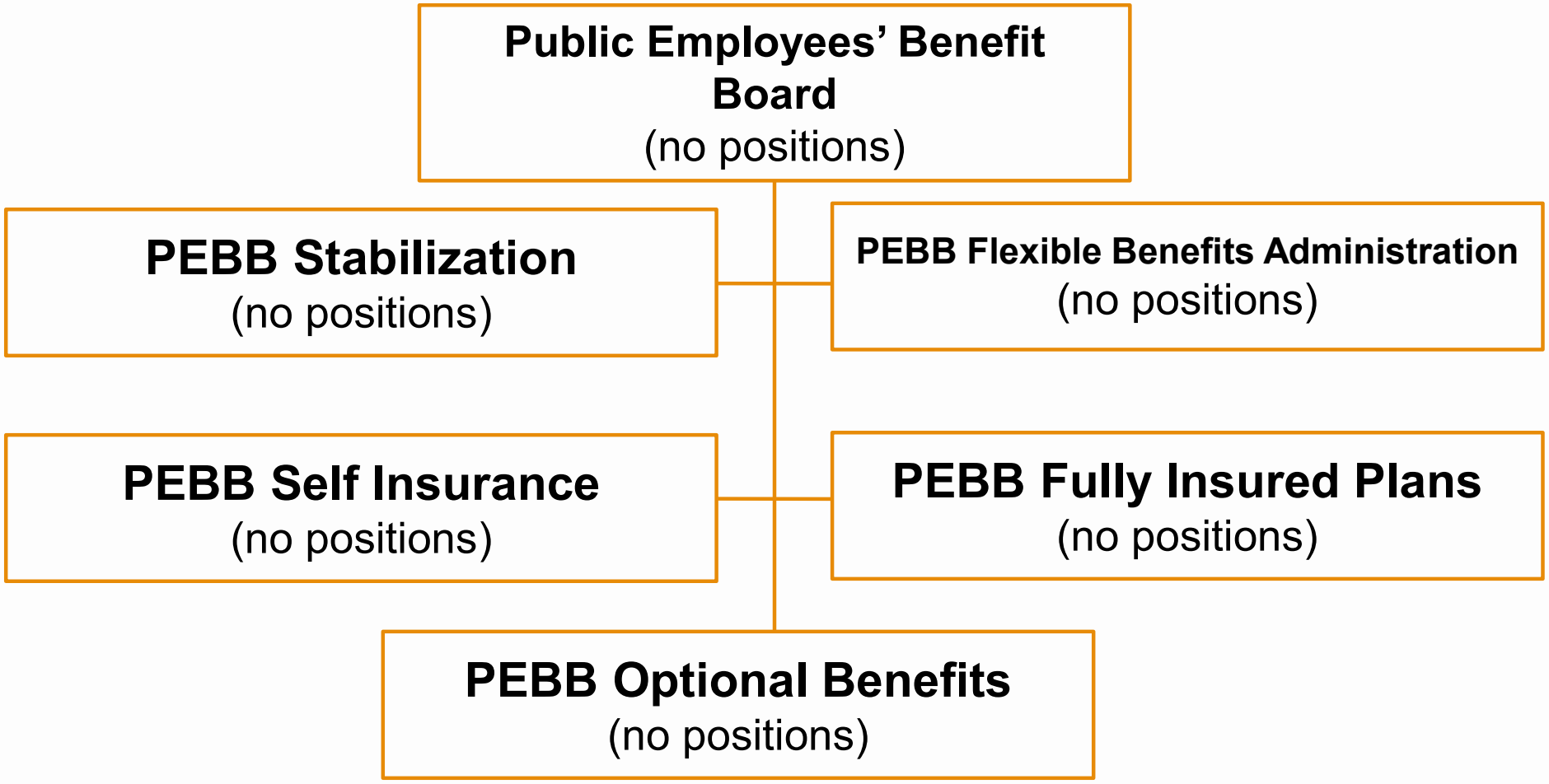
Oregon Health Authority
5,829 positions | 5,517 FTE

Central Services, Shared Services, State Assessments & Enterprise-wide Costs
940 positions | 921.78 FTE

Health Systems Programs
4,889 positions | 4,595 FTE

Oregon Health Authority

2023-25
Governor's Budget



Oregon Health Authority

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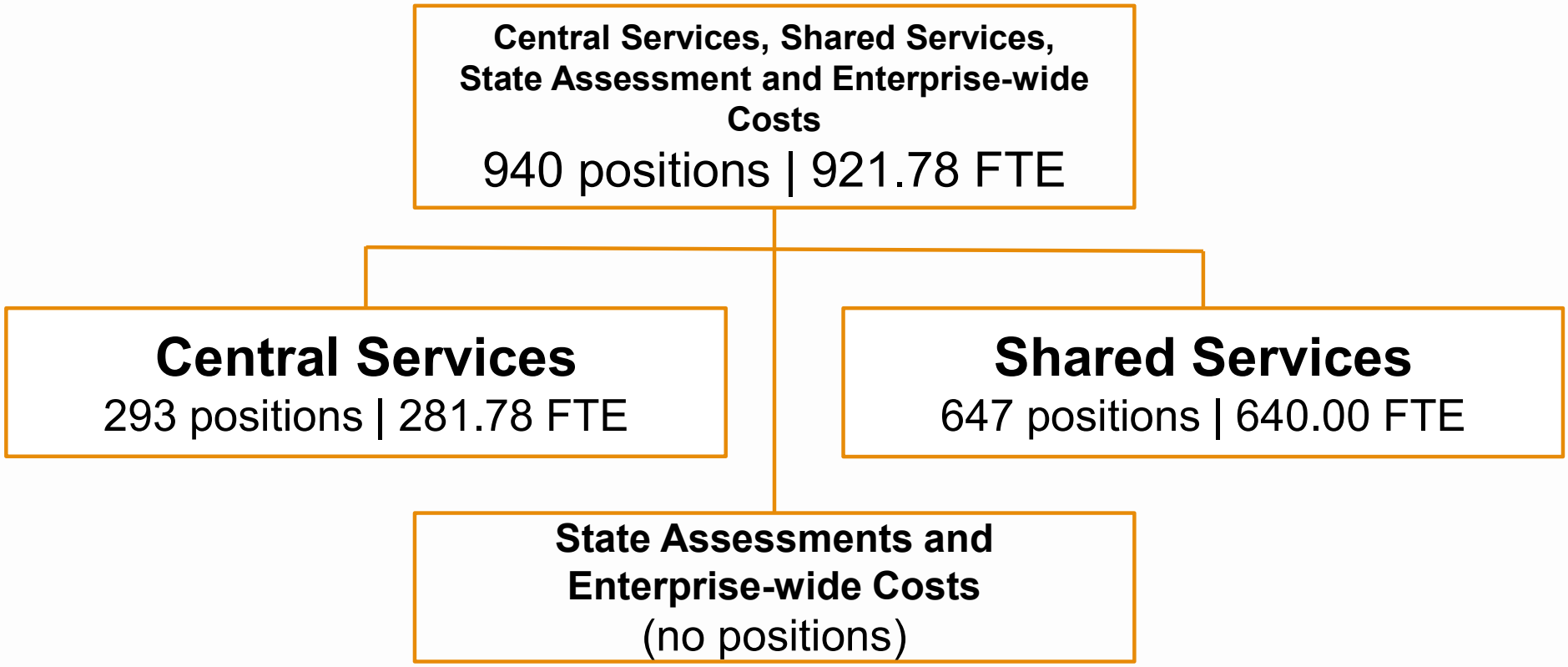


Oregon Health Authority

Oregon Health Authority: Agency Summary Narrative

Mission statement

The mission of the Oregon Health Authority (OHA) is helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Agency priorities and initiatives

OHA's strategic goal is to eliminate health inequities in Oregon by 2030. To advance that goal, OHA is focused on accelerating the transformation of Oregon's health care system, expanding health coverage and providing easier access to care, delivering better health outcomes, improving health care quality and containing health costs for Oregon Health Plan members, and improving public health services in all Oregon communities.

OHA's budget priorities directly support safer, healthier and thriving Oregonians, with emphasis on eliminating health inequities. OHA is committed to transparency, accountability and wise use of public resources.

The Governor's Budget (GB) for OHA reduces health inequities while improving outcomes by:

- Strengthening OHA's efforts to eliminate health inequity in Oregon. The budget expands staffing for specialized, culturally responsive treatment at the Oregon State Hospital; expands the OHA Equity and Inclusion Division and Strategic Action Team to ensure health equity principles are upheld in major new initiatives and provide additional staff for training, civil rights, and universal accessibility programs; and adds five additional Regional Health Equity Coalitions to new areas of the state.
- Accelerating the progress toward a stronger behavioral health continuum. It maintains prior investments in behavioral health while addressing current service gaps for children and families experiencing behavioral health issues and expanding the continuum of services to treat them. The budget infuses new Lottery Bond funding to expand acute psychiatric facilities in the community; invests in substance use disorder facilities and recovery centers, residential detox, and inpatient treatment; increases children's psychiatric residential treatment capacity; invests in improving civil commitment services; and expands jail diversion services.
- Enhancing health, safety and security at the Oregon State Hospital System. The Governor's Budget increases staffing levels to ensure consistent, high-quality care and staff safety; invests in the care of patients with

complex psychiatric needs, and provides funding for evidence-based transition case management for patients who are leaving OSH without housing.

- Sustaining and expanding the post-pandemic public health system. The Governor's Budget provides funding for disaster response at Regional Resource Hospitals and to advance public health modernization.
- Accelerating health transformation in Medicaid. The Governor's Budget provides funding to implement the new Section 1115 Medicaid Waiver's innovative coverage for temporary housing, food and benefits to help people adapted to climate change and expand health coverage. It also funds opening eligibility for Healthier Oregon to all ages as of July 1, 2023 and builds an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to expand health services to more children.

Program descriptions

OHA Central Services

OHA Central Services supports the OHA mission by providing leadership in key policy and business areas. This service area contains the following areas:

The Director's Office is responsible for overall leadership, policy and development, and administrative oversight for the Oregon Health Authority. This office coordinates with the Governor's Office, the Legislature, other state and federal agencies, Tribes, partners and stakeholders, local governments, advocacy and client groups, and the private sector.

The Director's Office provides leadership in achieving the agency's mission. In developing OHA's strategic plan, the agency has adopted the strategic goal of eliminating health inequities by 2030. And, to achieve that goal, the agency has adopted the following definition of health equity:

"Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Oregon Health Authority: Agency Summary Narrative

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power, and
- Recognizing, reconciling and rectifying historical and contemporary injustices."

OHA still has a clear direction to innovate, improve and transform the state health care system to meet three goals noted below. However, OHA recognizes, now, more than ever, that a health equity framework rectifying structural historical and contemporary injustices and racism must be incorporated into all components of the work, committees, and action plans to move these three goals forward:

- Improve the lifelong health of all Oregonians.
- Increase the quality, reliability and availability of care for all Oregonians.
- Lower or contain the cost of care so it is affordable to everyone.

The **Agency Operations Division** provides operational support and human resources services to the Oregon Health Authority. The division includes the following functional areas:

- Central Operations — Supports agency operations including public records requests, facility coordination, performance system management, Tribal Affairs and shared services coordination with the Oregon Department of Human Services.
- Human Resources — Provides recruitment, classification and compensation, employee relations, labor relations, organizational development, and business operational support across the agency.

Tribal Affairs is responsible for ensuring that the relationship between OHA and the nine federally recognized Tribes of Oregon is built on trust and mutual respect. It is important that the agency understands and follows the requirements laid out in Senate Bill 770 (2001, Relating to government-to-government relations between the State of Oregon and American Indian tribes in Oregon).

Oregon Health Authority: Agency Summary Narrative

Tribal Affairs supports Tribal Health Programs and the Urban Indian Health Program to successfully deliver health care services including physical, oral, behavioral and public health, so that the triple aim objectives of better care, better health, and lower costs are met. This includes implementing programs, policies, legislation and coordinating funding opportunities for Tribes to better serve their membership. Tribal Affairs provides training for various levels of staff in the agency and outside partners to enhance knowledge and understanding of tribal issues and federal mandates. Tribal Affairs provides leadership on agency-wide efforts to improve access, service equity, and outcomes for American Indian and Alaska Native people.

The **Fiscal Division** provides leadership and oversight of financing policies and coordinates budget development and execution for the Oregon Health Authority. The division includes three functional areas: budget, actuarial services, and program integrity.

- Budget — Developing, coordinating, executing, monitoring and managing OHA budgets within divisions and across the agency. Developing and updating the agency budget as it progresses through the statewide budget process, including Agency Request Budget, Governor's Budget, the Legislatively Adopted Budget, rebalance reports and various Emergency Board actions.

While the Office of Actuarial and Financial Analytics Unit and Office of Program Integrity are functionally within the Fiscal Division of Central Services, they are budgeted in the Health Systems Division Program Support and Administration unit.

The **OHA Equity and Inclusion Division** works on behalf of the Oregon Health Authority and the broader health system in Oregon to ensure the elimination of avoidable health gaps caused by social inequities and to promote optimal health in Oregon for everyone. The work is carried out in four major work units:

- Equity and Policy
- Diversity, Inclusion, Training, Compliance & Civil Rights
- Race, Ethnicity, Language, Disability/Sexual Orientation, Gender Identity (REALD/SOGI)
- Business Support and Administration

These units develop programs and initiatives relating to health equity policy, data and practice using an anti-racism framework and including the social determinants of health and equity; universal access for people with disabilities, people with limited English proficiency, etc.; diversity and inclusion; non-discrimination; the development of culturally and linguistically responsive practices and services; collection and analysis of race, ethnicity, language, disability, sexual orientation, gender identity and gender expression demographic data; and training among other work and initiatives. The division engages community partners and uses qualitative and quantitative data, best practice research and practice-based evidence to carry out its work. The division's policy, data and program initiatives address contemporary and historical injustices experienced predominantly by racially, ethnically, culturally and linguistically diverse populations, including people with disabilities so that all people can reach their greatest health potential and well-being, and participate in a more robust and inclusive health delivery system. This division has also led the adoption of an anti-racism framework for the agency including anti-racism training, statewide community engagement with diverse communities for the agency's strategic plan, the development of OHA's strategic goal to eliminate health inequities in Oregon and the health equity definition quoted above.

The **External Relations Division** has three sub-divisions: Communications, Government Relations, and Member and Stakeholder Support which includes the Community Partner Outreach Program (CPOP), Ombuds Program, and Innovator Agents. Together, they are responsible for building strong relationships with the public, community partners, media, the Legislature, and other agencies at the state and federal levels, as well as creating a broad understanding of the many ways in which OHA contributes to the health and well-being of Oregonians. Within OHA's commitment to partner directly with community to eliminate health inequities, each ERD team carries the voice and feedback from community, with a focus on communities and individuals in Oregon facing health inequities, internal to all agency operations, policies and programs to integrate community voice into agency work.

- Communications provides accurate and accessible information about OHA's mission and programs, responds to requests for information from the public and media, and produces content for a wide range of agency publications, websites and other channels for keeping the public informed. They elevate media channels and communications to best reach populations in Oregon most impacted by health inequities.
- Government Relations provides timely health data and analysis to the Legislature, federal partners, and local elected officials to inform evidence-based health policies and legislation. It also develops OHA legislative

concepts to ensure access to quality health care, contain costs of health care, ensure legislative concepts advance eliminating health inequities, and improve overall health for Oregonians.

- The Community Partner Outreach Program has built a one-of-a-kind network of Community Partner Organizations serving all Oregonians in every county in Oregon. The work CPOP and Community Partners do on behalf of OHA is essential to support health system transformation and adequately serve Oregonians to eliminate health inequities, ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians. CPOP is the backbone and network from which individuals enroll in the Oregon Health Plan (OHP), understand how to use services and support equity-centered, transformative care.
- The Ombuds Program advocates for OHP member access to care and quality of care provided through OHP; uses learnings from individual member issues to elevate OHP member voice through the OHA so Medicaid programs, policies, and operations are based on member experience; and elevates identified issues for system improvement. As required by legislation the program reports data and recommendations for improvement to the OHA Director, the Oregon Health Policy Board, and the Governor.
- The Innovator Agents work closely with Oregon's 15 coordinated care organizations (CCOs) as required by legislation and Oregon's Medicaid Waiver to coordinate between OHA, the community, and CCOs to ensure local adaptation and implementation of statewide health priorities. They understand the health needs of the region, the strengths and gaps of the health resources in the CCO and articulate these needs and gaps to OHA to ensure statewide and local coordination. They prioritize elevating OHP member voice within CCO operations and in CCO 2.0 they elevate local work with CCOs in health equity, Tribe relationships, behavioral health, and emerging statewide priorities.

Health Systems Division

The Health Systems Division (HSD) is responsible for developing and maintaining a statewide system of integrated physical, behavioral, and oral health care. HSD serves to complement the larger efforts of OHA to eliminate health inequities in Oregon by 2030. HSD operationalizes access to health care for all people in Oregon, with the triple aim of better health, better care, and lower costs.

The budget for the Health Systems Division is comprised of three units:

- Program Support and Administration
- Medicaid
- Non-Medicaid (Behavioral Health)

Program Support and Administration
The Health Systems Division Program Support and Administration unit provides administrative support, services and oversight for both Medicaid and Non-Medicaid programs. Program Support and Administration staff work directly with program staff, leadership, and other agency partners to support effective programs and achieve agency goals.

This unit includes critical business support staff for the Health Systems Division who execute the administrative budget; manage positions, hiring, and facilities; oversee county contracts and grants for behavioral health programs; and provide project management for major program and agency initiatives.

Program Support and Administration staff also ensure HSD's federal and legislative mandates under the Oregon State Plan and Title XIX of the Social Security Act Medical Assistance Program. The Medicaid section is made up of teams including:

- Federal Medicaid Policy Unit and MAGI Eligibility which focuses on coordination of policy development, submission, and implementation of waivers and State Plan authorities with the federal Centers for Medicare and Medicaid Services.
- Member and Provider Services which is responsible for delivery system support, provider support and enrollment, provider services training, and provider clinical support, Client and Enrollment Services (OHP Call Center), and Medical Hearings.
- CCO Operations which includes CCO Quality Assurance and Contract Oversight, CCO Contracting, CCO Claims and Encounter Data Services, and CCO Services.
- Fee-for-Service (FFS) Operations which includes the Medicaid Policy and Programs Unit responsible for physical, oral, and behavioral health program development, operations, policy, and special projects, and other staff responsible for quality assurance, strategies and initiatives, and community engagement.

Oregon Health Authority: Agency Summary Narrative

While functionally situated within the Fiscal Division of OHA Central Services, the Program Support and Administration budget also includes the Office of Actuarial and Financial Analytics (OAFA), which develops OHA's capitation rates for Medicaid managed care entities (CCOs, dental care organizations and mental health organization), and the Office of Program Integrity, which ensures that Oregon's Medicaid program follows federal Medicaid program integrity regulations.

Medicaid

The Medicaid budget includes state and federal funds used to deliver and pay for health care services to over 1.4 million Oregon Health Plan (OHP) members of which 43 percent are children. The OHP includes Medicaid, the Children's Health Insurance Program (CHIP), Cover All Kids, Reproductive Health Equity Act (RHEA), and other related services. Payments are made to individual health care providers as Fee-for-Service (FFS) and to the coordinated care organizations (CCOs) in the form of a global budget. CCOs serve over 90 percent of all OHP members.

Oregon is applying to the Centers for Medicare & Medicaid Services (CMS) for a new five-year Medicaid waiver. The waiver is also known as the 1115 Demonstration. The purpose of the waiver is to reform Oregon's Medicaid program. Medicaid is a state and federal program. The Oregon Health Plan (OHP) is the name of Oregon's Medicaid program. OHP delivers health care to people who have low income.

A federal waiver creates an opportunity for OHP to build on our state's health care transformation success and create a more equitable system.

Oregon has recently received approval for a new CMS 1115 waiver for 2022–2027. The new waiver includes first-in-the-nation changes to Oregon's Medicaid program and includes $1.1 billion in new Federal Funds to address inadequate food, housing and other root-cause issues that lead to poor health for people and families struggling to make ends meet. As part of the agreement, the federal government also approved expanded OHP coverage for young children, as well as extended eligibility for youth and adults.

Statutory Authority

Oregon Health Authority: Agency Summary Narrative

Oregon Revised Statute (ORS) 414.018 through 414.760 establish and authorize the programs administered by HSD-Medicaid.

Non-Medicaid (Behavioral Health)

Non-Medicaid Behavioral Health programs help all Oregonians achieve physical, mental and social well-being through access to mental health and addiction services and support (including housing services) for adults and children. The aim is to create a simple, meaningful, and responsive behavioral health system for every Oregonian who needs it. Ongoing supports and services improve a person's ability to be successful with their family, education, employment, and in their community. This often reduces public safety problems, negative health-related consequences and suicide risk. Timely access to behavioral health care is a critical aspect for increasing protective factors and reducing risk factors that lead to suicide.

Services and supports include those delivered by peers, such as help establishing personal relationships, obtaining employment or education, and independent living skills training such as cooking, recreation and cultural activities, and shopping and money management. They also include residential treatment services or adult foster care and supervision of people in the community who have committed crimes but were found "Guilty Except for Insanity." Services are provided in local mental health clinics, doctor offices and clinics, schools, drop-in centers and homes.

Non-Medicaid Behavioral Health programs use numerous partnerships to develop and administer a community-based continuum of care delivered in outpatient, residential, school, acute, hospital, and criminal justice and community settings. In partnership with CCOs, county governments, local community stakeholders and consumers, Behavioral Health programs provide funding and technical support for service provision to ensure investments and legislative mandates are implemented.

Statutory Authority

The statutory framework for Non-Medicaid programs administered by HSD is included in the following state and federal statutes:

- ORS 430 provides OHA the statutory framework for the development, implementation and continuous operation of the community treatment programs to serve people with addiction disorders and mental health disorders subject to the availability of funds.
- Alcohol and Drug Programs operate under the authority of Oregon Revised Statute (ORS) 430.254 through 430.426 and ORS 430.450- 430.590 and Federal PL 102-321 (1992) Sections 202 and 1926.
- Problem gambling treatment and prevention services are mandated by Oregon Revise Statute (ORS) 413.520, which directs OHA to develop and administer statewide gambling addiction programs and ensure delivery of program services.

Health Policy and Analytics

The Health Policy and Analytics division develops and implements innovative approaches to achieving health equity by lowering health care costs and achieving better health and better health care for all Oregonians, with a particular focus on communities of color, that have borne the brunt of systemic racism. This is accomplished through seven offices:

- The Office of Health Policy
- The Office of Delivery Systems Innovation
- The Office of Health Analytics
- The Office of Health Information Technology
- The Public Employees Benefit Board and the Oregon Educators Benefit Board (each board's operations budget is in HPA, while their program budgets are separate from HPA)
- The Oregon Health Insurance Marketplace
- The Office of Business Operations

These offices provide agency-wide policy development, strategic planning, clinical leadership, and statewide delivery system technology tools to support care coordination, health system transformation support, and health system performance evaluation reports. Together these offices provide services and support focused on achieving health equity through the triple aim of better health, better care, and lower costs.

Oregon Health Authority: Agency Summary Narrative

The Health Policy and Analytics division is accountable for leading the next phase of health system transformation against the backdrop of the COVID-19 pandemic and justified demands for addressing systemic racism by:

- Supporting and incentivizing payments for value, moving away from paying for service volume and incentivizing care delivery that promotes better health for all communities.
- Supporting the Oregon Health Policy Board's work including its plans to operationalize OHA's health equity definition and reimagine a health care system capable of achieving health equity.
- Focusing on addressing social determinants of health in addition to the delivery of medical care.
- Driving toward universal health care coverage in Oregon through Medicaid waiver applications, initiatives to ease transitions between public and commercial coverage, extend Oregon Health Plan coverage to undocumented immigrants and design a new public option for those over-income for the Oregon Health Plan.
- Innovating and implementing integration across behavioral health, oral health, physical health and social services using health information technology.
- Implementing legislative directives to align metrics and supporting new and innovative metrics for equity and social determinants of health.
- Facilitating multi-payer alignment to stabilize critical provider services and rebuild a health care system capable of achieving health equity.

Public Employees' Benefit Board

The Public Employees' Benefit Board (PEBB) is a division of the Oregon Health Authority (OHA). PEBB supports the goals of transforming the health care system in Oregon and fundamentally improving how care is paid for and delivered. The PEBB board's mission is to provide high-quality health plans and other benefits for state employees at a cost that is affordable to both the employees and the state.

PEBB serves diverse populations and constituencies and provides a critical public service to Oregonians. It offers medical, dental, vision, life, disability and accidental death and dismemberment benefit plans. PEBB is a federal IRS Section 125 Cafeteria Plan benefits program that is required to offer the same benefits to all members.

Statutory Authority

The Public Employees' Benefit Board authority lies in ORS 243.061 through ORS 243.302. House Bill 2279 (2013) expands participation eligibility to include local governments and special districts.

Oregon Educators Benefit Board

The Oregon Educators Benefit Board (OEBB) is a division of the Oregon Health Authority (OHA). OEBB supports the goals of transforming the health care system in Oregon and fundamentally improving how care is paid for and delivered. The OEBB board's mission is to provide a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and some special districts and local governments. OEBB's benefit plans are designed to be flexible and accommodate the needs of employers and members.

OEBB designs and maintains a full range of benefit plans for eligible publicly funded entities to offer to their employees and early retirees. Plans include medical, dental, vision, life, disability, accidental death and dismemberment, long term care, an employee assistance program, a health savings account and flexible spending accounts. Each of the 251 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing, and population. OEBB's plans are designed to be flexible and accommodate the needs of all employers participating in OEBB and the members enrolled in OEBB plans.

Statutory Authority

OEBB was established by Senate Bill 426 (2007). House Bill 2279 (2013) expands participation eligibility to include local governments and special districts. The OEBB Board, functions and responsibilities are authorized by ORS 243.860 to 243.886.

Public Health

Public health uses equity practice, data and science to achieve better health outcomes, improve care and lower or contain health care costs by preventing the leading causes of death, disease, and injury in Oregon. The OHA Public Health Division (OHA-PHD) works in partnership with local public health authorities (LPHAs), Tribes, community-

based organizations (CBOs), health systems and a number of sectors to elevate community priorities for health into programs designed to eliminate health inequities by 2030.

In the 2023-25 biennium, OHA-PHD will continue advancements in public health modernization by continuing a focus on health equity, communicable diseases, environmental health, emergency preparedness and the indirect impacts of COVID-19 on health, such as access to preventive care, behavioral health and community cohesion. COVID-19 has highlighted the critical foundational capabilities and programs necessary to respond to new public health threats and achieve OHA's goal of eliminating health inequities by 2030.

Statutory Authority
Chapters 431 and 433 of Oregon Revised Statutes set forth hundreds of code sections enabling and mandating a wide range of public health activities carried out by state public health and its county partners.

Oregon State Hospital

Oregon State Hospital (OSH) is an essential part of the statewide behavioral health system, providing the highest level of psychiatric care for adults from all 36 counties. The hospital's primary goal is to help people recover from their mental illness and return to life in the community, contributing to healthy and safe communities for all people in Oregon. Oregon State Hospital promotes public safety by treating people who are dangerous to themselves or others in a secure, therapeutic setting. The hospital works in partnership with the other divisions of the Oregon Health Authority including the Health Systems Division (HSD), the Psychiatric Security Review Board (PSRB), regional hospitals, community mental health programs, advocacy groups and other community partners to ensure people with mental illness get the right care, at the right time, in the right place.

OSH operates two campuses with a total of 743 licensed beds, with 592 beds in Salem and 151 beds in Junction City. OSH services are provided 24 hours per day, seven days a week. Oregon's only state-operated secure residential treatment facility also reports to the superintendent of OSH. Pendleton Cottage, a 16-bed facility, is located on the grounds of the former Eastern Oregon Training Center in Pendleton. The secure mental health

treatment program provides a community treatment setting for people who need a secure level of care as their first step out of the state hospital.

Statutory Authority
The following ORS references provide OSH its authority:

- ORS 161.295-400 – Determination of fitness to proceed/commitment
- ORS 179.321 – Authority to operate, control, manage and supervise OSH campuses and state-delivered residential treatment facilities
- ORS 426 – Powers, duties, and responsibilities of OHA
- ORS 443 – Residential treatment homes and facilities

OHA Shared Services

OHA Shared Services includes the Office of Information Services that exists to deliver technology solutions and services to OHA and ODHS and to the people of Oregon both directly and indirectly.

The OIS organization's number one priority is keeping the health and human services IT systems — the largest and most complex in the state — available to its customers. Through technology, OIS supports over 1.5 million clients, 16,000 staff, 50,000 partners, 140 offices and 32,000 devices (such as computers, printers and mobile devices.)

OIS provides technical expertise and partners with OHA and ODHS to run large technology projects, which most recently have included COVID-19 IT systems (for example, Get Vaccinated Oregon and Digital Vaccine Record), Oregon Eligibility (ONE) System; and Medicaid Modularity System (MES.)

Environmental factors

OHA programs are directly affected by the following environmental factors and are risks to the agency’s budget:

- Social determinants of health such as food security; income and employment; housing security; education access and quality; and racism, impacts of colonization, trauma and toxic stress affect community needs and outcomes.

- Economic changes, such as poverty and unemployment rates, affect Oregon Health Plan caseload growth.
- Federal policy and funding changes affect state funding needs (such as Medicaid match rates, Health System Transformation).
- Medical inflation and utilization affect the cost for provide health coverage to Oregon Health Plan members.
- New health challenges, which include emerging infectious diseases (like COVID-19), climate change, threats from human-caused and natural disasters, and an increase in chronic diseases. These challenges are all exacerbated by historic and contemporary health injustices and put pressure on Oregon's Public Health system, which is already stretched due to the ongoing need to respond to the pandemic.
- The adequacy and effectiveness of community behavioral health systems affect the Oregon State Hospital census.

Major information technology projects/initiatives

The Governor's Budget for OHA includes the following policy packages:

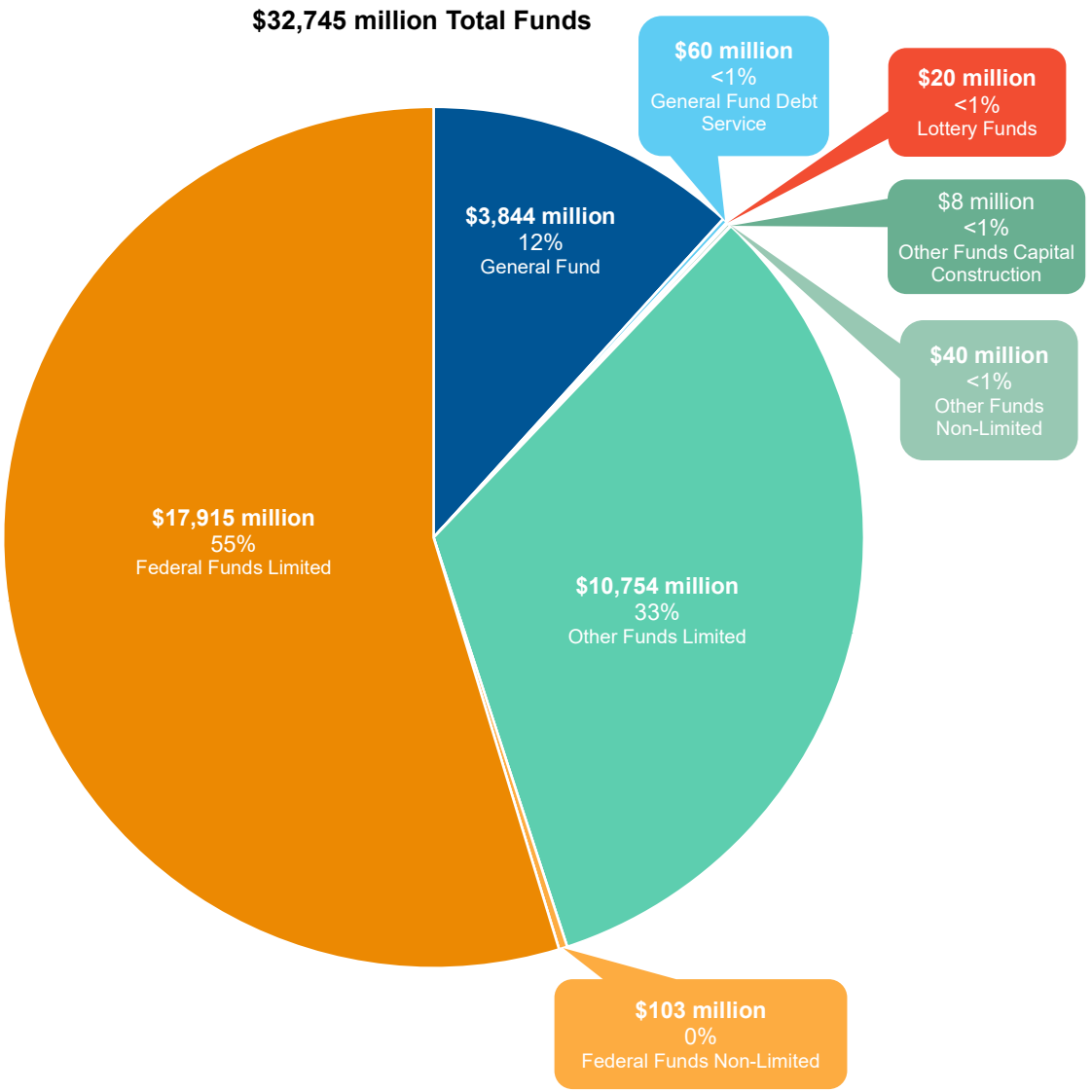
- **REALD & SOGI Implementation: Getting to Data Equity (policy package #403)** – This policy package requests funds to continue multi-biennia efforts to meet legislation outlined in House Bill 2134 (Standards for Collection of Demographic Data, 2013), House Bill 4212 (Strategies to Protect Oregonians from the Effects of the COVID-19 Pandemic, 2020), and House Bill 3159 (Data Justice Act, 2021). Supporting data collection by external providers, insurers, and individuals, the Initial Registry, Initial Repository, and creating the Enterprise Scale Statewide REALD & SOGI Registry and Repository represents an investment in data equity and facilitates data justice within communities most impacted by health inequities.
- **Mainframe Migration/Provider & Client Payment System (policy package #203)** – More than one million Oregonians count on the state's current mainframe platform to receive their benefit and provider payments and the old COBOL programming code was written over 40 years ago. There is significant and increasing risk OHA will be unable to make timely payments to Oregonians, potentially for an extended period. The Governor's Budget therefore includes resources to upgrade the mainframe platform and ensure continuity of payments and benefits. In addition, the demand on this system exceeds the capacity with resources extremely scarce across the USA due to COBOL programmers being of retirement age and beyond.

- **Marketplace Transition from SBM-FP to SBM (policy package #416)** – The purpose of this package is to end Oregon's reliance on the federal health insurance exchange eligibility and enrollment platform and the federal call center, and to fund the initial stage of its transition to a state-based marketplace platform and state-controlled call center.

Oregon Health Authority

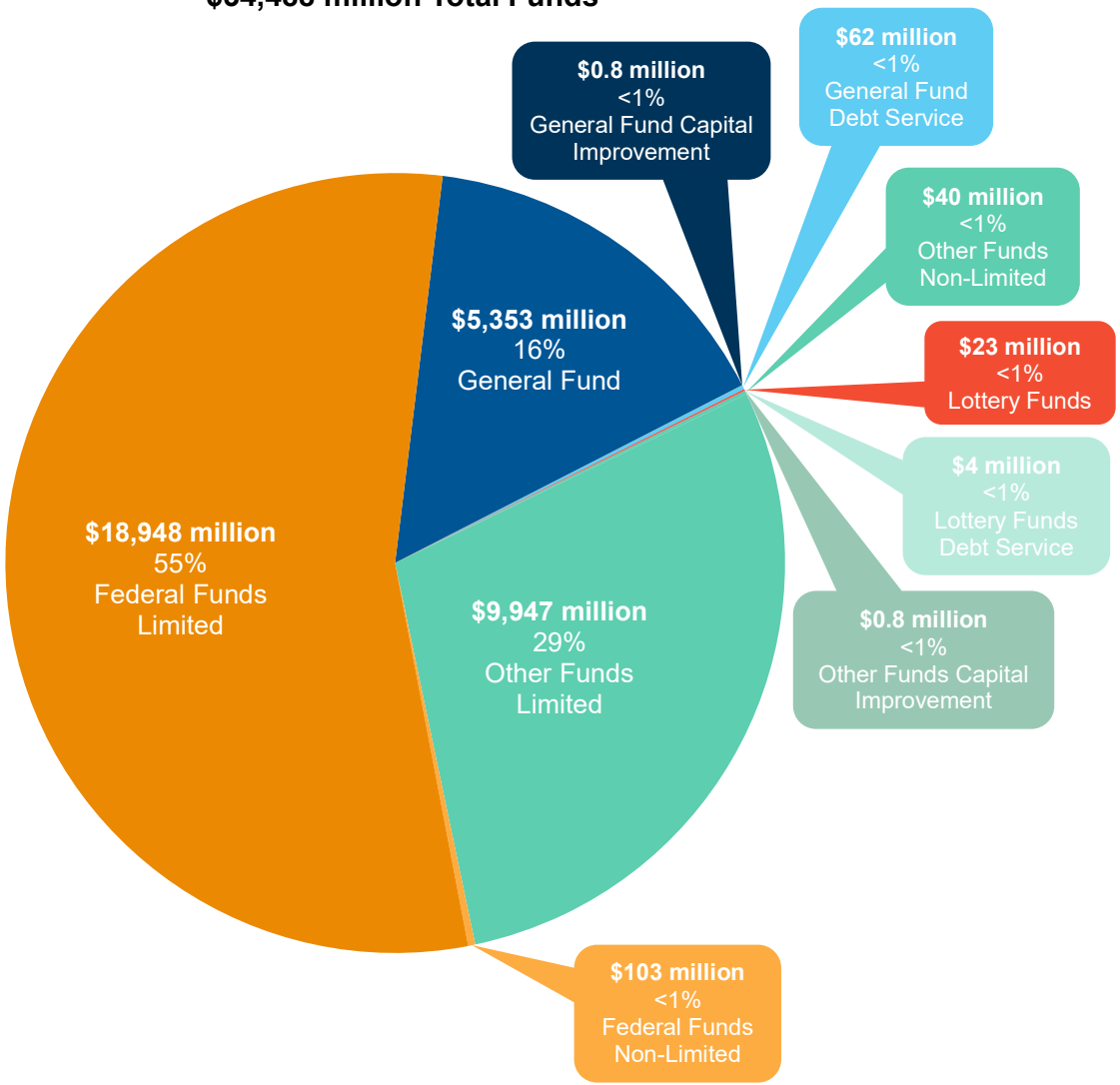
2021-23 Legislatively Approved Budget

By Fund Type



Oregon Health Authority
2023-25 Governor's Budget
By Fund Type

$34,488 million Total Funds



PLACEHOLDER- Details are not available at this time

Oregon Health Authority

Reduction Options: 2023-25 Agency Request Budget

Reductions included in the 2023-25 Ways and Means are in strike through font.

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2023-2025 Biennium

(Limited Other and Federal Funds only - does not include Non-Limited Funds)

	GF & LF	OF	FF	TF
Current Service Level Budget (OHA LEVEL)	**5,066,452,882**	**9,362,873,623**	**16,529,047,618**	**30,958,374,123**
10% Target	**(506,645,288)**	**(936,287,362)**	**(1,652,904,762)**	**(3,095,837,412)**

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
~~-0.02%~~	~~4~~	~~SAEC: FACILITIES~~	~~Reduction thru inflation/savings in budget projections for Expendable Prop and Office Expense~~		~~(1,044,000)~~	~~(372,000)~~	~~(534,000)~~	~~(1,950,000)~~	~~-~~	~~-~~	
~~-0.85%~~	~~2~~	~~Medicaid~~	~~Reduce Oregon Health Plan inflation for managed care and fee-for-service from 3.4% to 3.0% per year.~~	~~N~~	~~(41,900,000)~~		~~(100,300,000)~~	~~(142,200,000)~~			~~This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.~~
-1.26%	3	Medicaid	Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset indirect costs associated with their GME programs. IME includes indirect costs that arise from the inexperience of residents such as extra medical tests and reduced productivity. CMS APPROVAL REQUIRED.	Y	(20,710,000)		(30,231,000)	(50,941,000)			Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on these ten teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payment will also impact the physician workforce as there is already a shortage in the primary care specialty, which is one of the largest specialties in a teaching program. A reduction of trained providers may limit access to quality healthcare.
-1.33%	4	Medicaid	Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset costs associated with their graduate medical education programs. GME includes costs associated with stipends or salaries for residents, payments to supervising physicians, and direct program administration costs. CMS APPROVAL REQUIRED.	Y	(3,945,000)		(5,758,000)	(9,703,000)			Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on these ten teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payment will also impact the physician workforce as there is already a shortage in the primary care specialty, which is one of the largest specialties in a teaching program. A reduction of trained providers may limit access to quality healthcare.
-1.47%	5	Non-Medicaid	Remove inflation for Community Mental Health and Substance Use Disorder Programs.	N	(6,989,084)	(5,164,770)	(1,893,880)	(14,047,734)			Removal of inflation for the 2023-25 biennium will be devastating to the BH system. Programs reliant on OHP reimbursement for treating clients are in workforce crisis, with vacancies and tighter budgets impact availability of programing and services. Cuts disproportionately hurt the most susceptible to historic and contemporary racism and inequities, including BIPOC, those who are homeless, and children. Oregon has one of the highest rates of mental illness and addiction in the USA and drug overdose deaths in Oregon more than doubled between 2019 and 2021; suicide is the leading cause of death for children. Disruptions to daily life due to the COVID-19 pandemic have increased the need for behavioral health services that the system is not able to fully meet without continued investment and adequate fudning levels in an economy that is experiencing substantial inflation. We will see an increase in costly services including EDs, inpatient care and pressure on a health system that doesn't have capacity to address the need. Oregon will be at increased risk for non-compliance with current lawsuits, audit findings and increase the risk of more judicial oversight.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-2.09%	6	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 3.0% to 2.7% per year.	N	(31,200,000)		(74,600,000)	(105,800,000)			This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-2.70%	7	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.7% to 2.4% per year.	N	(31,000,000)		(74,400,000)	(105,400,000)			This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-2.70%	8	PH HST	Eliminate funding for Or-Epi	N	(21,000)	-	-	(21,000)	-	-	Eliminate of support for the annual Oregon Epidemiology Conference.
-2.70%	9	PH HST	Reduce services & supplies	N	(34,650)			(34,650)	-	-	Reduce training, travel and development support for internal and external partners.
-2.72%	10	PH OSPHD	Reduce Service and Supplies	N	(733,931)	0	(3,000,000)	(3,733,931)			Reduce ability to support office wide activities, including trainings and travel and greatly reducing supplies.
-2.72%	11	PH OSPHD	Eliminate Advance Directive activities	N	(51,490)	-	-	(51,490)	-	-	These funds would eliminate the ability to continue staffing and facilitating the Advance Directive Adoption Committee and would limit educational materials development related to the Oregon Advance Directive Form.
-2.72%	12	HPA	Reduce all staff supplies, development, travel to only essential activities (assume 90% reduction from previous expenditure)	N	(328,362)	-	(426,000)	(754,362)	-	-	The effectiveness of current staff would be greatly impacted by this reduction. Without continued training, knowledge of current best practices, innovation concepts, federal policy and program implementations, etc. may not be understood. Maintaining modernized programs would be extremely difficult.
-2.73%	13	HPA DSI / Transformation Center	Reduce Transformation Center technical assistance by 20%	N	(150,000)	-	(150,000)	(300,000)	-	-	These budget cuts will significantly impact the Transformation Center's capacity to support CCOs' innovation in key CCO 2.0 areas: value-based payment, social determinants of health and health equity, and behavioral health. The result will be an almost 20% decrease in the technical assistance CCOs receive, jeopardizing CCOs' ability to achieve CCO 2.0 goals. The remaining 80% of the program would shift reprioritize to focus first on health inequities.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-2.74%	**14**	HPA DSI / PCPCH	Reduce PCPCH Program by 30%	N	(596,211)	-	(381,186)	(977,397)	-	-	These cuts to the Patient-centered Primary Care Home (PCPCH) Program would lead to a significant scaling back of the PCPCH program, resulting in a decrease in the ability of Oregon's primary care system to deliver high-quality, high-value, equitable care, which is especially essential during COVID. The model was designed to promote holistic, patient-centered care, and has recently been redesigned through the lens of promoting health equity and minimizing disparities. Further, according to a 2016 Portland State University evaluation, each patient receiving care from a PCPCH experiences $162 lower annual total health care expenditures compared with a patient who receives care in a non-PCPCH clinic. Since almost 90% of all Oregonians currently receive care from a PCPCH, the program is associated with total annual savings of $614 M—savings that would decrease substantially with a significantly smaller PCPCH program. These budget reductions would also prevent the launch of the Behavioral Health Home (BHH) program, which is a building block for the Governor's CCO 2.0 vision of establishing high-quality, integrated behavioral and primary health care at the clinic level and is particularly essential during COVID recovery.
-2.74%	**15**	HPA DSI/PCO	Eliminate HRSA Oral Health Workforce Grant	N	-	-	(841,458)	(841,458)	-	-	The grant program builds on previous federal grants to increase the oral health workforce and access to services in areas of Oregon with the highest unmet health care need. This grant will integrate teledentistry services into primary care clinics, utilize new technology to expand dental preceptor capacity for student clinical rotations, and develop a tiny mobile dental home to provide comprehensive services to underserved populations. Eliminating this grant will have a huge impact on the state's ability to introduce innovative care delivery models for meeting oral health service needs in areas experiencing health inequities.
-2.75%	**16**	HPA DSI/Pharmacy	Reduction in Strategic Clinical Services by 50%	N	(577,412)	-	(1,044,141)	(1,621,553)	-	-	These budget cuts would significantly impact two priority areas for clinical support: pharmacy and oral health. Strategies to ensure patients have access to—and the state pays for— high-value medication will not be implemented. In addition, Oregon will lack oral health leadership, resulting in a continued delay in robust oral health and physical health integration, which will contribute to statewide delays in access to oral health care. This reduction would significantly reduce support for the Center for Evidence-based Practice related to oral health and pharmacy.
-2.75%	**17**	PH OMMP	Monitor staffing and services and supplies for Oregon Cannabis Commission	N	(49,313)			(49,313)			Reducing this budget might have some small impact to work done for the Oregon Cannabis Commission. Given current budget trends and intent to fill both positions (AS1 and OPA3), this reduction might have some impact that will cause a reduction in S&S spending and/or a decrease in percent time that one of the staff can charge to this fund. If that happens, the percent time reduced in GF will be offset by the same percent time increase to the OMMP OF fee.
-2.75%	**18**	PH Admin	Reduce Center administrative activities	N	(209,900)	-	-	(209,900)	-	-	Reduce ability to support Center wide activities, including trainings and travel
-2.76%	**19**	PH ADMIN	CHP-Center for Health Protection Administration	N	(104,023)			(104,023)			This amount represents a cost shift from GF funding to OF and FF for the administration of the Center for Health Protection.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-2.80%	20	Central Services	S&S reduction of Standard Inflation for all offices - pkg 31-01	N	(2,439,371)	(78,430)	(447,584)	(2,965,385)	-	-	
-2.84%	21	SAEC	S&S reduction of Standard Inflation for all offices - pkg 31-01	N	(1,723,384)	(562,888)	(727,509)	(3,013,781)	-	-	
-3.06%	22	SAEC: price list	SGSC, Risk, ETS - all DAS Price list items - reduce by 15%	N	(11,052,305)	(1,218,946)	(1,429,388)	(13,700,638)	-	-	This Comp Source Group, is directly audited to the Price list, if DAS doesn't pass along savings, this won't actualize. Achieved thru DAS lowering their invoice costs, and passing along their cuts to the agency's thru their invoicing.
-3.07%	23	HPA Health Information Technology	Eliminate contract for statewide Collective Platform	N	(769,338)	-	(2,308,008)	(3,077,346)	-	-	This contract covers Medicaid users on the statewide Collective Platform (aka Emergency Department Information Exchange (EDIE)/fka PreManage), including CCOs, Medicaid fee for service contractors, Tribal clinics, and OHA/ODHS programs. The Collective Platform plays a critical role in ensuring that all health care organizations working with high-risk patients to know when they have been in the emergency department or hospital, and coordinate their care across their primary care, CCO, behavioral health team, hospital, skilled nursing facilities, and OHA/ODHS programs. Without OHA's CMT contract, Medicaid members and OHA/ODHS clients would face increased barriers to coordination of care and worse health outcomes, including many people that typically face disparities due to racism and other social factors. OHA's funding is in partnership with all hospitals, CCOs and most commercial health plans, which together ensure participation by all hospitals and a huge swath of physical, behavioral, oral clinics and skilled nursing facilities across Oregon. OHA has also leveraged the Collective Platform infrastructure to support and promote health system transformation and health equity priorities, including behavioral health interventions, CCO metrics, and public health use cases including PDMP, MDRO, and COVID data sharing. OHA's participation is a cornerstone for this program – removing our participation will end the current statewide footprint for this infrastructure which would impact our public health, behavioral health, Medicaid and health system transformation work.
-3.21%	24	HPA DSI/PCO	Reduction in Funding for the Health Care Incentive Fund by 35%	N	(6,770,544)	(7,936,811)	-	(14,707,355)	-	-	The Health Care Incentive program provides financial and non-financial incentives to providers of physical, oral and behavioral health in underserved areas. The program has successfully established primary care providers in 20 of the 25 rural service areas that were lacking primary care services altogether. The program focuses on culturally competent health care - 36% of the providers receiving loan repayments speak a language other than English or come from a racial/ethnically diverse background. This reduction option would decrease funding by over 35%, significantly impacting multiple contracts currently in place and greatly reducing the intended outcomes of the program.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-3.55%	**25**	Medicaid	Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients. The agency would no longer cover the following dental services for adults (including pregnant adults) on OHP: Crowns, full and partial dentures; scaling & root planning. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	Y	(17,271,381)		(62,989,178)	(80,260,559)			Eliminate dental coverage for OHP non-pregnant adults, which would eliminate all services for non-pregnant adult dental coverage for the OHP benefit package. Legislative action and CMS negotiation and approval are required. The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits. Dental benefit reductions will impact an individual's over-all health. Reductions will create a worsening of chronic diseases such as diabetes, poor pregnancy outcomes, and create a shift in treatment need. Patients not receiving needed dental care will experience need to go to the Emergency Department, possibly elevating need for opioids and/or requests for opioids and higher ED costs. People will lose teeth unnecessarily with no means to replace them. People will experience more difficulty in getting jobs due to poor oral appearance and experience missed days from work due to oral disease and pain. Dental benefit reductions will hinder populations impacted by health inequities from achieving health equity or equitable health outcomes. Marginalized populations suffer the highest incidence or oral disease in all categories. It is well known these disease states also impact comorbid conditions, such as diabetes and high blood pressure, again, with the highest incidences in marginalized minority communities. Optimal diabetes care is vitally important for those individuals with diabetes, and as it relates to potential outcomes for those who become COVID involved, again with the minority and marginalized communities being the hardest hit.
-4.48%	**26**	Medicaid	Eliminate dental coverage for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	Y	(47,117,013)		(190,394,609)	(237,511,622)			Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients, no longer covering the following dental services for adults (including pregnant adults) including: crowns, full and partial dentures, scaling and root planning. CMS negotiation and approval are required. The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits. Dental benefit reductions will impact an individual's over-all health. Reductions will create a worsening of chronic diseases such as diabetes, poor pregnancy outcomes, and create a shift in treatment need. Patients not receiving needed dental care will experience need to go to the Emergency Department, possibly elevating need for opioids and/or requests for opioids and higher ED costs. People will lose teeth unnecessarily with no means to replace them. People will experience more difficulty in getting jobs due to poor oral appearance and experience missed days from work due to oral disease and pain. Dental benefit reductions will hinder populations impacted by health inequities from achieving health equity or equitable health outcomes. Marginalized populations suffer the highest incidence or oral disease in all categories. It is well known these disease states also impact comorbid conditions, such as diabetes and high blood pressure, again, with the highest incidences in marginalized minority communities. Optimal diabetes care is vitally important for those individuals with diabetes, and as it relates to potential outcomes for those who become COVID involved, again with the minority and marginalized communities being the hardest hit.
-4.48%	**27**	Medicaid	Leverage Reduction	Y/N	-	(165,923,016)	(277,183,717)	(443,106,733)	-	-	Reduction of Leverage programs including: GME-OHSU, MAC School Based, DOE School Based, BRS, TCM, UMG, Poison Control, GEMT (HB2910), GEMT HB4030

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-5.29%	28	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.4% to 2.0% per year.	N	(41,300,000)		(98,900,000)	(140,200,000)			This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-5.90%	29	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.0% to 1.7% per year.	N	(30,900,000)		(73,800,000)	(104,700,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
~~**-5.91%**~~	~~30~~	~~PH HCRQI~~	~~Oregon Patient Safety Commission.~~	~~N~~	~~(468,000)~~			~~(468,000)~~			~~Early Discussion Resolution program, pass-through funding. This will reduce the amount sent to the Patient Safety Commission. A 24% reduction to Early Discussion and Resoultion program funding for OPSC's biennial budget would be accounted for with the following reduction strategies:~~ ~~□ Eliminate in-person educational offerings~~ ~~□ Share EDR personnel with our PSRP program that currently has a vacancy.~~
-5.91%	31	PHD/NHS	Elimination of the USDA/Senior Farmer's Market Program	N	(6,169)		(1,028,288)	(1,034,457)			Provides vouchers to 43,000 low income seniors each summer to purchase fresh locally grown fruits and vegetables. Additionally, there would be reduced income to local farmers as over 90% of the dollars of directly to 500+ local farmers; biennium; and reduced access to healthy choices for this population at risk for inadequate intake of fruits and vegetables and food insecurity. This program supports the SHIP priority: Slow the increase of obesity, Strategy 4: improve availability of affordable, healthy food and beverage choices for adults, a primary target group.

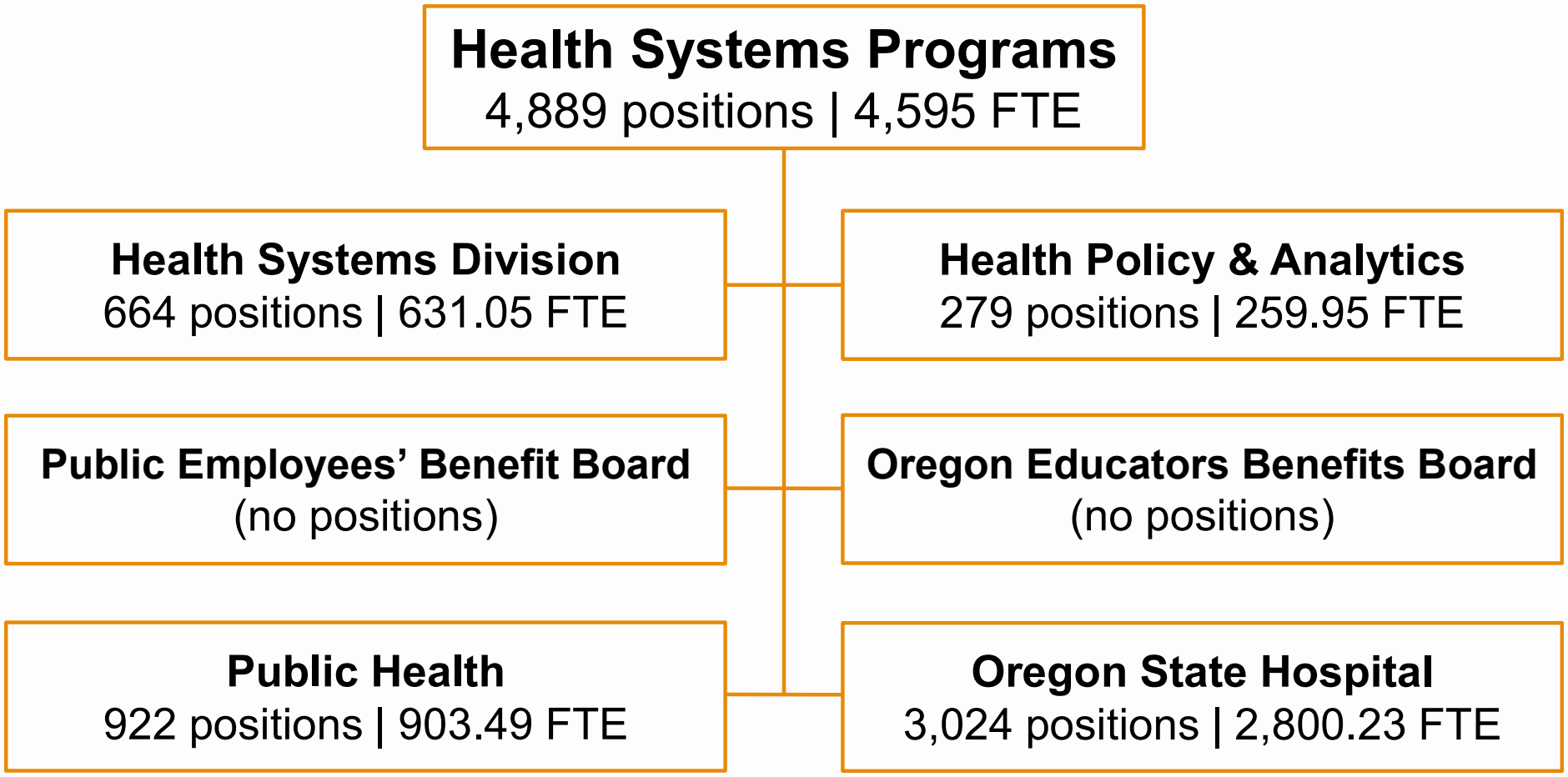
Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
~~-5.93%~~	~~32~~	~~PHD/MCH~~	~~Reduction in the Universally offered Home Visiting program~~	~~N~~	~~(1,032,119)~~			~~(1,032,119)~~			~~The Universally offered Home Visiting/Family Connects Oregon initiative will bring evidence-based nurse home visiting services and referrals to all families of newborns in Oregon. SB 526 mandates OHA design, implement and sustain the program and commercial health plans cover these services for their members. Four of 8 Early Adopter communities are currently engaged in providing services and referrals. COVID paused work in the other 4 communities. The proposed reductions would reduce the CSI GF funding levels from $7,792,011 to $6,5444,615. This reduction would come from temporary staff vacancies, reduced Medicaid match needs due to the slower rollout, and temporary and reduced local support due to fewer implementing communities. We will also postpone establishing a Center of Excellence in Oregon for model implementation. We would maintain CSL for the TA contract for Family Connects International; program evaluation and current level of state infrastructure. The plan was to increase the 23-25 investment to continue the statewide rollout of the initiative. This reduction will minimally maintain the initial implementation started in the 21-23 biennium and not provide resources to re-engage the paused communities or expand into new communities. This will further lengthen the timeframe to statewide reach of the program.~~
-6.00%	**33**	OSPHD	Reduce state Support to Local Public Health Authorities	N	(3,700,000)		-	(3,700,000)	-	-	Local public health authorities (LPHAs) would receive 35% fewer dollars per capita for public health services. Funds are used to conduct early detection, epidemiological investigations and prevention activities to help report, monitor, and control communicable diseases, tuberculosis, sexually transmitted infections, influenza, foodborne illnesses, Zika and emerging infectious diseases such as Novel Coronavirus. Communicable diseases disproportionately impact BIPOC communities due to longstanding health inequities as a result of systemic racism and oppression. As a result, local public health authorities will have a decreased ability to prevent communicable diseases within BIPOC communities.
-6.01%	**34**	OSPHD	Reduce Planning and Response to Public Health Emerging Events	N	(300,000)	-	-	(300,000)	-	-	This would reduce the funds the public health division receives to address urgent issues. Examples of the work are wildfires, Vaping, COVID-19, and currently drinking water services. This funding provides $1.0M GF state level support for the planning, and operational readiness for communicable disease preparedness and response, and mitigation for other disasters to Oregon communities. The PHD is funded largely through categorical federal grants and fee revenue statutorily dedicated to specific programs and activities which prevents the division from being able to plan, respond and help vulnerable Oregon communities respond to and recover from hazards and emergencies. Public health emergencies disproportionately impact BIPOC communities due to longstanding inequities rooted in systemic racism and oppression. Elimination of these funds will impact emergency response efforts targeting BIPOC communities.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-6.08%	**35**	OSPHD	Reduce Public Health Modernization	N	(3,700,000)	-	-	(3,700,000)	-	-	Reduce the Local support to LPHA's by 11%. This reduction will greatly impact the critical work both the state and local partners are completing. A focus area of public health modernization is to transform governmental public health in the area of health equity and cultural responsiveness through internal and community policy and program change. This reduction would impact local public health work with the BIPOC community. The locals will have to reduce staff and be unable to address emerging events, provide critical support to Oregonians and will impact the work done to modernize the public health system. Currently, both the state and local partners are addressing COVID-19. Reducing funding will impact the state's ability to address this pandemic. At the state level reductions will impact our equity work with various communities and data collection, the BRFSS survey will not be conducted, all health equity and learning collaborative work addressing health disparities will not occur and staffing will be reduced. Public Health is a critical component in ensuring Oregonians are healthy, safe and informed. Reducing any portion of these funds will greatly impact the ability of public health to be effective in Oregon.
-6.08%	**36**	OSPHD	Reduce Indirect Limitation	N	0	(500,000)	(4,000,000)	(4,500,000)			As PHD is working to create a division-wide indirect cost rate this limitation is needed to provide the technical accounting entries required to operationalize an indirect cost rate to ensure we do not have duplicative expenditure data in an internal services fund specific to tracking and reconciling indirect costs assessed to Public Health.
-6.12%	**37**	OSPHD	Reduce GF Inflation	N	(2,000,000)	-	-	(2,000,000)	-	-	This reduction in inflation would result in LPHAs receiving a 29 percent decrease on GF received for Modernization and State Support of Local Pubilc Health.
-6.93%	**38**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.4% to 1.0% per year.	N	(40,900,000)		(97,800,000)	(138,700,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-7.53%	**39**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.0% to 0.7% per year.	N	(30,600,000)		(73,100,000)	(103,700,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-8.13%	**40**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 0.7% to 0.4% per year.	N	(30,400,000)		(73,000,000)	(103,400,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-8.93%	**41**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 0.4% to 0% per year.	N	(40,500,000)		(96,900,000)	(137,400,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-9.39%	**42**	Medicaid	DRG Hospitals : DSH3.	Y	(23,000,000)		(34,000,000)	(57,000,000)			Reducing the reimbursement rate/level for DRG hospitals could adversely affect the Oregon Health Authority's relations with DRG hospitals that serve a large majority of our clients across the state. Reduced reimbursement could lead to a corresponding provider reduction of expenditures to adjust for the reduced amount of reimbursement, potentially leading to overall changes in the level of care or other service levels provided to Medicaid clients.
-9.52%	**43**	Non-Medicaid	SUD and CMH Inflation	Y/N	(6,693,791)			(6,693,791)	-	-	
-9.52%	**44**	PEBB	PEBB fully insured and self-insured plan reductions	N	-	(451,244,858)	-	(451,244,858)	-	-	PEBB contracts with insurance carriers for employee benefit plans. The operating budget for PEBB is 0.50%. The remaining 99.5% is program budget, which is dedicated funding for payment of self-insured and fully insured benefit plans. Taking reductions at any level may potentially default PEBB in its contractual obligations with carriers. Major plan design changes could possibly hit the reduction targets, but it would take a major reduction in medical plan coverage and would jeopardize the stabilization of the statewide risk pool. A major shift in cost sharing between employee, and employer could also potentially hit the reduction target but the reductions would have to be taken at the state agency budget level, as it passes employee benefit dedicated dollars through to PEBB.

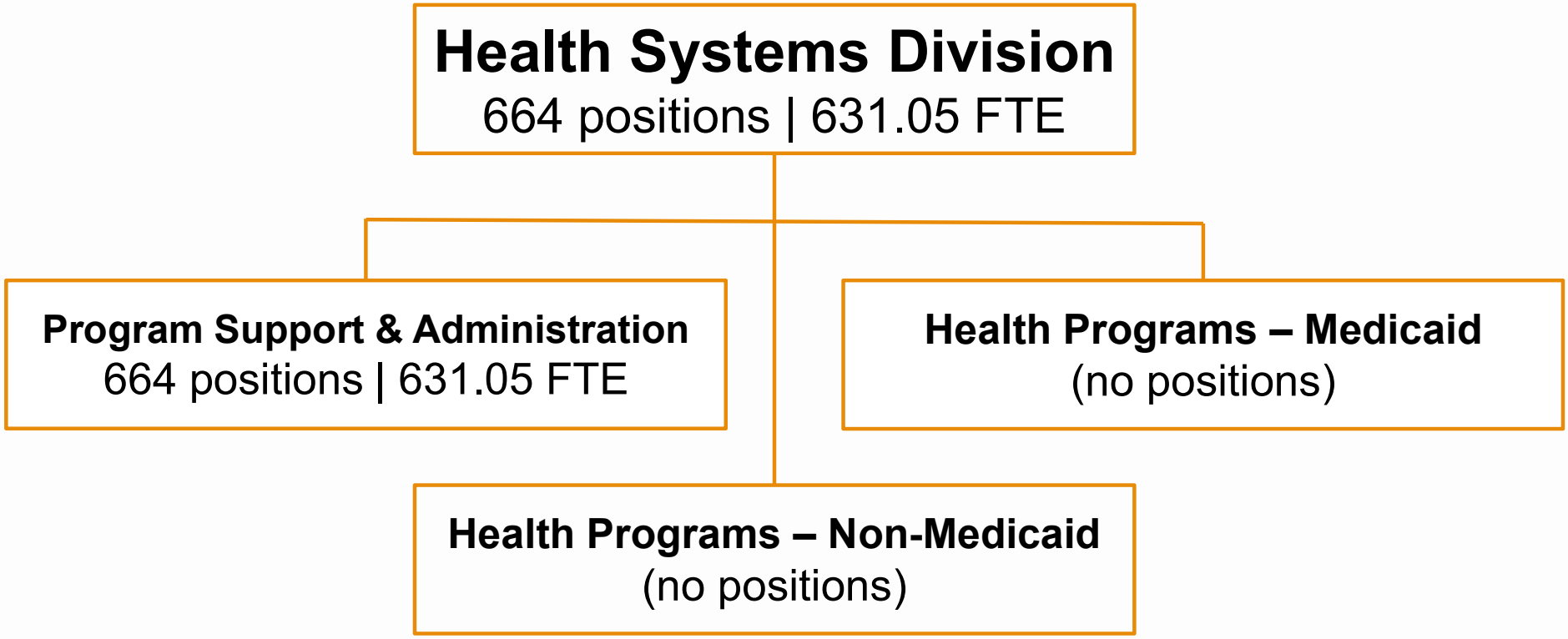
Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-9.52%	45	OEBB	OEBB plan reductions	N	-	(301,545,594)	-	(301,545,594)	-	-	OEBB contracts with insurance carriers for Entity and Self-Pay member benefit plans. The operating budget for OEBB is 0.5%. The remaining 99.5% are dedicated funds for payment of fully insured benefit plans that OEBB is contractually obligated to pass-through to carriers. The passthrough premiums include other taxes and fees at the state and federal level. Taking reductions at any level may potentially default OEBB in its contractual obligations with carriers. Premium shifts to members will not change the pass-through budget dollars needed to meet contractual obligations with carriers.
-9.54%	46	Central Services	S&S reduction could take - but would hurt programs some	N	(1,055,017)	(112,050)	(221,124)	(1,388,191)	-	-	
-9.58%	47	SAEC	S&S reduction could take - but would hurt programs some		(2,100,000)	(2,000,000)	(1,000,000)	(5,100,000)	-	-	ETS, Unemployment, OAH and P&H DCR's
-10.00%	48	Medicaid	Cut to Medicaid .2%	Y/N	(21,202,480)	-	(48,450,000)	(69,652,480)	-	-	About 4% cut to programs, including BH New Investments
-10.00%	49	Medicaid	Remove Federal Match				(222,200,032)				
							.				
					-	-	-	-	-	-	
			Total		**$ (506,645,288)**	**$ (936,287,362)**	**$ (1,652,905,102)**	**$ (2,874,543,720)**	**0**	**0.00**	
			Difference to 10% Target (over)/under		**0**	**(0)**	**(340)**				

2023-25
Governor's Budget



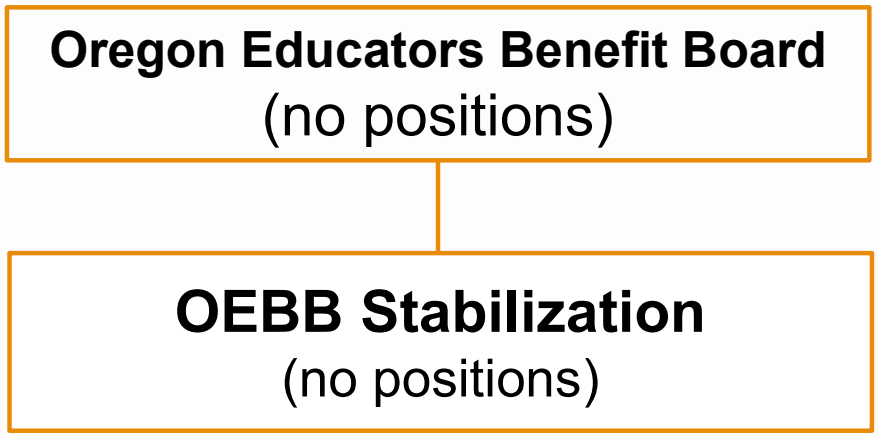
Oregon Health Authority

2023-25
Governor's Budget



Oregon Health Authority

2023-25
Governor's Budget



Oregon Health Authority

2023-25
Governor's Budget

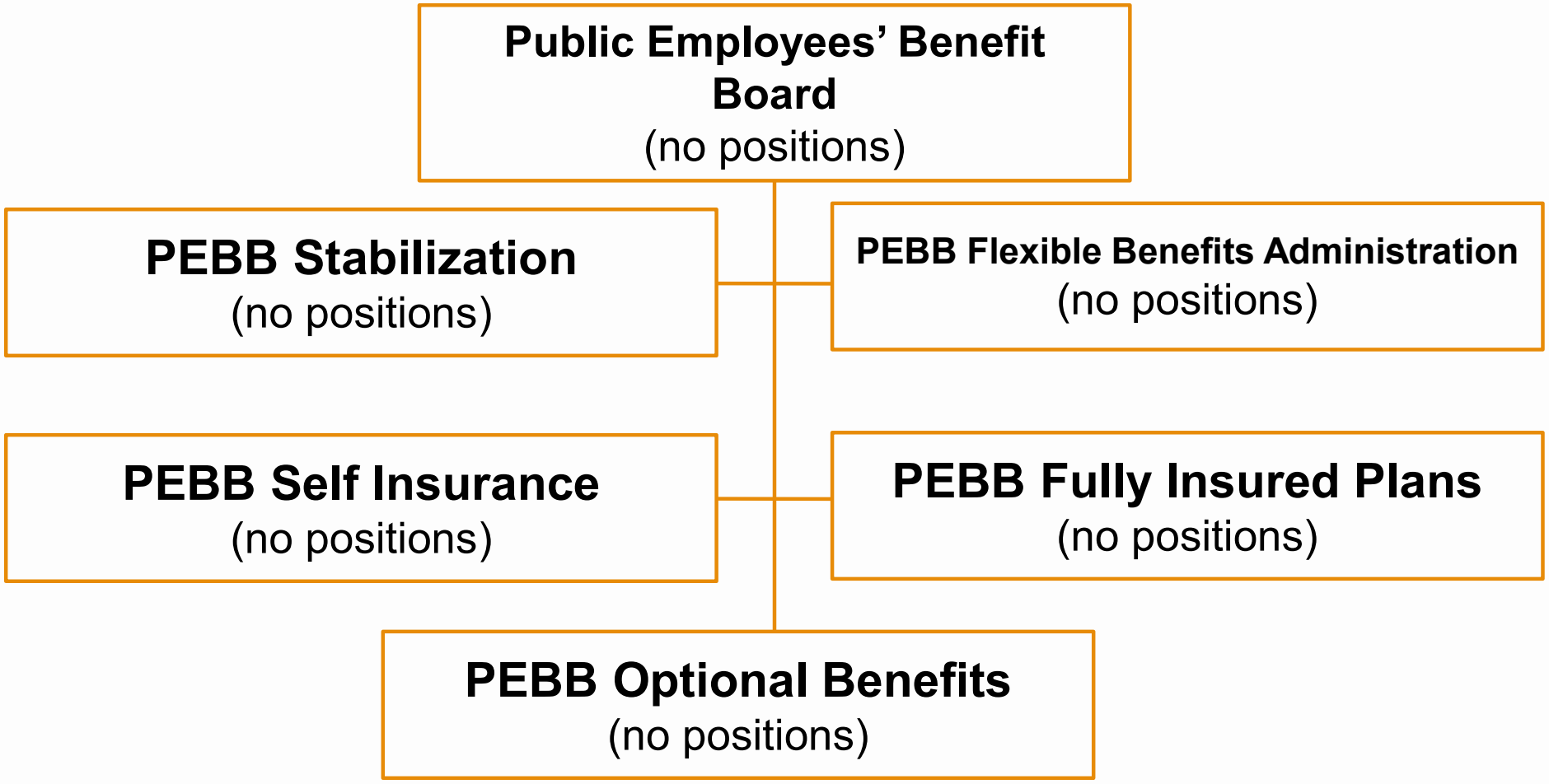
Oregon Health Authority
5,829 positions | 5,517 FTE

Central Services, Shared Services, State Assessments & Enterprise-wide Costs
940 positions | 921.78 FTE

Health Systems Programs
4,889 positions | 4,595 FTE

Oregon Health Authority

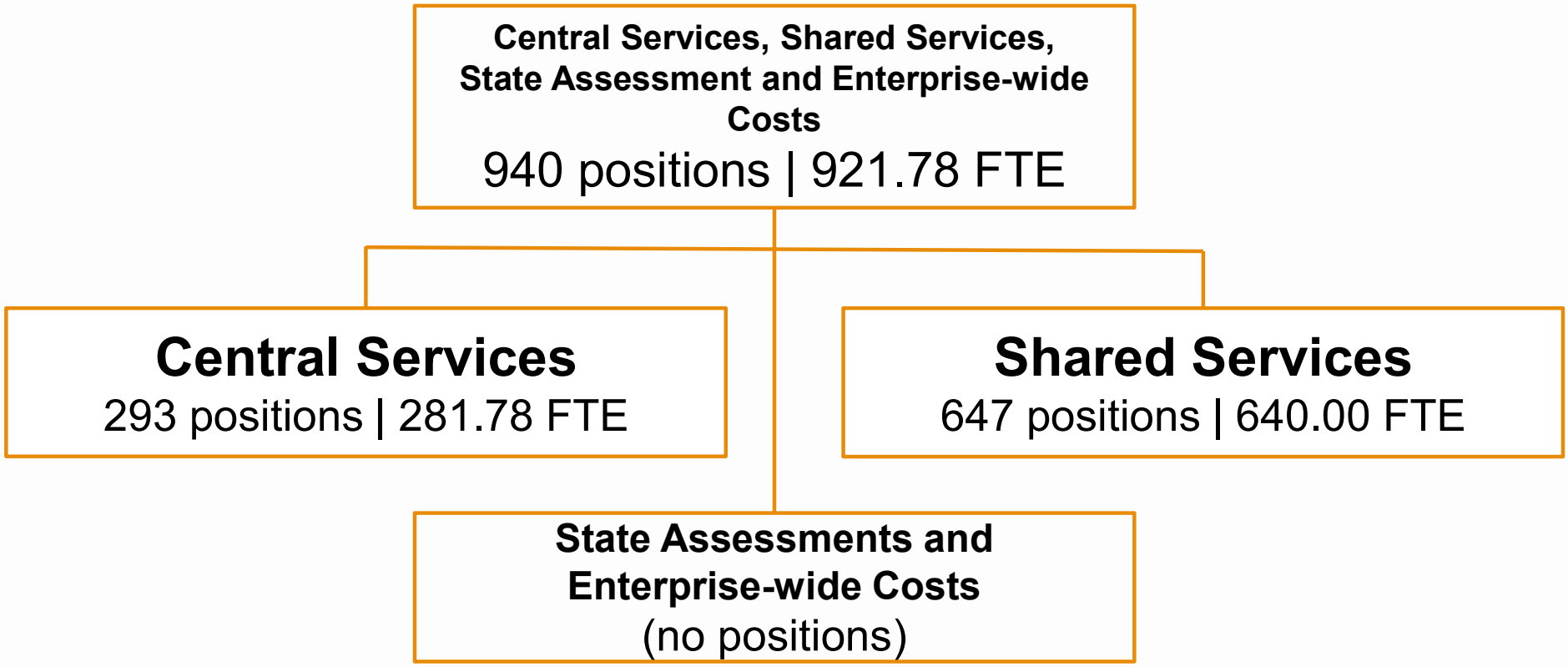
2023-25
Governor's Budget



Oregon Health Authority

2023-25

Governor's Budget



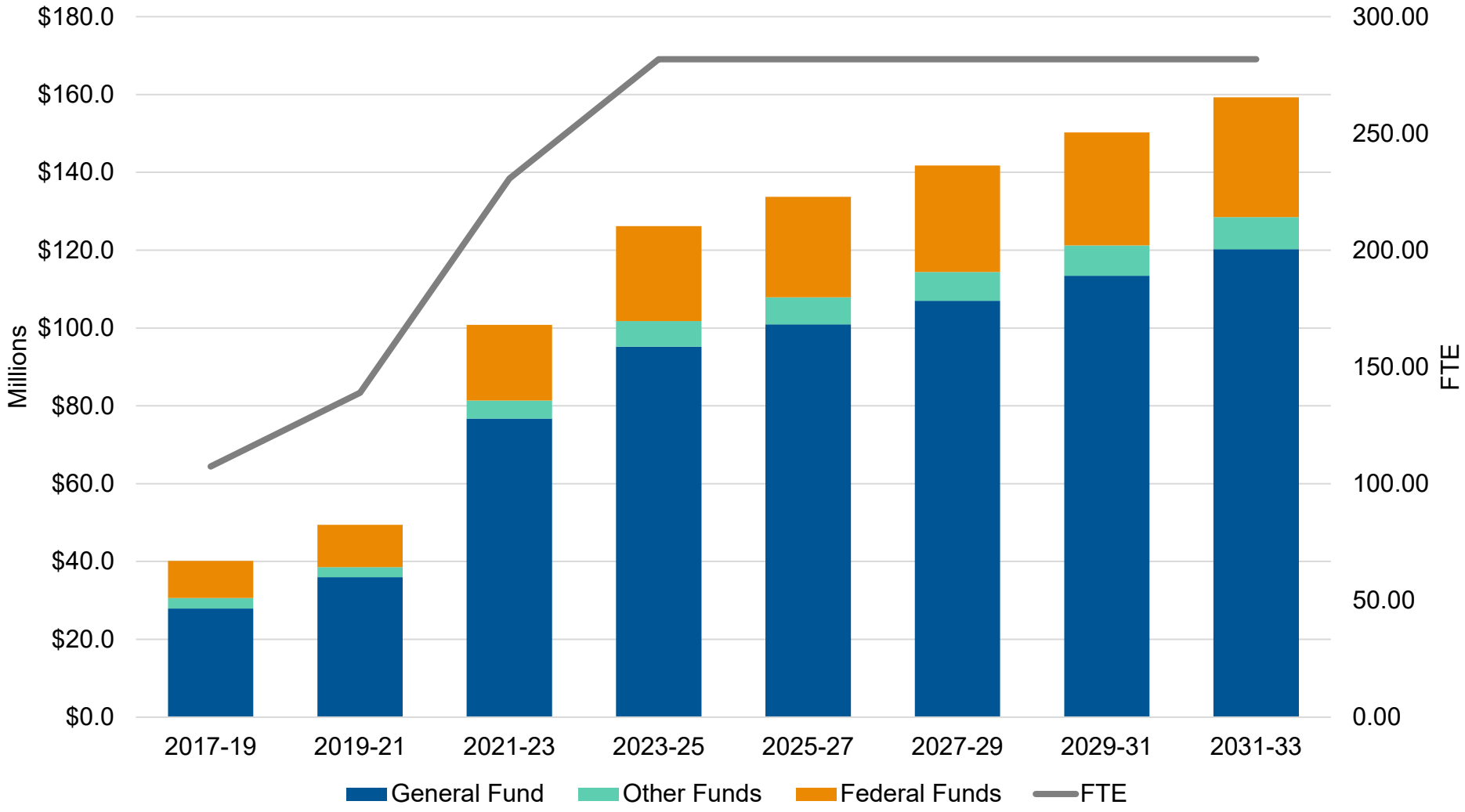
Oregon Health Authority

PLACEHOLDER- Details are not available at this time

Oregon Health Authority: Central Services

Executive Summary

Program Contact: Janell Evans, Budget Director
503-945-5775



Executive Summary

Division overview

Central Services supports the Oregon Health Authority's (OHA) mission by providing leadership in key policy and business areas. It includes:

- Director's Office
- Fiscal Division
- Agency Operations Division
- OHA Equity and Inclusion Division
- External Relations Division

Funding request

The Governor's Budget of $126.2 million Total Funds for Central Services continues funding at the current service level for the 2023-25 biennium. The budget includes policy packages to invest in closing the gap on health inequities that prevent the opportunity for all people in Oregon to achieve optimal health, including staffing and resources across Central Services; expanding Regional Health Equity Coalitions; and continuing the expansion of race, ethnicity, language, and disability (REALD) and sexual orientation and gender identity (SOGI) data.

Program descriptions

The Director's Office is responsible for overall leadership, policy and development, and administrative oversight for the Oregon Health Authority. This office coordinates with the Governor's Office, the Legislature, other state and federal agencies, Tribes, partners and stakeholders, local governments, advocacy and client groups, and the private sector.

The Director's Office provides leadership in achieving the agency's mission. In developing OHA's strategic plan, the agency has adopted the strategic goal of eliminating health inequities by 2030. And, to achieve that goal, the agency has adopted the following definition of health equity:

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> "Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
>
> Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
>
> - The equitable distribution or redistribution of resources and power, and
> - Recognizing, reconciling and rectifying historical and contemporary injustices."

OHA still has a clear direction to innovate, improve and transform the state health care system to meet three goals noted below. However, OHA recognizes, now, more than ever, that a health equity framework rectifying structural historical and contemporary injustices and racism must be incorporated into all components of the work, committees, and action plans to move these three goals forward:

- Improve the lifelong health of all Oregonians.
- Increase the quality, reliability and availability of care for all Oregonians.
- Lower or contain the cost of care so it is affordable to everyone.

The **Agency Operations Division** provides operational support and human resources services to the Oregon Health Authority. The division includes the following functional areas:

- Central Operations — Supports agency operations including public records requests, facility coordination, performance system management, Tribal Affairs and shared services coordination with the Oregon Department of Human Services.
- Human Resources — Provides recruitment, classification and compensation, employee relations, labor relations, organizational development, and business operational support across the agency.

Executive Summary

Tribal Affairs is responsible for ensuring that the relationship between OHA and the nine federally recognized Tribes of Oregon is built on trust and mutual respect. It is important that the agency understands and follows the requirements laid out in Senate Bill 770 (2001, Relating to government-to-government relations between the State of Oregon and American Indian tribes in Oregon).

Tribal Affairs supports Tribal Health Programs and the Urban Indian Health Program to successfully deliver health care services including physical, oral, behavioral and public health, so that the triple aim objectives of better care, better health, and lower costs are met. This includes implementing programs, policies, legislation and coordinating funding opportunities for Tribes to better serve their membership. Tribal Affairs provides training for various levels of staff in the agency and outside partners to enhance knowledge and understanding of tribal issues and federal mandates. Tribal Affairs provides leadership on agency-wide efforts to improve access, service equity, and outcomes for American Indian and Alaska Native people.

The **Fiscal Division** provides leadership and oversight of financing policies and coordinates budget development and execution for the Oregon Health Authority. The division includes three functional areas: budget, actuarial services, and program integrity.

- Budget — Developing, coordinating, executing, monitoring and managing OHA budgets within divisions and across the agency. Developing and updating the agency budget as it progresses through the statewide budget process, including Agency Request Budget, Governor's Budget, the Legislatively Adopted Budget, rebalance reports and various Emergency Board actions.

While the Office of Actuarial and Financial Analytics Unit and Office of Program Integrity are functionally within the Fiscal Division of Central Services, they are budgeted in the Health Systems Division Program Support and Administration unit.

The **OHA Equity and Inclusion Division** works on behalf of the Oregon Health Authority and the broader health system in Oregon to ensure the elimination of avoidable health gaps caused by social inequities and to promote optimal health in Oregon for everyone. The work is carried out in four major work units:

Executive Summary

- Equity and Policy
- Diversity, Inclusion, Training, Compliance & Civil Rights
- Race, Ethnicity, Language, Disability/Sexual Orientation, Gender Identity (REALD/SOGI)
- Business Support and Administration

These units develop programs and initiatives relating to health equity policy, data and practice using an anti-racism framework and including the social determinants of health and equity; universal access for people with disabilities, people with limited English proficiency, etc.; diversity and inclusion; non-discrimination; the development of culturally and linguistically responsive practices and services; collection and analysis of race, ethnicity, language, disability, sexual orientation, gender identity and gender expression demographic data; and training among other work and initiatives. The division engages community partners and uses qualitative and quantitative data, best practice research and practice-based evidence to carry out its work. The division's policy, data and program initiatives address contemporary and historical injustices experienced predominantly by racially, ethnically, culturally and linguistically diverse populations, including people with disabilities so that all people can reach their greatest health potential and well-being, and participate in a more robust and inclusive health delivery system. This division has also led the adoption of an anti-racism framework for the agency including anti-racism training, statewide community engagement with diverse communities for the agency's strategic plan, the development of OHA's strategic goal to eliminate health inequities in Oregon and the health equity definition quoted above.

The **External Relations Division** has three sub-divisions: Communications, Government Relations, and Member and Stakeholder Support which includes the Community Partner Outreach Program (CPOP), Ombuds Program, and Innovator Agents. Together, they are responsible for building strong relationships with the public, community partners, media, the Legislature, and other agencies at the state and federal levels, as well as creating a broad understanding of the many ways in which OHA contributes to the health and well-being of Oregonians. Within OHA's commitment to partner directly with community to eliminate health inequities, each ERD team carries the voice and feedback from

Executive Summary

community, with a focus on communities and individuals in Oregon facing health inequities, internal to all agency operations, policies and programs to integrate community voice into agency work.

- Communications provides accurate and accessible information about OHA's mission and programs, responds to requests for information from the public and media, and produces content for a wide range of agency publications, websites and other channels for keeping the public informed. They elevate media channels and communications to best reach populations in Oregon most impacted by health inequities.
- Government Relations provides timely health data and analysis to the Legislature, federal partners, and local elected officials to inform evidence-based health policies and legislation. It also develops OHA legislative concepts to ensure access to quality health care, contain costs of health care, ensure legislative concepts advance eliminating health inequities, and improve overall health for Oregonians.
- The Community Partner Outreach Program has built a one-of-a-kind network of Community Partner Organizations serving all Oregonians in every county in Oregon. The work CPOP and Community Partners do on behalf of OHA is essential to support health system transformation and adequately serve Oregonians to eliminate health inequities, ensure access to quality health care, contain costs of health care, and improve overall health for Oregonians. CPOP is the backbone and network from which individuals enroll in the Oregon Health Plan (OHP), understand how to use services and support equity-centered, transformative care.
- The Ombuds Program advocates for OHP member access to care and quality of care provided through OHP; uses learnings from individual member issues to elevate OHP member voice through the OHA so Medicaid programs, policies, and operations are based on member experience; and elevates identified issues for system improvement. As required by legislation the program reports data and recommendations for improvement to the OHA Director, the Oregon Health Policy Board, and the Governor.
- The Innovator Agents work closely with Oregon's 15 coordinated care organizations (CCOs) as required by legislation and Oregon's Medicaid Waiver to coordinate between OHA, the community, and CCOs to ensure local adaptation and implementation of statewide health priorities. They understand the health needs of the region, the strengths and gaps of the health resources in the CCO and articulate these needs and gaps to OHA to ensure statewide and local coordination. They prioritize elevating OHP member voice within CCO operations and in

Executive Summary

CCO 2.0 they elevate local work with CCOs in health equity, Tribe relationships, behavioral health, and emerging statewide priorities.

Program justification and link to long-term outcomes

OHA Central Services provide critical business support necessary to achieve the agency's mission: helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality affordable health care.

Program performance

The Agency Operations Division's **Human Resources** activities include but aren't limited to the following (average yearly metrics):

- **27,473** applications for positions, each of which HR manually grades to determine minimum qualifications
- **1,309** hires
- **358** promotions and **502** internal transfers
- **56** HR investigations, **50** that required corrective action
- **69** manager fact findings, **57** that required corrective action
- **24** grievances responded to at step 2
- **414** managers trained on Performance Accountability & Feedback Module 1, 419 on Module 2, 416 on Module 3
- **7,977** quarterly performance check-ins completed
- **187** classification reviews, 306 positions reclassed after ORPICS update
- **1,743** pay equity analyses completed

The Office of Human Resources serves as a business partner to its customers. Through this partnership HR provides proactive, comprehensive human resource services that support the agency in achieving its mission and goals. HR works closely with internal customers on workforce initiatives and strategies at the program and agency level. It promotes a healthy workplace culture of ongoing development and feedback to ensure the workforce has the needed

Executive Summary

skills to be successful and engaged. HR is committed to assisting the agency in moving toward the vision of a healthy Oregon and eliminating health inequities by 2030.

Within the **Fiscal Division**, budget staff implement and monitor the OHA budget of over $32 billion Total Funds and nearly $4 billion in General Fund dollars. The Health Care Finance staff provided financial oversight of coordinated care organizations, which receive over $5 billion dollars annually in gross premiums.

In 2021, accomplishments for the **OHA Equity and Inclusion Division** include but are not limited to:

Sponsored the Coalition of Communities of Color (CCC) to research, develop, publish and release the first statewide, community-based Behavioral Health report centering the Culturally and Linguistically Appropriate Services (CLAS) standards and health equity.

Created a four-person equity-focused Behavioral Health team in the division to focus on community engagement and cross-divisional systems change.

Graduated two cohorts of the Developing Equity Leadership Through Training and Action (DELTA) program focusing on building health equity leadership capacity within community, coordinated care organizations (CCOs), provider organizations and OHA.

Streamlined the invoicing process for telephonic interpretation services.

Provided workforce and health equity technical assistance and consultation across the agency and health system at unprecedented levels.

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Increased collaboration between Human Resources, the Office of Information Services, the COVID Response and Recovery Unit (CRRU) and the Accessibility (A) Team to more effectively serve disability communities and people with disabilities.

Collected, compiled and evaluated health equity plans contractually required of the coordinated care organizations (report pending).

Passage of Senate Bill 70 which has been 3 years in the making to codify the Regional Health Equity Coalition (RHEC) model in statute and define key terms related to health equity work including: Regional Health Equity Coalitions, communities of color, priority populations, cross-sector, culturally specific, and community-led.

- Requested and received expansion resources for the RHEC program to add four more RHECs, plus three new staff.
- Continued capacity building with RHECs related to navigate legislative session, advocacy, rules processes, and policy and systems change.
- The RHECs successfully advocated for House Resolution 6 and House Bill 4052 to declare racism a public health crisis. This provides resources to support development of a mobile health unit to serve communities most harmed by health inequities.
- RHECs successfully advocated for House Bill 3353 to allocate resources to community partners to address health inequities through allocation of coordinated care organization resources. It also develops a Community Oversight Committee which will be composed of community partners who have decision-making authority to award resources to communities across the state.

Researched and developed report, per House Bill 2359, on the impact of sight translation requirements for Health Care Interpreters (HCI), determining options and optimal conditions for this requirement which has been creating difficulties in service delivery (report submitted 2022).

Executive Summary

Researched and developed report, per House Bill 2359, the feasibility of an interactive web portal for HCIs determining options and optimal models for greater ease of scheduling for HCIs to better serve community (report submitted 2022).

Cross-divisional collaboration on House Bill 3159 successfully led to adoption of Sexual Orientation and Gender Identity (SOGI) data collection standards to be added to the OARs associated with House Bill 2134 (Race, Ethnicity, Language and Disability-REALD) data collection standards, and for OHA to create a centralized registry for providers, insurers and coordinated care organizations (CCOs). The passage of House Bill 3159 also set forth requirements to collect REALD and SOGI data from providers and insurers in a consistent manner and develop a centralized registry/repository for information and data collected (initial repository will be built by December 2022).

Developed processes, strategically, operationally and culturally to prepare for and expand the OHA Equity and Inclusion Division from 22 to 71 team members.

Worked collaboratively with Fiscal, Tribal Affairs and the Community Partner Outreach Program (External Relations) to distribute $11 million to non-profit and community-based organizations throughout the state to extend 2020 COVID-19 related relief, prioritizing tribal communities and communities of color.

The External Relations Division, according to average annual metrics:

- Responds to more than 1,000 media requests per year.
- Issues more than 250 news releases per year.
- Produces a wide variety of publications, including a health newsletter with more than 200,000 subscribers in Oregon and some of the most-visited websites in the state.
- Advocates for over 2,000 concerns on an individual and systems level for Medicaid and OHP members through the Ombuds Program.

Executive Summary

- Identifies through the Ombuds Program over 100 systemic issues, in nearly every service type in OHP, that have been monitored and shared with Health Systems Division to improve overall access to and quality of OHP-provided services.
- Developed and staffed the COVID-19 feedback team which handled 2,533 pieces of feedback. Of those, 6 percent (153) were related to a systems issue. Five percent (127) were equity-related. In addition, in late 2021, ERD responded to 13,336 pieces of feedback with questions or comments about the upcoming Digital Vaccination Records Project (now known as My Electronic Vaccine Card).
- Supports, through the CPOP Team, 1,482 active community partner assisters representing over 322 different community-based organizations, clinics and hospitals across Oregon. This network assists OHP applicants and members in over 80 different languages. Over half of all OHP members have been assisted by a CPOP-certified community partner. This number rises to as high as 70 percent in communities that have historically been under-resourced and underrepresented.
- Assisted, during the 7 seven months of 2022, through the community partner network, 116,227 incidences of assisting OHP members with health care system navigation to help members understand how to use and access benefits, encourage preventative care, improve health and reduce costs to the health care system.

Enabling legislation/program authorization

The Legislature created and authorized the Oregon Health Authority under House Bill 2009 during the 2009 legislative session. All OHA program areas have accompanying federal and state legislative authority for the operations of their respective programs. See program unit summaries for specific enabling legislation.

Funding streams

OHA Central Services receives funding through a federally-approved cost allocation plan. A grant allocation module aggregates costs on a monthly basis and charges those costs, as outlined in the federally approved plan, to the various state and federal funding sources.

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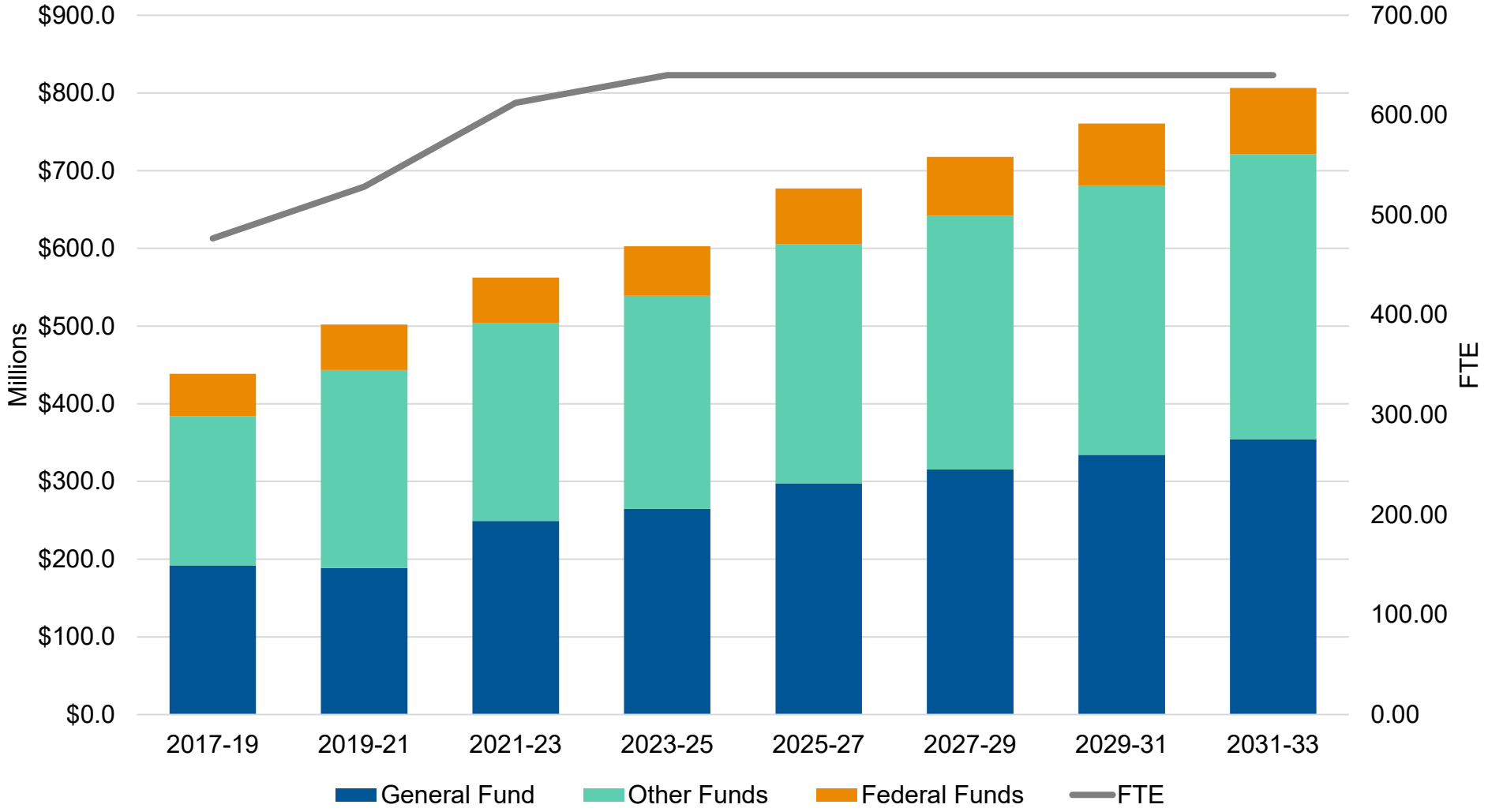
Significant proposed program changes from 2021-23

The Governor's Budget includes policy package #401 to provide additional assets necessary to achieve the state's and agency's imperative for health systems transformation and close the gap on health inequities that prevent the opportunity for all people in Oregon to achieve optimal health. The Governor's Budget also includes policy package #410 for the staffing and programmatic expansion necessary to implement the intent of Senate Bill 70 by furthering the expansion of the Regional Health Equity Coalitions and policy package #403 for the continued expansion of REALD & SOGI put forth in House Bill 4212 and House Bill 3154.

Oregon Health Authority: Shared Services & State Assessments & Enterprise-wide Costs

Executive Summary

Program Contact: Sara Singer, ODHS | OHA Shared Services Budget Administrator
503-385-7537



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Division overview

Shared Services supports the Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) by providing leadership in the delivery of efficient, consistent, and coordinated infrastructure services to all programs in both departments.

Funding request

OHA Shared Services contains the Office of Information Services. The Governor's Budget of $233.3 million Total Funds continues funding for the Office of Information Services for 2023-25 at current service level, as well as policy package #203 to support mainframe migration and provider and client payment systems (#203).

OHA State Assessments and Enterprise-wide Costs (SA&EC) includes the budget for costs that affect the entire agency. The Governor's Budget of $369.2 million Total Funds continues the SA&EC budget for 2023-25 at current service level.

State government service charges (SGSC), price list

The Department of Administrative Services (DAS) charges a mandatory assessment to all state agencies (SGSC) and an estimated fee-for-service charge provided by the following programs and others not listed here:

- DAS — Chief Financial Office (CFO)
- DAS — Capitol Planning Comm.
- DAS — Enterprise Asset Management Offices
- DAS — Chief Operating Office
- DAS — Chief Human Resources Office
- DAS — Enterprise Information Services
- Secretary of State Audits & Archives Divisions
- State Controllers Division
- Enterprise Goods and Services (EGS)
- State Library of Oregon
- All others

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Risk Management Program, price list

Under ORS 278.405, DAS manages state government risk management and insurance programs. It has responsibility to:

- Provide insurance coverage for tort liability, state property, and workers' compensation.
- Purchase insurance policies, develop and administer self-insurance programs.
- Purchase risk management, actuarial and other required professional services.
- Provide technical services in risk management and insurance.
- Adopt rules and policies governing the administration of the state's insurance and risk management activities.

Enterprise Information Services (EIS), price list

Enterprise Information Services, formerly known as the State Data Center, provides and manages a common computing and network infrastructure for state agencies and local governments. ETS provides services in the following service areas:

- Mainframe
- Distributed services
- Midrange
- Disaster recovery
- Storage
- Network
- Voice

Telecom, price list and usage based

The telecommunications budget is the cost per IBM headset budget and DAS financing charges for the IBM telecommunications system. Expenditures for work contracted to IBM for phone system adjustments is paid out of this budget as well.

Facilities

Facilities provides coordination for ODHS and OHA offices. Expenditures include:

- Rent or lease workspace for staff (includes escalations and reconciliation costs).

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- Lease building maintenance management (janitorial, repair and maintenance).
- Fuels and utilities (includes rate increases).
- DAS leasing fees and building rent.
- Copier maintenance.
- Professional services for furniture movers, installers and emergency repairs.
- Attorney General cost for legal sufficiency reviews for leases, negotiations related to legal issues for facility related matters and legal opinions.
- Inventory replenishment.
- Costs of systems furniture reconfigurations, building remodels, facilities relocations and staff moves.

IT direct – internal computer replacement
Lifecycle replacement, repairs, and new computers for new positions. If the agency requests an upgrade or purchase that is not considered replacement, repair or a new computer for an existing employee, the purchase is charged to the program.

Shared Services funding
Funding is based on cost allocation statistics as applied to Shared Services office expenditures. The allocation method determines distribution of expenditures between OHA and ODHS and the revenue distribution by General Fund, Lottery Funds, Other Funds or Federal Funds.

Debt service
Debt service is the obligation to repay principal and interest on funds borrowed through the sale of certificates of participation (COPs) and bonds. The state uses proceeds of COPs and bonds to build and improve its facilities. They also are used to provide staff support for related activities including project management, community development coordination and fiscal services support. Repayment periods range from 6 to 26 years depending on the nature and value of the project. The Department of Administrative Services Capital Finance Section provides

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schedules of debt service obligations for each sale; these are the values used to develop the budget. Occasionally, the Capital Finance Section can refinance existing debt, which can reduce or delay debt obligations.

Mass transit
Transit taxes are employer taxes used to fund a mass transit district. These are not deducted from employee pay. The transit tax is imposed directly on the employer. The tax is figured only on the amount of gross payroll for services performed within the TriMet or Lane Transit Districts. This includes traveling sales representatives and employees working from home. The Oregon Department of Revenue administers tax programs. Nearly every employer who pays wages for services performed in these districts must pay transit payroll tax. It is based on state-only (General Fund) funding.

Unemployment insurance
Benefits provide temporary financial assistance to workers unemployed through no fault of their own who meet Oregon's eligibility requirements. Invoiced and paid quarterly.

Office of Administrative Hearings
The Employment Department bills all state agencies for actual expenses incurred due to utilization of Administrative Hearings.

Program descriptions

Office of Information Services (OIS) is a shared service provider for ODHS and OHA. It provides information technology (IT) systems and services for nearly 66,000 agency and partner staff at 140 local offices, Oregon State Hospital locations, and the public health laboratory.

OIS provides support for more than 30,500 desktop/laptop computers and 1,520 printers. The Service Desk responds to more than 14,000 service requests each month.

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OIS provides information systems and services to ODHS and OHA staff and partners statewide in support of programs that:

- Determine client eligibility.
- Provide medical, housing, food and job assistance.
- Provide addiction, mental health, and vocational and rehabilitative services.
- Protect children, seniors and people with physical and developmental disabilities.
- Process claims and benefits.
- Manage provider licensing and state hospital facilities.
- Promote and protect public health.
- Respond to and coordinate statewide disasters and health emergencies and support Health Alert Network and emergency preparedness activities.

OIS also supports partners around the state that use ODHS and OHA systems. Many of the IT systems used by ODHS, OHA and agency partners are needed 24 hours a day, seven days a week.

OIS now also provides a sub-section of services which were formerly provided by the Information Security and Privacy Office (ISPO), primarily the IT security functions.

Program justification and link to long-term outcomes

OHA Shared Services provides critical business supports necessary for OHA programs to achieve the agency's mission.

Its budget is structured and administered according to the following principles:

Control over major costs. OHA centrally manages many major costs. Some, such as many DAS charges, are essentially fixed to the agency. Others, such as facility rents, are managed centrally to control the costs. OHA Shared

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Services supports both ODHS and OHA by providing leadership in the delivery of efficient, consistent and coordinated administrative services to all programs within both departments.

Customer-driven shared services. With the creation of separate agencies, ODHS and OHA agreed to maintain many infrastructure functions as shared services to minimize costs, avoid duplication of effort, maintain centers of excellence, and preserve standards that help the agencies work together.

ODHS and OHA govern their shared services through a board of the two agencies' operational leaders. This approach ensures that shared services are prioritized and managed to support program needs. The board and its chartered subgroups have:

- Established service-level agreements and performance measures for each service.
- Selectively implemented mandated budget cuts and budget investments.
- Managed staff within the shared services to deliver services in a rational way.
- Started implementing more integrated systems to support the performance of all our employees.

Program performance

OIS performance measures focus on customer service, system performance, responsiveness and information security. Other support areas have their own performance measures based on their systems and the services they provide.

Enabling legislation/program authorization

House Bill 2009 created the Oregon Health Authority in 2009.

Funding streams

Funding streams in support of Shared Services are billed through a federally approved cost allocation plan. The model contains a billing allocation module and a grant allocation module. The billing allocation module first allocates Shared Services costs to the two agencies. The billing module then allocates the costs to customers within each agency. The

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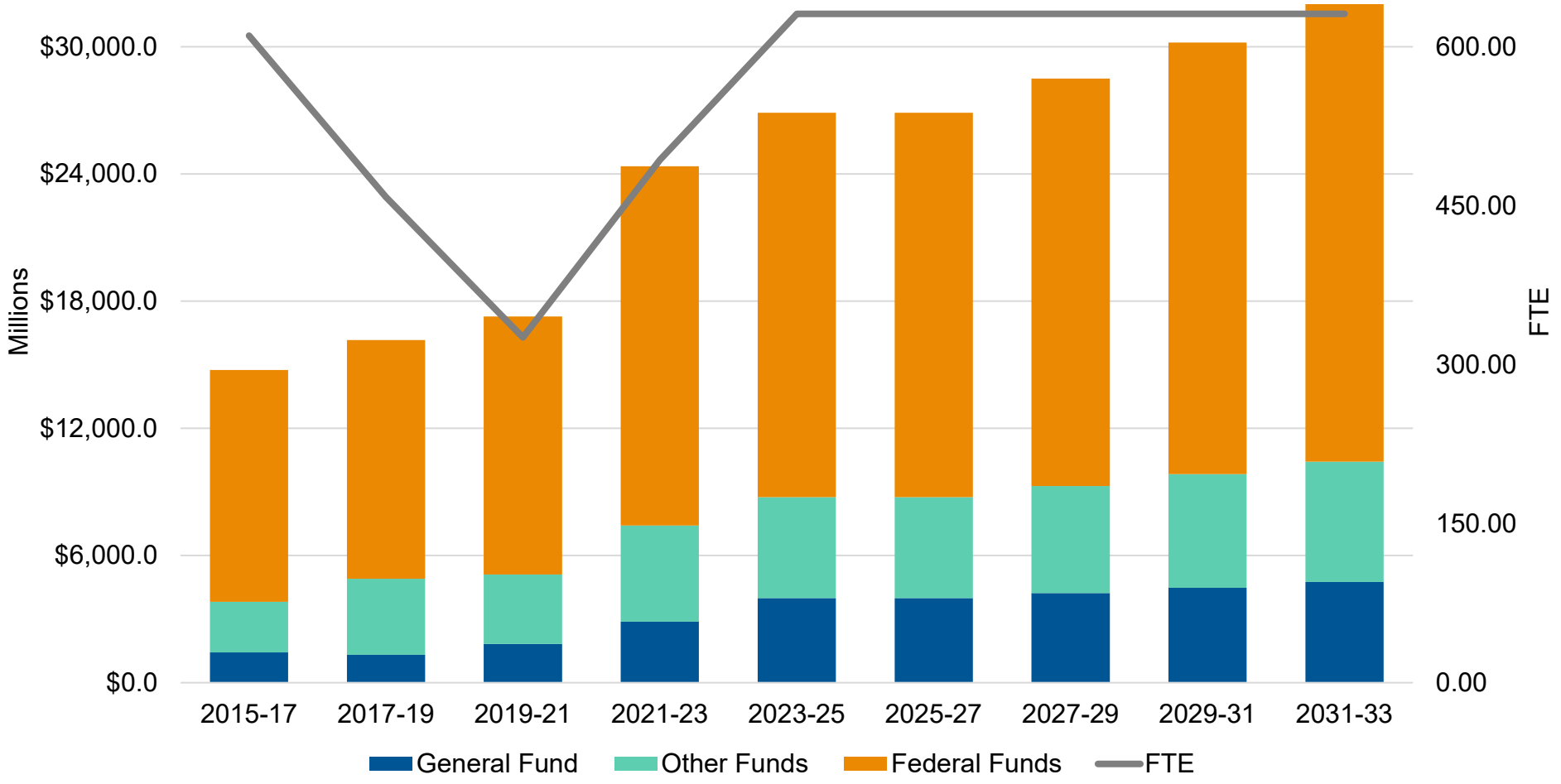
grant allocation module allocates those costs to their respective state and federal funding sources. Both modules allocate aggregated costs monthly as outlined in the federally approved plan.

Significant proposed program changes from 2021-23

None.

Oregon Health Authority: Health Systems Division

Executive Summary



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Division Overview

The Health Systems Division (HSD) is responsible for developing and maintaining a statewide system of integrated physical, behavioral, and oral health care. HSD serves to complement the larger efforts of OHA to eliminate health inequities in Oregon by 2030. HSD operationalizes access to health care for all people in Oregon, with the triple aim of better health, better care, and lower costs.

To do this, HSD is committed to establishing a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power, and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

HSD works with partners statewide to build and advance a system of care to create a healthy Oregon. This includes managing the Oregon Health Plan (OHP), Oregon's Medicaid and Children's Health Insurance Program, and maintaining and providing oversight for Oregon's health care system in several ways, including:

- Making the OHP member experience simpler and easier
- Developing business and operational policies for the OHP, addiction services and behavioral health delivery systems
- Contracting with coordinated care organizations (CCOs), behavioral health programs and other partners to support community-based health services and oversee compliance with state and federal regulations
- Implementing technologies and information systems that support HSD programs
- Reducing behavioral health inequities and elevating quality and accountability
- Facilitating community-centered engagement and person-directed services
- Increasing overall capacity, coverage and integration across settings and services

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- Incentivizing trauma-informed, culturally responsive & linguistically specific services
- Improving workforce diversity and increasing staff retention

Funding request

The Governor's Budget of $26,882 million Total Funds continues funding for the Health Systems Divisions' (HSD) Medicaid and Behavioral Health Non-Medicaid programs at the current service level for the 2023-25 biennium. The Medicaid budget includes savings to recognize cost reduction in the Medicaid program from downward trends in utilization in 2023, and savings related to reducing Medicaid inflation from 3.4 percent per year in 2023-25 to 2.4 percent in 2024 and 3.0 percent in 2025 and the truing up of the ongoing cost for operating the residential bed investment in 2021-23 on an ongoing basis.

The Governor's Budget for HSD addresses unmet behavioral health needs and protects and extends health coverage while demonstrating a clear and consistent commitment to health equity.

- Funds the expansion of the Healthier Oregon program to all adults, regardless of age, who would qualify for Medicaid except for immigration status ($500 million General Fund).
- New funding to expand treatment capacity through $100 million in Lottery Bond proceeds to expand acute psychiatric facilities in the community as well as $15 million General Fund for substance use disorder facilities and recovery centers, and $2.3 million General Fund for additional children's psychiatric residential treatment capacity.
- Proposes $10 million General Fund to improve civil commitment services.

Additionally, HSD proposes the following policy packages:

- **Policy package #404** provides funding for 988 call centers to hire and train crisis intervention specialists, clinical supervisors and other relevant staff imperative to operating a crisis call center.
- **Policy package #203** More than one million Oregonians count on the state's current mainframe platform to receive their benefit and provider payments. There is increasing risk OHA will be unable to make timely

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payments to Oregonians, potentially for an extended period. The Governor's Budget includes resources to upgrade the mainframe platform and ensure continuity of payments and benefits.

- **Policy package #201** Oregon has recently received approval for a new CMS 1115 waiver for 2022–2027. The new waiver includes first-in-the-nation changes to Oregon's Medicaid program and includes $1.1 billion in new Federal Funds to address inadequate food, housing and other root-cause issues that lead to poor health for people and families struggling to make ends meet. As part of the agreement, the federal government also approved expanded OHP coverage for young children, as well as extended eligibility for youth and adults.
- **Policy package #202** In 2022, the Legislature passed House Bill 4035 to fund federally mandated redetermination process to help maintain health care coverage when the Public Health Emergency expires by funding short-term coverage for people who earn too much for Medicaid but not enough to afford other coverage and authorize development of a sustainable long-term solution. This policy package supports ongoing development of both a temporary expansion to Medicaid eligibility and a Basic Health Plan (BHP).
- **Policy package #414** In response to strong community feedback that Oregon's longstanding waiver from federal Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) requirements is harmful and needs to end, with recognition that this waiver is a barrier to meeting OHA's goal to eliminate health inequities by 2030, this policy package funds the staff and system updates necessary for OHA to build an EPSDT program that will meet federal regulations and ensure children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services required by EPSDT.
- **Policy package #415** would address inequities in access to and quality of mental health and substance use treatment for Oregonians at risk of entering the criminal justice system through the expansion of jail diversion programs and an overhaul of the civil commitment system.
- **Policy package #426** would address gaps identified by youth and families to strategically expand the continuum of services available to children, youth and families experiencing behavioral health challenges, using low barrier procurement processes centering communities of color and people with lived experience in the development and implementation of investment and infrastructure. This proposal would expand access to

services in Behavior Rehabilitation Services, Youth Hubs, and improve availability of both child psychiatry and developmental pediatrics services for youth in Oregon.

- **Policy package #446** would address Oregon's high suicide rate across the lifespan and fuel prevention work grounded in local communities. It provides funding primarily to launch the currently unfunded Adult Suicide Intervention and Prevention Plan (ASIPP), creates an OHA Suicide Prevention unit, and supports parts of the Youth Suicide Intervention and Prevention Plan (YSIPP). The YSIPP and ASIPP plans represent a comprehensive approach to suicide prevention, intervention and postvention needed to produce long-lasting decreases in suicide rates – both of which were created with extensive community input.

Program descriptions

The Health Systems Division's (HSD) is comprised of three different program units – Program Support & Administration, Medicaid and Non-Medicaid. Across all three program units, the shared mission is to build and advance a system of care to help all people in Oregon be healthier. The division is conducting innovative programing and ambitious community-led efforts to change the quality and access to care, as is necessary to eliminate health inequities in Oregon and to ensure the health system serves and respects the diversity, cultures, and languages across Oregon communities.

HSD works with the federal government, Tribes, health care providers, community partners, public health programs, community behavioral health programs, and other state agencies to maintain and improve access to physical, behavioral, and oral health care. HSD administers state and federal funds to deliver and pay for health care services to over 1.4 million people in Oregon, primarily through the Oregon Health Plan (OHP). This enrollment includes a significant increase resulting from federal policies to ensure people maintain their coverage during the COVID-19 pandemic, and the recent addition of Oregonians through Healthier Oregon who would qualify for Medicaid except for their immigration status.

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HSD is also guiding transformational change in the behavioral health system through the historic investments made during the 2021-23 biennium by the Oregon legislature and the investments in substance use disorder treatment from Ballot Measure 110 (2021). The investments made in Behavioral Health for the 2021-23 biennium include:

- **Behavioral Health Accountability and Quality** enhanced support for culturally-specific peer led services, including support for Tribal-based practices; integrated treatment for co-occurring disorders (substance addiction and mental health disorders together); reduction of administrative burdens in behavioral health clinical documentation and reporting; an analysis of pay and equity disparities affecting the behavioral health workforce; high quality and rapid access to alcohol and drug treatment as guided by the Alcohol & Drug Policy Commission; specialized housing navigation assistance; expansion and enhancement of the child, family and adolescent behavioral health system specific to access of services at all levels of care that is driven by real-time data.
- **Behavioral Health Workforce Diversity and Stability** provide incentives to increase the recruitment and retention of providers in the behavioral health care workforce who are people of color, Tribal members, or residents of rural areas in this state, to provide culturally responsive care for diverse communities.
- **Behavioral Health Rates and Financial Sustainability** support an increase in fee-for-service payment rates for behavioral health services, raising rates by an average of 30 percent, contingent on federal approval. This includes a 22 percent differential for culturally and linguistically specific services with an extra 5 percent differential for these services when provided in a rural setting.
- **Behavioral Health Infrastructure Expansion and Capacity Building** directly distribute to community mental health programs (CMHPs) via a formula using existing funding mechanisms such as County Financial Assistance Agreements (CFAA). These funds are primarily to repurpose or build new secure behavioral health residential treatment facilities, residential treatment homes, and other types of necessary housing.
- **Behavioral Health Services Integration and Community-led Innovation**, which includes:
    - Establishing 988 as the National Suicide Prevention Hotline (similar to 911 for emergencies) effective July 16, 2022, call centers and enhanced mobile crisis services.

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- Community restoration and clinical services, rental assistance and wraparound support, and OHA operations for supporting individuals who have been ordered by a court to receive services enabling them to “aid and assist” in their own criminal defense.
- Making screening health assessment, treatment and recovery services for substance use disorder and harmful substance use available to all those who need and want access to those services and adopting a health approach to substance use by removing criminal penalties for low-level drug possession.
- Establishment of an Opioid Settlement Prevention, Treatment and Recovery Fund to receive settlement monies from lawsuits against opioid distributors, manufacturers, and pharmacies.
- The System of Care (SOC) Advisory Council, which is directed to improve the effectiveness and efficacy of child serving state agencies and the continuum of care that provides services to youth ages 0–25 by providing centralized and impartial forum for statewide policy development, funding strategy recommendations and planning.

Services are delivered through Tribal programs, community mental health programs, individual health care provider agreements, coordinated care organizations (CCO), other managed care plans, and funding opportunities to support additional housing for individuals with severe and persistent mental illness.

As OHA looks to the 2023-25 biennium, HSD forecasts the following areas of growth to meet Oregonians’ needs and help eliminate health inequities:

- Maintain the COVID-19 pandemic gains in health care access, especially for communities of color.
- Expand health care access through the full implementation of Healthier Oregon, a program to provide Oregon Health Plan (OHP) services to Oregonians who would qualify for Medicaid except for immigration status.
- Meet increased demand for community-based behavioral health services with clear outcome metrics and goals.
- Fully operationalize the Behavioral Health Resource Networks (BHRNs) in each county as envisioned by Measure 110 partners to improve outcomes for Oregonians with substance use disorder.

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- Increase health care workforce investments and incentives to attract and retain workers, especially those who can meet a diversity of culturally and linguistically specific needs.
- Provide additional coordination of health services for justice-involved Oregonians as they transition back to their communities.
- Expand community partnership and investments in social determinants of health.
- Build-out climate-related health services and supports for Oregonians most at risk of being harmed by climate change impacts.

Program justification and link to long-term outcomes

People with health care coverage and access to care are more likely to receive preventive care and to seek care quickly when they are sick, both of which help avoid or minimize many serious health conditions. Losing that coverage contributes to poorer health and health inequities, from short-term acute health problems as well as long-term chronic ones, and to higher expenses for the individual and the entire health care system. A statewide, integrated system of care is essential to eliminate health inequities, drive down health care costs, and improve behavioral and physical health outcomes. HSD incentivizes preventive practices and quality care through quality payments to CCOs and hospitals.

HSD works with community partners to develop and strengthen culturally, and linguistically appropriate and responsive services aligned with social determinants of health. Examples of this include; the Problem Gambling Program's partnership with Asian-American and Latino advisory councils; and applying the race, ethnicity, language and disability (REALD) and sexual orientation and gender identity (SOGI) data collection standards to assess how racism, disablism, lack of language access, sexism and heteronormative dominance impact individual and community health as well as to close the significant gaps in health inequities experienced by populations that remain invisible.

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Program performance

As established in House Bill 2086, the Behavioral Health Committee ("the Committee") is authorized to increase the quality of services and transform the behavioral health system through outcomes, metrics, and incentives. The Committee is tasked with the following:

- **Establishing metrics and incentives** for behavioral health services provided by CCOs, health care providers, counties, and other government entities and establishing incentives to improve the quality of behavioral health services
- **Qualifications for quality metrics and incentives** that improve timely access to behavioral health care; reduce hospitalizations; reduce overdoses; improve the integration of physical and behavioral health care; and ensure individuals are supported in the least restrictive environment that meets their behavioral health needs.

To show how well CCOs are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care, OHA has implemented the following:

- **CCO incentive measures** for which CCOs are eligible to receive payments based on their performance each year (CCO Quality Incentive Program pay-for-performance measures)
- **State quality measures** which OHA has agreed to report to the Centers for Medicare and Medicaid Services (CMS) as part of Oregon's 1115 Medicaid waiver

Additionally, the 2022-2027 1115 Medicaid waiver will establish new metrics focused on health equity.

In contrast to CCOs, Fee For Service (FFS) does not have systemic standards and metrics in place to ensure FFS members receive timely (responsive and proactive) and quality care. FFS is not currently resourced to provide the level of care and coordination — especially to identify and eliminate health inequities — to meet the unique needs of the people it serves. OHA plans to establish FFS measures and metrics that align with the health equity metrics being developed under the 2022-2027 1115 Medicaid waiver.

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Enabling legislation/program authorization

Chapters 309, 413, 414, 426, 427, 428 and 430 of the Oregon Revised Statutes authorize the Oregon Health Authority to administer Oregon's medical assistance and behavioral health programs. Federally funded programs, such as Medicaid, the Children's Health Insurance Program (CHIP), and programs funded through federal grants, are implemented according to federal laws and requirements.

Funding streams

For the 2023-25 biennium, HSD's budget comprises 67 percent Federal Funds, 15 percent General Fund, and 18 percent Other/Lottery Funds. Federal revenue sources include Medicaid and the Children's Health Insurance Program for approximately 1.4 million OHP members, as well as various federal mental health and substance use disorder grants.

HSD's Other Funds include a hospital tax, insurers tax, an intergovernmental transfer from Oregon Health & Sciences University, tobacco taxes, the Tobacco Master Settlement Agreement, recreational marijuana taxes, the Community Housing Trust Fund, beer and wine taxes, the Intoxicated Driver Program Fund and state lottery revenues. The Governor's Budget also includes $37 million in new Other Funds revenue from the establishment of a $0.40 per line per month charge on phone lines to offset General Fund supporting 988 crisis intervention.

Significant proposed program changes from 2021-23

In the 2023-25 biennium, HSD plans to expand a robust system of care that is culturally and linguistically appropriate. Specifically, with this budget, HSD would:

- Continue work towards a Basic Health Program to maintain coverage for people in Oregon who would otherwise lose health insurance during the unwinding of the Public Health Emergency.
- Transform health care delivery for Oregonians with complex health needs who receive Medicaid benefits through a fee-for-service model to person-centered, quality care with a focus on improved health outcomes.
- Provide better and more comprehensive care for the behavioral health of children.

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- Operationalize a new waiver from CMS to provide care and coordination for justice-involved Oregonians.
- Implement federal Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) requirements, to ensure children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Program Support and Administration

The Governor's Budget continues funding for Program Support and Administration at the current level for the 2023-25 biennium and includes funding and positions to support several policy packages for both the Medicaid and Non-Medicaid Behavioral Health programs.

Activities, programs, and issues in the program unit base budget

The Program Support and Administration budget includes funding for administrative support, services, and oversight for the Health Systems Division (HSD), including both Medicaid and Non-Medicaid (Behavioral Health) programs. The Division is supported by Business Operations, Government and Process Improvement, the Office of Actuarial and Financial Analytics, and the Office of Program Integrity.

This budget also includes staff supporting the Oregon Health Plan, including Medicaid Programs; Provider and Member Services; Eligibility Policy; Quality Assurance; and Hearings. For Non-Medicaid Behavioral Health, this budget includes staff for Addiction Treatment, Recovery and Prevention Services; Adult Mental Health and Housing Services; Behavioral Health Policy; Child and Family Behavioral Health Services; and Licensing and Certification. It also includes funding and staff for information systems, such as the Medicaid Management Information System (MMIS) and the Community Outcome Management and Performance Accountability Support System (COMPASS).

Division Administration and Support

Business Operations

The Business Office oversees the administrative budget, program budget, position management, hiring and facilities, office management, complaints and both program and administrative invoices and settlements.

The Contracts Unit oversees county contracts and grants that fund mental health and substance use disorder programs. These include intergovernmental agreements with local mental health authorities (LMHA) and community mental health programs (CMHP), direct contracts with Tribes and Tribal organizations, and contracts administered

by the Oregon Health Authority (OHA). Program Support and Administration works directly with staff, program, leadership, community mental health programs and other agency partners to support effective programs and successful agency outcomes.

Governance and Process Improvement

The Governance & Performance Improvement unit has several areas of work:

- The Risk Management portion of this unit works to ensure audit findings are resolved, complaints are handled appropriately and timely, and issues on the Issues Resolution list are completed thoroughly. This team also tracks internal issues to elevate for leadership prioritization. It also provides additional assistance when high-priority, highly visible initiatives are being implemented. Measure 110 has been an integral part of our workload since it passed. The team focuses on Medicaid and Behavioral Health oversight with the intent of ensuring all state and federal regulations are met. This includes process overview, ensuring the adoption of new rules, and evaluating deliverables. The unit works closely with the Medicaid and Behavioral Health teams to ensure they complete requirements as efficiently as possible. It also supports the development of compliance programs within the different areas and will facilitate process development and brainstorming as needed. The team is in the process of developing a risk assessment process for HSD teams to quantify risk and mitigate it prior to crisis status.

- The Performance System is a methodology adopted by OHA to ensure coordination of work priorities with the agency's vision. This methodology includes metrics development and coordination across the agency horizontally and vertically. This unit supports the Performance System actions for HSD, working closely with the Tier 1 team and external consultants. The Performance System will be integral in the implementation of OHA's 2030 strategic goal of eliminating health inequities in Oregon.

Program Support and Administration

- The Project Management team focuses on the highest priority and most complex HSD projects. They utilize project management tools to facilitate operationalizing projects within HSD. In addition, this team trains and consults with HSD staff on implementing their own business initiatives. Not every project requires full project management support so ensuring HSD staff are trained on the proper processes results in the standardization and streamlining of new initiatives and changes to current initiatives. This team regularly consults with HSD staff and ensures metrics are developed to track progress. This team also coordinates the utilization of the PMO Bank, which allows for small, focused bursts of contracting assistance for project management, facilitation, and report writing and analysis through a 5-year price agreement. This unit has also created and continues to maintain several resources for HSD teams to utilize for short-term help, but that also creates future employment opportunities for participants. These programs include: the Oregon State University MPH Internship program through an affiliation agreement; Portland State University Fellowship program also through an affiliation agreement; and the AmeriCorps VISTA volunteer program through the OHA Public Health program.

- Process Documentation is integral to all functions of this unit. This team has identified and developed the standard HSD processes that apply to all teams and has prioritized their standardization, documentation, and completion for the utilization of all HSD teams.

- This team prioritizes areas needing Process Improvement that affect those living in Oregon every day. For example, improvements to our OHP Complaints process and developing a more comprehensive Behavioral Health Complex Case Escalation pathway. This team is also championing the utilization of division-wide tools for implementation tracking and coordination of work. Because HSD is so large, it is imperative that intentional focus be put on division-wide standardization to ensure collaboration and coordination.

Program Support and Administration

Business Information Systems

Business Information Systems (BIS) works on OHA and enterprise-wide data quality and integrity projects with ODHS and OIS, including coordination of efforts with the Oregon State Data Officer to support efforts to identify and eliminate health inequities and provide a 360-degree view of Oregonians receiving services. This work to treat data as an asset increases OHA's ability to support work on antiracism, health equity, workforce development, system transparency and community engagement. These efforts also support OHA's compliance with DAS policy (107-004-160) on Data Governance and Transparency.

BIS functions also include Medicaid Management Information System (MMIS) Business Support Unit and the Community Outcome Management and Performance Accountability Support System Unit (COMPASS).

The MMIS team manages benefits, drug and pharmacy programs, enrollment, claim processing, provider portal, prior authorizations and plans of care issues, user training, MMIS security protocols, including system access agreements, third party liability functions, and payments for services delivered through the Oregon Health Plan. The MMIS also issues payments to coordinated care organizations (CCO) and individual providers.

MMIS staff coordinate system changes mandated by state and federal requirements, as well as system improvements. This work includes the design, planning, testing and implementation of enhancements. Staff work to ensure proper processing of claims and support mandated and business-critical changes and activities. To accomplish these functions, staff work with multiple state agencies and the contracted MMIS vendor, Gainwell, to make these changes.

For MMIS, the major cost drivers are the number of and rising cost for required MMIS system changes, and the increased number and scale of changes that have been mandated over the past three years. The existing system requires a variety of changes to implement any single policy or benefit change, as well as intensive work by MMIS staff and Gainwell. Some examples include:

Program Support and Administration

- Drug rebate changes mandated by the Centers for Medicare and Medicaid Services (CMS)
- COVID-19 changes in claims coding and rules, and financial configurations in MMIS
- Healthier Oregon
- Veteran's Dental Program
- DCO's to a CCO-F model
- COFA Dental Program
- Redetermination changes mandated when the Public Health Emergency ends
- SOGI (Sexual Orientation & Gender Identity) changes
- Daily Auto Assignment change that will allow for faster enrollment into a CCO
- FFS Transformation system change work
- 1115 Medicaid demonstration waiver system change work.

Compass (Community Outcome Management and Performance Accountability Support System) is charged with two vital bodies of work: the operation of existing Health Systems Division (HSD) non-Medicaid Behavioral Health systems, and the migration and modernization of those systems. The Compass Team collects and reports data on behavioral health, substance use disorder, and problem gambling services provided to people in Oregon through approximately 400 behavioral health agencies and providers. Compass staff collaborate with the Office of Information Services, HSD Behavioral Health program staff, MMIS team members, and behavioral health providers to maintain the systems and improve data submission quality.

The Compass team provides support for the following data systems:

- Measures and Outcomes Tracking System (MOTS) is used by providers to submit client status and non-Medicaid service data for required state and federal reporting for continued funding and to report client trends and outcomes. As of August 15, 2022, MOTS tracks over 137,000 people with an active behavioral health treatment status. The system is scheduled for replacement in Winter 2023.

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- Acute Care Reporting System (ACS) is the system used by acute care hospitals to submit client information for civil commitment admissions and discharges to HSD.
- The Problem Gambling Network (PG Net) is the system collects gambling treatment data for client enrollment, assessment, diagnosis, termination, and surveys to measure outcomes. In 2021, PG Net replaced the Gambling Participant Monitoring System (GPMS) and replaces a largely manual process.

The Compass team also manages an ongoing portfolio of work to modernize the behavioral health data systems. Many of the outdated computer systems require time-consuming and costly manual workarounds to meet the data and reporting needs of HSD behavioral health programs. Existing information systems do not easily integrate with providers' external systems (including electronic health records systems) or with OHA internal systems, which affects reporting frequency and accuracy. Upgrading these systems would decrease system and administrative costs for behavioral health programs and their partners. The Compass modernization work includes leading projects, gathering and prioritizing IT system requirements that align with federal and state policies, and determining short and long-term technology strategies that support OHA's goals.

Compass supports the following major modernization projects:

- The Behavioral Health Data Warehouse (BHDW) is the central repository for all Agency behavioral health data that interfaces with behavioral health program applications and databases, and provides comprehensive analysis and reporting for state, federal, and ad hoc data requests. The data in this system will be used to report out on progress of Measure 110. This project is in development and expected to go-live in early 2023 with seven data sources and will begin preparations for ingesting additional critical data sets.
- The Resilience Outcomes Analysis and Data Submission (ROADS) System will replace the aging MOTS data collection with a completely modernized interface and process for behavioral health providers to submit client level data. This new system will migrate the paper-based CANS assessment (Child and Adolescent Needs and Strengths) from a paper-based system to an electronic system to facilitate data collection and reporting.

This system will also gather the required data to support Measure 110. The ROADS System is in development and expected to go-live in late 2023.

The Program Support and Administration budget also includes the following analytical and oversight units supporting HSD's Medicaid and Behavioral Health programs.

Office of Actuarial and Financial Analytics
OHA's Fiscal Division of Central Services oversees the Office of Actuarial and Financial Analytics (OAFA), which develops OHA's capitation rates for the Program of All-inclusive Care for the Elderly (PACE) and Healthier Oregon (HOP). OAFA also supports rate development for Medicaid managed care entities (coordinated care organizations and dental care organizations). Also known as a "per member per month" payment, capitation rates are based on the cost of care and services provided to the members each organization serves.

OAFA supports OHA and CCOs through data analysis and collaboration; analysis and communication of rates-related and financial information; budgetary impact analyses for legislative and program change proposals; calculation of CCO financial incentives and settlements; development and implementation of cost-containment strategies; review and analysis of fee-for-service reimbursement rates; evaluation of alternative payment methodologies; and policy development in support of Oregon's health system transformation. OAFA also collects, reviews, consolidates, and publishes CCOs' quarterly and annual financial reports. Under CCO 2.0, OAFA regulates CCOs' financial reporting, fiscal solvency, risk-based capital measurement, and financial solvency under NAIC standards. OAFA is authorized to design and establish a reinsurance program for CCOs. Finally, OAFA monitors and assesses CCO contract compliance.

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Office of Program Integrity

OHA's Fiscal Division of Central Services oversees the Office of Program Integrity (OPI), which ensures Oregon's Medicaid program and its providers, either through contract or by fee-for-service, follow federal and state Medicaid service and billing regulations. OPI also oversees programs supported by state funds only. OPI detects, prevents and investigates Medicaid and non-Medicaid fraud, waste and abuse.

OPI's work is pivotal to ensuring public resources maximize the health care benefits delivered to the people of Oregon. Investment in this office enables OHA to mature and improve its programs for investigating Medicaid and non-Medicaid fraud, waste and abuse; provide better oversight of how the state's health care partners spend public resources; and comply with federal and state Medicaid regulations and requirements.

Non-Medicaid (Behavioral Health)

The Office of Behavioral Health Services (OBHS) includes the following areas: Behavioral Health Administration; Behavioral Health Strategic Operations; Adult Behavioral Health Services; and Child and Family Behavioral Health Services. The staff of the OBHS focus on Medicaid- and non-Medicaid-funded community-based behavioral health program development, operations, policy, and special project.

Adult Behavioral Health Services consists of the Addictions Services, Adult Mental Health, Intensive Services and Measure 110 units. Specific activities of the units include:

Addiction Treatment, Recovery and Prevention Services promote treatment for addictive and co-occurring disorders, recovery and prevention, coordinate state opioid use and misuse initiatives, houses the State Opioid Treatment Authority, and oversees the training and certification of the people who monitor Driving Under the Influence of Intoxicants (DUII) offenders, and DUII treatment programs. Effective substance use disorder (SUD) treatment results in decreased criminal activity and recidivism rates for people who complete treatment. Oregon's Problem

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Gambling Services program, which provides treatment for people impacted by gambling disorders and prevention services in every county and with every Tribe is included, as well as veteran's behavioral health and Tribal alcohol, tobacco and other drug prevention.

This work includes:

- Oversight of intoxicated driver services.
- Oversight of problem gambling treatment and prevention programs in all 36 counties in Oregon through community mental health programs and by for-profit and non-profit providers. The state also has one residential treatment program for people with gambling disorders.
- Funding, development, and oversight of several initiatives to address opioid use and misuse issues, in partnership with the Public Health Division and community partners throughout the state. This includes increasing patient access to Naloxone and office-based opioid treatment options, especially in underserved, rural and frontier areas.
- Oversight of peer-delivered addiction treatment and recovery services. This is an evidence-based practice that uses trained and certified recovery mentors as part of a comprehensive recovery support team.
- Oversight of outpatient, intensive outpatient, crisis, and residential treatment programs for people with substance use disorders.
- Implementation of a statewide program to provide enhanced payment rates for integrated co-occurring disorder services.
- Oversight of Tribal Substance Misuse Prevention Services in Oregon (includes set up, technical assistance, compliance).
- Collaboration with stakeholders and program implementation regarding Veterans' Behavioral Health Issues
- Establishing a more health-based, equitable, and effective approach to treating substance use disorders by shifting the response to drug possession from criminalization to treatment and recovery.
- The State Opioid Authority (SOTA), which is responsible for:

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- Federal oversight of 19 state and federally licensed opioid treatment programs (OTPs) in Oregon, ensures compliance with state and federal regulations regarding medication assisted treatment (MAT) in the OTP setting, including site visitation, technical assistance, diversion prevention, and approval of clinically appropriate requests for deviation from Federally regulated take-home medication limits.
- Training, education, and work with a variety of federal agencies to support patient care in the OTP setting and MAT throughout Oregon, including approving Substance Abuse and Mental Health Services Administration (SAMHSA) certifications for OTPs in Oregon.
- Primary Addiction Treatment, Recovery and Prevention (ATRP) and HSD point of contact for topics related to opioid use, misuse, and treatment in Oregon, including working with internal and external stakeholders on topics such as expansion of MAT in residential and primary care settings, prescription and illicit opioid overdose prevention, community awareness of opioid misuse, evidenced based treatment and education around opioid use and misuse.
- Principal investigator and subject matter expert on the State Opioid Response (SOR) and State Targeted Response (STR) grants, increasing capacity to address opioid use disorder (OUD) through enhanced treatment, prevention, and recovery services.

Adult Mental Health Services promotes the health, well-being, and safety of Oregonians over age 18 living with mental illness. The unit:

- Supports community-based crisis intervention services such as transportation, assessment, de-escalation and referral to treatment. This helps people experiencing a mental health crisis avoid needing a higher level of care their community may not offer.
- Supports the funding of Behavioral Health Housing for capital, start-up, and operational costs related to increasing statewide capacity of licensed residential facilities and housing for people with behavioral health needs as well as Certified Community Behavioral Health Clinics.

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- Monitors, funds, and develops strategies to expedite discharge of Oregon State Hospital (OSH) residents and prevent re-hospitalization. This includes ensuring safety and stability in housing, employment and community integration. This unit works with the Psychiatric Security Review Board, OSH treatment teams and community mental health programs to ensure individuals are placed in the appropriate level of care and receive the treatments and services needed to live as independently as possible. Supports the provision of evidence-based practices including Assertive Community Treatment, Supported Employment, Suicide Prevention, and Peer Delivered Services.
- Oversees the Senior Behavioral Health Investment and provides technical assistance to 24 care coordinators throughout Oregon. The coordinators help seniors and people with disabilities access care, navigate multiple systems and learn about the resources in their community.
- Monitors evaluation and restoration services for people with mental illness who have been accused or convicted of a crime. For people accused of a crime, restoration services can be court-ordered to restore them to a condition in which they can assist in their defense. For those convicted of a crime, restoration services divert them from jail and into treatment. Restoration services can be provided in the community or at the Oregon State Hospital.
- Supports Oregon's crisis care system, which includes the 988 phone line (like 911 but focused on behavioral health) to provide behavioral health crisis intervention services and crisis care coordination anywhere in the state 24 hours per day, seven days per week, 365 days per year.

Behavioral Health Administration is comprised of the Behavioral Health Director, Behavioral Health Deputy Director, Behavioral Health Equity and Community Partnership unit, Office of Recovery and Resilience, and Behavioral Health Tribal Liaison. This unit and individual unit directors provide overall vision, direction and leadership for all of Oregon's publicly funded behavioral health activities, as described below:

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The Behavioral Health Equity and Community Partnership Unit leads OHA's efforts to reduce disparities in behavioral health services across populations. This includes meeting OHA's 2030 goals of eliminating health inequities. This work includes:

- Gathering, analyzing and utilizing federal, state and community data to identify, monitor, and lead efforts to reduce behavioral health disparities.
- Promoting and executing policy initiatives that strengthen the impact of OHA programs in advancing behavioral health equity as directed by community and those with lived experience.
- Providing training, technical assistance and other resources so that the behavioral health workforce is prepared to transform the behavioral health system to achieve the goal of eliminating health inequities.
- Increasing awareness and access to information about behavioral health inequity and create and implement strategies that promote behavioral health equity.
- Promoting trauma-informed approaches that acknowledge the traumatizing impact of structural racism and oppression and engage in community centered healing and sustainable structural change.

The Behavioral Health Equity and Community Partnership area also consists of the Behavioral Health Metrics and Committee unit and the Behavioral Health Workforce units.

The Behavioral Health Metrics and Committee unit does the following:

- Provides Medicaid expertise to facilitate the development and implementation of programs created and/or enhanced by the Behavioral Health Metrics and Incentives Committee, established by House Bill 2086 (2021).
- Takes a transformative approach across the agency and with partners to ensure that all work supports health-based, equitable and effective approaches to behavioral health system transformation.
- Provides operational and technical expertise as it relates to optimizing Behavioral Health Medicaid policy, funding, accountability, and integration, in coordination and consultation with subject matter experts across all

behavioral health services, programs, and administrative rules, as well as federal and state regulations and policies that impact Medicaid.

- Reviews and advise on policy issues involving related system changes to the behavioral health continuum of care and accountability measures to meet the mission, vision, values and goals of the Oregon Health Authority and the Health Systems Division. These include, improving behavioral health outcomes, reducing behavioral health disparities, promoting trauma-informed approaches, and advancing behavioral health equity as directed by community and those with lived experience.
- Develops methods to gather data and analyzes collected data to monitor and manage contract/program efficacy. This evaluation and assessment will synthesize quantitative and qualitative data insights to facilitate appreciative inquiry and to identify relational and experiential dynamics as much as financial and operational impacts.
- Provides a health equity lens to the development and implementation of programs created and/or enhanced by the Behavioral Health Metrics and Incentives Committee
- Applies large concepts to the local level for program implementation, as well as articulate the concepts and their application to a wide variety of interested persons and communities.
- Ensures mental health parity by ensuring that treatment and services for mental health and substance use disorders are provided in a broadly similar manner to comparable physical health services, including provider reimbursement. The bill requires CCOs to provide information to OHA on treatment limitations and denials of behavioral health services, and requires OHA to annually report on CCO compliance with federal parity law, adequacy of provider networks, and coverage of behavioral health services (House Bill 3046).

The Behavioral Health Workforce Unit was set up in June 2021 under Oregon Legislative House Bill (House Bill) 2949 to increase the recruitment and retention of behavioral health providers who are people of color, Tribal

community members, or residents of rural areas in this state, in order to provide culturally responsive care for diverse communities. This included funding to develop a diverse behavioral health workforce in licensed and non-licensed occupations through workforce incentives (e.g. scholarships, loan repayment), and a grant program to licensed behavioral health providers to provide supervised clinical experience to associates or other individuals so they may obtain a license or certification to practice. Aligned with the aims of House Bill 2949, the focus of this unit is to:

- Increase the behavioral health system's capacity to provide culturally responsive care that is deeply embedded in equity-centered cultural responsiveness, de-stigmatization of services, promotion of restorative healing and community empowerment.
- Develop and invest in culturally specific workforce and increase access to culturally responsive services and interventions.
- Engage communities in shared decision-making to build structures, processes, resources and supports for increasing recruitment and retention of a culturally specific behavioral health workforce.

The Office of Recovery and Resilience (ORR) is a team of policy and program analysts who all have lived experience with behavioral health needs. The ORR team serves as the bridge between OHA behavioral health and behavioral health service users in the community and is responsible for ensuring that the voices of people with lived experience – including youth, families of youth, and adults - guide all aspects of Oregon's behavioral health system. The ORR is also responsible for oversight, strategy, and support for peer delivered services throughout the state. The team accomplishes their work by:

- Representing the voice of lived and living experience within OHA behavioral health, throughout HSD, and across the agency. Applying lived experience to program and policy analysis, development, and implementation. Identifying and implementing necessary changes to create a more person-directed, equitable, and effective behavioral health system.

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- Facilitating meaningful involvement of people with lived experience at all levels of behavioral health policy creation, service delivery, and program evaluation. This includes provision of training and technical assistance to OHA colleagues, community partners, and people with lived experience. Responsible for oversight and coordination of HSD behavioral health advisory groups.
- Promoting continued growth and incorporation of Peer Delivered Services (PDS) in Oregon's behavioral health system. Exercising oversight of all peer-delivered services programming in Oregon, including youth support, family support, and adult peer support. Providing technical assistance and support to members of the PDS workforce and other system partners. Collaborating with members of the PDS workforce and other partners for strategic planning related to peer services, workforce development, and identifying and promoting sustainable funding for PDS in Oregon.
- Connecting with and building meaningful partnerships between OHA behavioral health and the communities we serve. Building community, connection, and relationships that contribute to the elimination of stigma and discrimination faced by people who experience mental health or addiction needs and their families. Creating culture change within OHA and in our communities.
- In collaboration with the behavioral health equity team, work to advance an equitable behavioral health system that offers individualized, person-directed, culturally and linguistically appropriate services and supports.

Behavioral Health Strategic Operations Unit staff provide strategic and operational support for the Behavioral Health enterprise to ensure best practices in program and policy development and execution. Staff collaborate extensively with stakeholders including the Legislature and Governor's Office, behavioral health consumers and families, provider associations and contractors, academia, clinical staff and advisors, Community Mental Health Programs (CMHPs) and payors including Oregon Health Plan CCOs and private insurers, and staff from other OHA divisions, including the Director's Office, Budget, DHS Shared Services, Public Health, as well as other federal, state and local agencies including CMS, SAMHSA, CDC, USDOJ, Department of Human Services, Housing and

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Community Services, Department of Education and schools, Judicial, Corrections, and Law Enforcement. Specific activities of the unit include:

Behavioral Health Medicaid, Policy and Planning provides overall policy direction for behavioral health services. This unit:

- Plans and administers federal behavioral health block grants and State Opioid Response grant for non-Medicaid services.
- Plans, coordinates, and oversees the County Financial Assistance Agreements (CFAA) and the SUD Medicaid Waiver
- Plans and coordinates efforts to fill gaps in services through federal grants and CCO partnerships
- Ensures consumers provide input into the planning and delivery of services and supports at state and local levels through the Office of Consumer Activities.
- Ensures service planning centers equity and intentionally work towards the elimination of health inequities
- Advances equity and consumer voice through policy decision making related to rates, rules and project deliverables
- Monitors and directs the implementation of the services to reach metrics identified in the US-DOJ Oregon Performance Plan, which seeks to improve mental health services for adults with serious and persistent mental illness.
- Develops and supports policies that foster the integration of behavioral and physical health care. Specifically responsible for expansion and oversight of Certified Community Behavioral Health Centers.
- Advances policies and supports implementation of behavioral health integration through CCOs to improve the behavioral health system.
- Manages administrative rulemaking for Behavioral Health programs.
- Reviews and provides technical assistance to CCOs related to behavioral health deliverables

- Plans and analyzes behavioral health funding streams to inform policy decisions related to behavioral health transformation

Child and Family Behavioral Health Services use System of Care values and principles, developmental science, and trauma-informed approaches and best practices to champion effective and efficient statewide behavioral health services, supports and safety for Oregonians ages 0–25 and their families.

System of Care is "a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life." [1]

Serving children, youth and their families in their local communities through robust community-based interventions that can safely support youth, including assessing them for suicide risk, in their homes; and that can reinforce out of home care, including foster homes and residential-based interventions, serving those who need specialized or substitute care. Child and Family Behavioral Health Services accomplishes these goals in the following ways:

- Provide support for the Governor's System of Care Advisory Council created by Senate Bill 1 (2019); tasked with forming policy to improve Oregon's System of Care.
- Administer funding and oversight of technical support in coordinating care for children, youth and young adults with emotional and behavioral disorders served across multiple systems such as the juvenile justice, education, child welfare, and mental health.
- Have created investments that support early identification and community-based treatment, such as the Early Assessment Support Alliance for young adults with psychosis and the Oregon Psychiatric Access Line about

[1] Source: https://gucchd.georgetown.edu/productGs/Toolkit_SOC_Resource1.pdf (accessed Dec. 13, 2018).

Kids (OPAL-K) and the Oregon Psychiatric Access Line about Adults (OPAL-A) to provide clinical consultation to primary care physicians about their patients' behavioral health needs.

- Administer funding, promotion and oversight of effective interventions that improve outcomes for children and their families experiencing parent-child relationship problems, behavioral problems, or mental health/addiction disorders to include addiction and problem gambling.
- Parent-Child Interaction Therapy (PCIT) is a preferred treatment for families with young children.
- Collaborative Problem Solving reduces the use of seclusion and restraint in child programs and improves parent-child communication.
- "Triple P" is an evidence-based positive parenting program utilized to prevent behavioral and emotional problems for children and youth at home, in school and in the community, creating family environments that encourage children to realize their potential.
- Parent Management Training of Oregon (PMTO)
- Trauma Focused Cognitive Behavioral Treatment (TFCBT)
- Wraparound
- Administer funding for Crisis and Acute Transition Services (CATS), a community- based alternative to psychiatric hospitalization for children and their families presenting with a mental health crisis to the emergency room. CATS providers respond to the emergency room within 3 hours of referral and work directly with the child and family to assess the clinical and safety needs of the family. The existing CATS program will be integrated into the new Mobile Response Stabilization Services (MRSS) being launched in January 2023, to provide mobile crisis response under the 988 Crisis Response program across the lifespan.
- Promoting peer-delivered services, where a person with lived experience provides supports and services to parents, caregivers and youth experiencing behavioral health challenges.

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- Provide funds for a statewide Parent/Caregiver/family audio and virtual help line to support positive solutions to parenting issues and connection with formal and informal resources to reduce the use of crisis services by de-escalation of tension and stress.
- Engaging youth and their families in policy development, planning and oversight of youth behavioral health programs and systems through engagement with the Children's System Advisory Council, the Youth and Young Adult Engagement Advisory group and the System of Care Advisory Council.
- Provide robust reporting, coordination, and oversight to implement the action items in Oregon's Youth Suicide Intervention and Prevention Plan, 2021-2025 per ORS 418.704. This includes contract management and coordination of the Big River suicide prevention programs, suicide prevention work with school districts, and evaluation efforts.
- Administer funding and technical assistance for community mental health programs to bring behavioral health care to children and their families in the schools through School Based Mental Health services and supports.
- Provide funding and technical assistance to local communities for mental wellness, mental health promotion and prevention, and reduction of stigma for utilizing behavioral health and peer-delivered services when needed. This includes but is not limited to suicide prevention, addiction prevention, and community connections which enhance social and emotional determinants of health, provide support and prevent isolation and other types of marginalization.
- Administer funding of the Commercial Sexual Exploitation of Children residential program, which works with law enforcement, child welfare, Oregon Youth Authority, faith-based organizations, service providers, survivors and advocates to disrupt exploitation and provide survivors with skills and opportunities which hopefully prevent further victimization upon return to the community.
- Administer funding and provide oversight of juvenile Fitness to Proceed services for youth who have been charged with a crime and have been found to be not competent to fully participate in their court process, due to their inability to understand the nature of the court proceedings, inability to assist and cooperate with

counsel, and/or ability to participate in their own defense. This program provides Restorative Services to assist youth in gaining competency in these areas.

- Provide training, funding and oversight for Intensive In-Home Behavioral Health Treatment (IIBHT) –a level of care serving children and youth up to age 17. IIBHT offers intensive mental health treatment for children and their families to children with complex mental health needs who are at risk of being placed out of their home or who are stepping down from facility-based care. IIBHT services may include individual and family therapy, family support services, skills training, psychiatric services and 24/7 crisis response.
- Collaborate with Portland State University in funding and administering Trauma Informed Oregon, a resource for trauma informed approaches for organizations in care and service delivery.

Senate Bill 4 (2021) – System of Care Advisory Council. The System of Care (SOC) Advisory Council is directed under Senate Bill 1 (2019) to improve the effectiveness and efficacy of child serving state agencies and the continuum of care that provides services to youth ages 0 to 25 by providing centralized and impartial forum for statewide policy development, funding strategy recommendations and planning. Senate Bill 4 gives the Council authority to award grants from funds appropriated by the Legislature; appoint an Executive Director; and requires OHA, ODHS, and the Council to submit joint biennial report on funding for system of care services and supports.

The Licensing and Certification Unit regulates provider compliance with state laws related to residential and outpatient behavioral health facilities and programs. This includes licensing, certification and oversight of over 1,100 behavioral health providers, including:

- Adult Foster Homes
- Community Mental Health Providers (CMHP)
- Child and Adolescent Programs: Intensive Treatment Services (ITS) including Psychiatric Residential Treatment Facilities and Children's Emergency Safety Intervention Specialists (CESIS)

- Civil Commitment, including Training and Certifying Examiners and Investigators, the certification of acute care psychiatric units and hold rooms, hold rooms within Emergency Departments, as well as certifying 5-day hold hospitals, transport custody hospitals, and secure transport.
- Community-Based Structured Housing
- Outpatient Programs: Mental Health, Substance Use Disorders, Medication Assisted Treatment (MAT) including Opioid Treatment Programs (OTP), Driving Under the Influence of Intoxicants (DUII), and Problem Gambling, and Co-Occurring disorders
- Alcohol and Other Drug Screening Specialists (ADSS); Residential Treatment Facilities: Mental Health Residential Treatment Homes and Facilities and Secure Residential Treatment Facilities (SRTF) for adults; Substance Use Disorders (SUD) for adults and youth, and Problem Gambling programs for adults.
- Sobering Facilities

Medical Assistance Programs

Medicaid Programs staff are responsible for all aspects of maintaining and managing the more than 27 Oregon Administrative Rules divisions, over 500 rules, that govern Oregon Health Plan (OHP)-covered health care services, eligible health care providers and participating managed care plans, including CCOs.

Staff work with provider associations, community partners, the CMS, ODHS, other state agencies, and other OHA divisions to implement and promote changes to benefits or programs. Recent efforts include establishing policy and issuing guidance for COVID-19 response. This response included adding OHP coverage for COVID-19 testing and treatment, expanding access to telehealth services, and working with providers and partners to address financial challenges. COVID-19 response has been an all-hands-on-deck effort that came on top of the tremendous work involved with implementing new CCO 2.0 contracts and several other major initiatives. Other notable efforts include

working with Oregon's Tribes to develop first in the nation Indian Managed Care Entities, working with ODHS and OYA to update rates and improve operations for the Behavioral Rehabilitation Services program serving

The Medicaid program (including the CCO, Fee For Service (FFS) and Eligibility Policy and Program Policy teams) oversees the following elements of Oregon's medical assistance program administration:

- Implementation and monitoring of the CCO contracts including the new CCO 2.0 contracts that began January 1, 2020.
- Fee For Service Transformation of the delivery of person-centered services to OHP members who are best served by a state-wide system (people with complex behavioral or physical health needs, dual eligible members, Tribal members).
- The policies, rules and processes that govern Oregon Health Plan eligibility, covered health care services, eligible health care providers and participating managed care health plans, including CCOs.
- Contracts and agreements with CCOs, health care providers, and other vendors that approve, coordinate and/or deliver care to members.
- Changes to Oregon's Medicaid and Children's Health Insurance Program (CHIP) State Plans and the Medicaid 1115 Demonstration Waiver. Combined, these documents explain how Oregon administers its federally funded medical assistance programs and the requirements for members and providers to participate in these programs.
- Implementation of Healthier Oregon (formerly Cover all People).

The state's Medicaid Management Information System (MMIS), which manages benefits, enrollment, claim processing and payments for services delivered through the Oregon Health Plan. The MMIS also issues payments to managed care entities (coordinated care organizations, dental care organizations and mental health organization), individual providers and organizational providers.

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- Customer service for participating health care providers and plans to ensure they meet state and federal requirements. This includes provider enrollment, a provider services call center, clinical review staff, claim processing and reporting.
- Customer service for members.
- Contested case hearings for OHP members who disagree with a state or CCO decision to deny, reduce or their medical assistance is terminated.
- Administrative reviews for OHP providers who disagree with a state or CCO decision to deny, reduce or end coverage of a specific health care service.

The Medicaid program also provides administrative oversight of all Medicaid-funded programs operated by the Oregon Department of Human Services, including, but not limited to Long-Term Services and Supports (LTSS) and developmentally disabled (DD).

Additionally, Medicaid staff work with CCOs, community partners, Tribes, and other state agencies to develop and strengthen culturally and linguistically responsive services and applying the Race, Ethnicity, Language and Disability(REALD) and Sexual Orientation and Gender Identity (SOGI) data collection standards mandated by House Bill 2134 (2013) and The Data Justice Act House Bill 3159 (2021) to assess how racism, disablism, lack of language access, sexism and heteronormative dominance impact individual and community health as well as to close the significant gaps in health inequities experienced by populations that remain invisible.

Other successes include system improvements, benefit expansions, value-based payments to reduce rural health costs, investments in Oregon's Tribes and the first Indian Managed Care Entity (IMCE), investments in improving FFS dental access and implementation of CCO 2.0 Request for Application (RFA) process and member transition.

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With CCO 2.0, social determinants of health are a primary focus for the Medicaid program. As part of CCO 2.0, HSD is involved in the implementation and operationalization of social determinants of health activities as they relate to the CCO service delivery system. HSD is responsible for assuring that social determinants of health activities undertaken by the agency, and for which Medicaid funding is claimed, align with the goals and requirements set forth in the 1115 OHP Demonstration Waiver. This is a critical function to ensure ongoing compliance and continued federal Medicaid-funding. The RFA for CCO 2.0 specifically called out the following areas:

- **Community Engagement:** Engaging key collaborators including OHP consumers, community-based organizations that address disparities and social determinants of health, providers within the delivery system, local public health authorities, Tribes, and other partners.
- **Social Determinants of Health and Equity Spending, Priorities, and Partnership**: Investing in services and initiatives to address the Social Determinants of Health and Health Equity in line with community priorities through a transparent decision-making process that involves the CCO's Community Advisory Council (CAC) and other partners. For the first two years of Social Determinants of Health and Health Equity spending, priority for spending has been designated on housing related services and supports.

Fee For Service (FFS) Operations Unit develops and maintains policies and services that directly impact more than 100,000 people that receive their Medicaid benefit through Fee For Service. This unit also provides the foundation for CCO policies and directly guides FFS contracts and services, maintains FFS rate schedules and works with community partners to identify gaps in policy and services and collaborate on solutions. HSD is transforming Fee For Service to create a statewide, person-centered system of care to aid in eliminating health inequities by 2030.

Provider Services staff provide customer service for over 103,000 health care providers. Services include but are not limited to clinical and technical review of health care claims and requests to approve payment of health care services; enrollment of participating providers; and the Provider Services customer service line for help with billing, provider enrollment, prior authorization requests and MMIS access. Provider Services staff also work with Oregon's

contracted managed care entities to ensure they submit data about the health care encounters they coordinate for OHP members, and review provider appeals of OHA and CCO coverage decisions through claim redeterminations and administrative reviews.

Member Services staff assist all members. Client Services Unit (CSU) assists members in getting access to care, explaining OHP coverage and how to navigate the care OHP covers, and connects members with their CCOs as appropriate. CSU assists members with billing concerns and helps resolve any complaints or concerns. Client Enrollment Services (CES) team ensures accurate and timely enrollment of members into CCOs, they fix any enrollment or dis-enrollment errors for all Medicaid programs

Eligibility Policy staff work with Medicaid Programs and Department of Human Services staff to coordinate updates in state policies, programs, and information systems when federal Medicaid and CHIP eligibility rules change. Staff inform system enhancements, such as the integrated eligibility system in 2020. Enhancements not only improved accuracy but also allow for faster, more automated, and more consistent determinations.

Hearings staff work with members, health care providers, CCOs and Oregon's Office of Administrative Hearings to coordinate the contested case hearing process for Oregon Health Plan members. From July 2021 through June 2022, staff processed approximately 900 hearing requests.

Quality Assurance staff work with Oregon's External Quality Review Organization (EQRO) to provide technical assistance and oversight to help CCOs demonstrate compliance with state and federal requirements.
Claims and Encounter Data Services staff work with CCOs on submitting encounter data. This includes enrolling CCO providers, identifying and correcting errors and submitting necessary backup documentation. The unit also includes staff who work on fee-for-service claims and appeals that need to be handled manually. Electronic Data Interchange is also housed within CEDSU. Those staff work with providers and clearinghouses on being set up,

testing and production issues around the submission and retrieval of electronic claims, enrollment and eligibility data. Other functions in this unit are enrollment and capitation reconciliation with the CCOs, Administrative Reviews requested by providers who disagree with claims determinations made by CCOs and running queries of DSSURS data utilized internally by other teams within HSD.

Innovator Agents work closely with Oregon's 15 CCOs as required by legislation and Oregon's Medicaid Waiver to coordinate between OHA, the community, and CCOs to ensure local adaptation and implementation of statewide health priorities. They understand the health needs of the region, the strengths and gaps of the health resources in the CCO and articulate these needs and gaps to OHA to ensure statewide and local coordination. Their in-depth knowledge of local communities and CCOs helps inform Medicaid operations and policy staff to ensure policies, programs and operations are designed and implemented in way that advances health equity, increases access to care and support OHP members. In addition, Innovator Agents prioritize elevating OHP member voice within CCO operations, supports CCOs to advance health equity work, strengthen Tribe relationships, implement behavioral health initiatives, and understand and act on emerging statewide priorities such as the COVID-19 response, wildfire response, heat events, etc.

Background information

Program Support and Administration provides the following services to support administrative, behavioral health and Medicaid programs:

- Administrative support for nearly 300 permanent full-time employees.
- Oversight and support for Medicaid, non-Medicaid services and administrative budget and invoices.
- Development and support for over 270 non-Medicaid contracts and grants.
- Managing and monitoring the implementation of legislative initiatives.
- Monitoring and improving division compliance and performance.
- Development and management of capitation rates.

Program Support and Administration

- Ensures Oregon's Medicaid program and its providers, either through contract or by fee-for-service, follow federal and state Medicaid service and billing regulations
- Development and maintenance of behavioral health and Medicaid data and reporting systems.

Medicaid Management Information System (MMIS)
Currently provides more than 120 annual trainings to end users and completes hundreds of system changes per year. In the next few years, the MMIS system will undergo modular changes, which will allow for future changes without replacing an entire system. Modularity is approved and encouraged by CMS and will also affect the cost of change requests and change orders.

Community Outcome Management and Performance Accountability Support System (COMPASS)
Provides more than 30 annual trainings to end users and up to 3 monthly reports to 250 behavioral health agencies.

For COMPASS, the outdated computer systems require time-consuming and costly manual workarounds to meet the data and reporting needs of OHA-HSD Behavioral Health Programs. Existing information systems do not easily integrate with providers' external systems (including electronic health records systems) or with OHA internal systems, which affects reporting frequency and accuracy. Upgrading these systems would decrease system and administrative costs for Behavioral Health Programs and their partners. COMPASS will also be migrating the CANS assessment (Child and Adolescent Needs and Strengths) from a paper-based system to an electronic system to facilitate data collection and reporting.

Revenue Sources

The 2023-25 budget for Program Support and Administration comprises 48 percent Federal Funds, 42 percent General Fund, and 9 percent Other/Lottery Funds.

Program Support and Administration

General Fund revenue funds administrative support, staffing, services and supplies, and the maintenance and operations of the information technology systems for the division's Medicaid and behavioral health programs.

Program Support and Administration receives Federal Funds through Medicaid administrative match, small amounts of federal block grants to meet administrative requirements, and other federal grants to fulfill the grant obligations. Medicaid provides a 50 percent Federal Funds match for staff and administrative expenditures that support the Medicaid program and a 75 percent Federal Funds match for administrative expenditures directly related to eligibility determinations and enrollment.

Other Funds include allocations from Medicaid and non-Medicaid funding sources for admin, including:

- The Tobacco Master Settlement Agreement
- Tobacco taxes
- Marijuana taxes
- A portion of court fines, fees and assessments related to Driving Under the Influence of Intoxicants program
- Licensing revenue and small contracts for data reporting to the federal government and education about the U.S. Supreme Court's Olmstead decision
- Drug Treatment and Recovery Services Fund (Measure 110)
- Lottery Funds

Proposed new laws that apply to the program unit

Please see the HSD Medicaid and Non-Medicaid Behavioral Health program unit narratives for new laws impacting this program unit.

Medicaid

The Governor's Budget continues funding for Oregon's medical assistance programs at the current service level for the 2023-25 biennium and requests additional investments that include funding to maintain health care coverage gains in the Oregon Health Plan, advance health equity, and support the renewal of the 1115 Medicaid demonstration waiver.

Activities, programs, and issues in the program unit base budget

The Medicaid budget includes state and Federal Funds used to deliver and pay for health care services to over 1.4 million Oregon Health Plan (OHP) members. The OHP includes Medicaid, the Children's Health Insurance Program (CHIP), Cover All Kids, Reproductive Health Equity Act (RHEA), Healthier Oregon, and other related services. Payments are made to individual health care providers as Fee For Service (FFS) and to the coordinated care organizations (CCOs) in the form of a global budget. CCOs serve over 90 percent of all OHP members and FFS covers the remainder of Oregonians receiving OHP.

Healthier Oregon is a program for children and youth under 19 as well as adults who are eligible for full Oregon Health Plan (OHP) and other medical assistance benefits, regardless of their immigration status. This is possible because House Bill 3352 (2021) put into law a program called "Cover All People." The program is now known as Healthier Oregon. During the first year of the program, it will be open to people under 26 and 55 and older. Beginning in July 2023, OHA expects to open the program to all age groups as allowed in current statute and the Medicaid budget.

The Medicaid budget is based on caseload forecasts and cost estimates projected for the coming two years. Because of the budget's size, even minor changes from forecasted caseload numbers to actual caseload numbers can result significant changes from the projected budget—either shortfalls or savings. During the COVID-19 Public Health Emergency (PHE), in accordance with the federal Families First Coronavirus Response Act (FFCRA), OHA has not removed OHP members based on eligibility, leading to an increase in caseload from about 1.0 million to about 1.4 million Oregonians. Forecasting the caseload for the upcoming biennium is complicated by the redeterminations that

will be required upon the expiration of the PHE, when the extension of Medicaid eligibility allowed during the emergency will end. As intended by the Oregon Legislature in House Bill 4035 (2022), OHA is developing a redeterminations plan to maintain OHP coverage for Oregonians who are currently receiving health care access through OHP, including the implementation of a Basic Health Program, to ensure Oregonians under 200 Federal Poverty Level (FPL) have uninterrupted access to health services.

The managed care plans capitation rates are also a significant budget driver. According to federal managed care regulations, OHA cannot set the capitation rates. Instead, each calendar year an independent actuary certifies the capitation rates, and the federal government approves for actuarial soundness.

Background information

By 2030, Oregon's mission is to have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

As part of Oregon’s current 1115 Medicaid demonstration waiver negotiations, OHA has an opportunity to further this goal over the next five years. In July 2012, the Centers for Medicare & Medicaid Services (CMS) approved Oregon’s 1115 Medicaid Demonstration waiver that was necessary to implement coordinated care organizations and initiate health system transformation for the Oregon Health Plan. This waiver was for a five-year period, running from July 2012 through June 2017. CMS approved Oregon’s Medicaid demonstration renewal request that ran from January 12, 2017 through June 30, 2022. CMS extended the waiver period while CMS and the state negotiated Oregon’s five-year renewal application for the 2022 to 2027 waiver period, which was approved on September 28, 2022. The new waiver

includes first-in-the-nation changes to Oregon's Medicaid program and includes $1.1 billion in new Federal Funds to address inadequate food, housing and other root-cause issues that lead to poor health for people and families struggling to make ends meet. As part of the agreement, the federal government also approved expanded OHP coverage for young children, as well as extended eligibility for youth and adults.

Revenue sources and changes

The 2023-25 Medicaid budget comprises Federal Funds, General Fund, and Other Funds.

The Medicaid program (OHP) receives Federal Funds for services provided to Medicaid-eligible individuals. On March 18, 2020, the President signed into Law H.R. 6021, the Families First Coronavirus Response Act (FFCRA), which provided a temporary increase to each state's Federal Medical Assistance Percentage (FMAP) effective January 1, 2020, and extending through the last day of the calendar quarter in which the PHE terminates. The Governor's Budget assumes the increased FMAP will phase down from April 1, 2023 to December 31, 2023. State General Fund or Other Funds must be used to match federal Medicaid dollars for direct service payments. The Governor's Budget assumes Oregon's non-enhanced (i.e., base) match rates averaged over the biennium, as follows:

- For health care services to Medicaid members not eligible under the Affordable Care Act (ACA) Medicaid expansion, 59.80 percent.
- For health care services to Medicaid members eligible under the ACA Medicaid expansion, 90.00 percent.
- For health care services to CHIP members, 71.86 percent.

Other Funds revenues include tobacco tax revenues, hospital assessments, an intergovernmental transfer agreement with the Oregon Health & Science University (OHSU), insurers assessments, grants, third party recoveries, pharmaceutical rebates, and the Tobacco Master Settlement Agreement (TMSA).

Medicaid

Proposed new laws that apply to the program unit

- Legislative Concept #475: Medicaid Waiver / Metrics & Scoring Committee
- House Bill 2286 (2023): FMAP Tribal Savings and Reinvestment Program
- Senate Bill 216 (2023): REALD and SOGI Data Confidentiality

Non-Medicaid

The Governor's Budget continues funding for Non-Medicaid Behavioral Health programs at the current service level for the 2023-25 and includes major investments that sustain, expand and accelerate progress toward a stronger behavioral health continuum.

Activities, programs and issues in the program unit base budget

The programs and services in this budget will advance the OHA strategic goal to eliminate inequities in health outcomes, particularly for people who need behavioral health services. Further, OHA seeks to ensure behavioral health services are simple to access, responsive to people's needs, and result in meaningful outcomes for people. COVID-19 has had a profound impact on people who receive behavioral health services and how services are provided. The extended duration of the pandemic continues to exacerbate a workforce crisis fueled both by limited availability of staffing resources, flexibility, and scalability as well as the heightened demand for services. Thus, the need for enhanced and expanded behavioral health services and supports continues into 2023-25.

Overall, Policy Priorities seek to lay the foundation and create the financial conditions to:

- Reduce behavioral health inequities and elevate quality and accountability.
- Result in community-centered engagement and person-directed services.
- Result in better care coordination for people with intensive Behavioral Health Service needs.
- Increase overall capacity, coverage and integration across settings and services.
- Incentivize trauma-informed, culturally responsive & linguistically specific services.
- Improve workforce diversity and increase staff retention.

Non-Medicaid Behavioral Health programs help all Oregonians achieve physical, mental and social well-being through access to mental health and addiction services and support for adults and children including:

- A safety net of behavioral health crisis services.

Non-Medicaid

- Supports and services for people who are uninsured or underinsured to improve their ability to be successful with their family, education, employment, and in their community.
- Timely access to behavioral health care that is a critical aspect for increasing protective factors and reducing risk factors that lead to suicide.
- Assistance with housing and other social determinants of health.

The Non-Medicaid Behavioral Health service system is a community-based continuum that relies on numerous partnerships. Services are delivered in outpatient, residential, school, acute, hospital, and criminal justice and community settings. Partners include consumers and people with lived experience, Community-Based Organizations (CBOs), coordinated care organizations (CCOs), county governments, service providers, families, and local community stakeholders.

Cost drivers:
Issues driving cost for behavioral health services in the current base budget include:

- Increased need for behavioral health services in response to COVID-19.
- A youth suicide rate that has been increasing since 2011 and remains well above the national average.
- Stigma and bias present barriers to tribal communities, communities of color, people with low-income, people with disabilities, people who are lesbian, gay, bisexual, transgender, queer, questioning, intersex and two spirit (LGBTQIA2S+), immigrants and refugees, and people living in rural areas of the seeking or receiving behavioral health care. Stigma and bias present barriers to tribal communities, and communities, communities, communities of color and other priority populations seeking or receiving behavioral health care.
- Need for more services options in people's home communities.
- The number of people entering mental health treatment through crisis services, including emergency departments and arrest.
- The number of people entering treatment who have multiple and complex physical and mental health needs.

Non-Medicaid

- Behavioral health workforce shortage across all provider types.
- Access to methamphetamines and opioids, which drives social problems including overdose, death and the demand for treatment.
- Increased alcohol misuse, which drives health problems and costs as well as driving demand for treatment.
- Lack of safe, affordable and drug-free housing.
- Ease of access to highly addictive gambling games.

The 2023-25 continuing caseload is forecast for a biennial average of 74,855 clients, which 3.4 percent higher than the 2021-23 biennium. The caseload includes clients in forensic, aid and assist, guilty except for insanity (GEI), civil commitments, previously committed, never committed populations.

Opportunities for improvement:

- Expanding access to a range of mental health and addiction services that engage people in the community with the services and supports they need, when they need them, where they need them, and at the right intensity.
- Increasing members of tribal communities and communities of color in our stakeholder and advisory groups to create an equitable behavioral health system.
- Since 2016, Oregon has experienced a shortage of beds for youth under age 18 at the intensive psychiatric residential level of care. OHA is actively working with the Oregon Department of Human Services (ODHS) on capacity, developing a short-term strategy to address needs. Additionally, OHA and ODHS are engaging CCOs, counties, stakeholders and partners in investigating mid- to long-term solutions for meeting the intensive service needs of our youth and families in the state while conceptualizing alternatives to the current model.

Non-Medicaid

Orchestrated interdependently, and reliant on collaborative action with community, current programs and new investments serve as a meaningful mechanism to further elevate our strategic goal to eliminate health inequities in Oregon by 2030.

Background information

In 2019, over 145,400 people received mental health services and over 42,600 received substance use disorder treatment and support services. Following is a non-exhaustive list of program highlights funded through the current service level budget.

Adult Mental Health Services includes critical safety net services as well as intensive behavioral health services for adults with severe and persistent mental illness (SPMI)

- Mobile Crisis and Jail Diversion services in every county to assist people in getting services prior to encounters with law enforcement and to encourage treatment options instead of jail.
- Assertive Community Treatment (ACT) services for people in their homes and communities.
- Supported Employment (SE).
- Older Adult Programs.
- Community services for people under the jurisdiction of the Psychiatric Security Review Board
- Care coordination and Intensive Care Coordination.
- 114 Residential Programs serve 869 people in the community in various levels of licensed care including Residential Treatment Homes and Facilities as well as Secure Residential Treatment Homes.

Child and Family Behavioral Health Services includes critical safety net services as well as intensive behavioral health services for children and their families with serious emotional disturbances (SED).

- Early and young childhood training and interventions with parents
- School-based mental health

Non-Medicaid

- Early assessment and support for young adults experiencing initial onset of behavioral health symptoms
- Long-term stabilization and treatment program for survivors of commercial sexual exploitation
- Emergency room diversion with children and families to reintegrate child home as quickly as possible
- Residential service for young adults to transition into adulthood

Addiction Treatment and Substance Use Disorder Services and Supports includes critical safety net services as well as intensive treatment and support programs, for people experiencing substance use disorders (SUD). This includes Residential Treatment and Withdrawal Management facilities.

- Full continuum of care for people experiencing substance use disorder or harms related to substance misuse
- Oversight of federally licensed opioid treatment programs (OTPs).
- Opioid Response: The SAMHSA State Opioid Response Grant provides Oregon with targeted funds to address the opioid epidemic.
- Housing Services: OHA and Oregon Housing and Community Services (OHCS) are engaged in an ongoing collaborative effort to expand Permanent Supportive Housing. Rental assistance is available statewide for up to 1,254 people.
- Problem Gambling Services: Lottery revenues fund problem gambling treatment and prevention services. Fifty treatment programs ensure problem gambling treatment services are offered in every county. These programs include traditional outpatient, residential, respite, home-based, and prison-based programs as well as a full-service help line. In state fiscal year 2021,341 Oregonians received problem gambling treatment services, including people with gambling disorders and their family members at a cost of $1,743 per case. Of the people in outpatient services, 28 percent successfully completed treatment. Of those who completed treatment, 51 percent reported they were still abstaining from gambling six months later and 45 percent reported gambling much less. NOTE: OHA’s Problem Gambling Services program transitioned from our longstanding external data collection system in mid-2021. This impacted the accuracy of data reporting. The number of clients served in 2019, before the severe impact to system capacity from the COVID pandemic, was 1,026.

Revenue sources and changes

The 2023-25 Non-Medicaid Behavioral Health revenues include General Fund, Other Funds, Federal Funds, and Lottery Funds.

Behavioral health programs receive Federal Funds through the following federal grants:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant
- SAMHSA State Opioid Treatment funds
- Opioid Settlement Funds
- The SAMHSA Community Mental Health Services Block Grant
- The SAMHSA Projects for Assistance in Transition from Homelessness formula grant
- The Department of Health & Human Services Temporary Assistance for Needy Families (TANF) Block Grant
- Other Funds revenues include:
- Statutorily dedicated funds under the Tobacco Use Reduction Account (TURA), Intoxicated Driver Program Fund (IDPF), Community Housing Trust Funds, and Lottery Fund.
- Tax revenue from beer, wine, tobacco and marijuana sales.
- Miscellaneous revenue from contract settlements, sponsored travel reimbursements, and the Tobacco Master Settlement Agreement (TMSA).

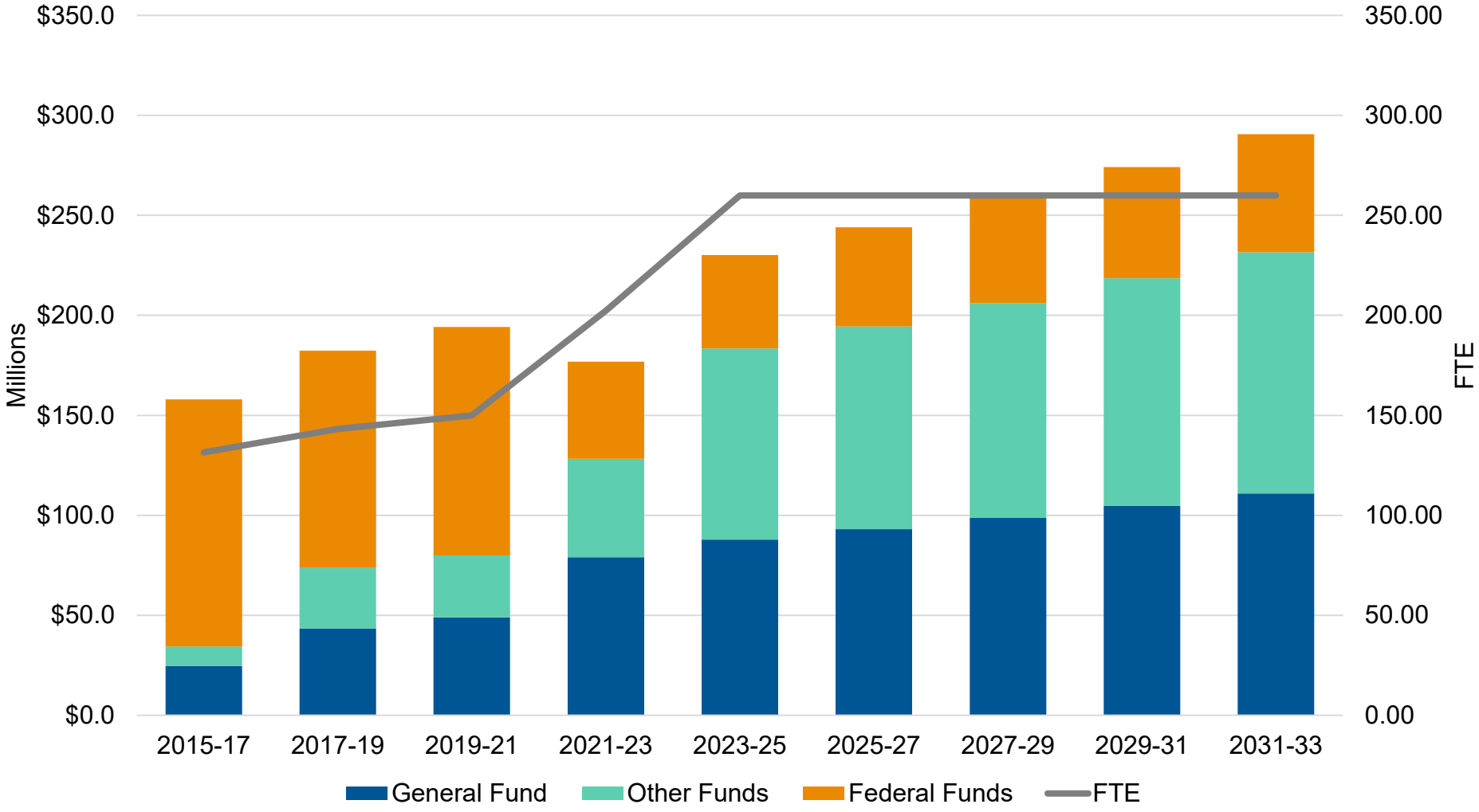
Proposed new laws that apply to the program unit

Senate Bill 216 (2023): REALD and SOGI Data Confidentiality

Oregon Health Authority: Health Policy & Analytics

Executive Summary

Program Contact: Ali Hassoun, Interim Director of Health Policy & Analytics
(503) 378-2798



Executive Summary

Division overview

The Health Policy and Analytics division develops and implements innovative approaches to achieving health equity by lowering health care costs and achieving better health and better health care for all Oregonians, with a particular focus on communities of color, that have borne the brunt of systemic racism. This is accomplished through seven offices:

- The Office of Health Policy
- The Office of Delivery Systems Innovation
- The Office of Health Analytics
- The Office of Health Information Technology
- The Public Employees Benefit Board and the Oregon Educators Benefit Board (each program budget is separate from HPA)
- The Oregon Health Insurance Marketplace
- The Office of Business Operations

These offices provide agency-wide policy development, strategic planning, clinical leadership, and statewide delivery system technology tools to support care coordination, health system transformation support, and health system performance evaluation reports. Together these offices provide services and support focused on achieving health equity through the triple aim of better health, better care, and lower costs.

The Health Policy and Analytics division is accountable for leading the next phase of health system transformation against the backdrop of the COVID-19 pandemic and justified demands for addressing systemic racism by:

- Supporting and incentivizing payments for value, moving away from paying for service volume and incentivizing care delivery that promotes better health for all communities.
- Supporting the Oregon Health Policy Board's work including its plans to operationalize OHA's health equity definition and reimagine a health care system capable of achieving health equity.
- Focusing on addressing social determinants of health in addition to the delivery of medical care.

Executive Summary

- Driving toward universal health care coverage in Oregon through Medicaid waiver applications, initiatives to ease transitions between public and commercial coverage, extend Oregon Health Plan coverage to undocumented immigrants and design a new public option for those over-income for the Oregon Health Plan.
- Innovating and implementing integration across behavioral health, oral health, physical health and social services using health information technology.
- Implementing legislative directives to align metrics and supporting new and innovative metrics for equity and social determinants of health.
- Facilitating multi-payer alignment to stabilize critical provider services and rebuild a health care system capable of achieving health equity.

Funding request

The Governor's Budget of $230.2 million Total Funds continues funding for the Health Policy and Analytics division at the current service level for the 2023-25 biennium. This budget also includes policy packages to do the following:

- Implement a federal standard to ensure state Medicaid programs meet the health care needs of children ages 0–21 (Early and Periodic, Screening, Diagnostic and Treatment)
- Begin transitioning to a state-based eligibility and enrollment platform and call center for Oregon's health insurance exchange
- Temporarily backfill the HCMO revenue shortfall with General Fund
- Expand outreach and education initiatives for the Marketplace to advance OHA's goal of 98 percent coverage by 2024
- Continue the OEBB and PEBB benefits management system replacement project
- Meet federal Affordable Cara Act reporting requirements

Executive Summary

Program descriptions

The division's **Director of Health Policy and Analytics** coordinates with the Governor's office, the Legislature, other state and federal agencies, partners and stakeholders, local governments, advocacy and client groups, and the private sector to achieve health equity, universal coverage and a stable health care system while remaining focused on the triple aim of better health, better care, and lower costs.

The **Office of Delivery Systems Innovation** (DSI) is designed to align and integrate clinical resources and policies to support implementation of the coordinated care model throughout OHA and all provider and payer organizations in the state. The Delivery System Innovation Office includes the Transformation Center and related quality improvement activities; the Patient Centered Primary Care Home program and Workforce initiatives of the Primary Care Office; Workforce, both housed within the Clinical Support, Integration and Workforce Unit; the Health Evidence Review Commission; and the Agency's pharmacy work.

The **Office of Health Policy** analyzes and develops policy options, facilitates stakeholder discussions, coordinates strategic and implementation planning efforts, and evaluates health services research and policy for the Governor's Office, the Legislature, the Oregon Health Policy Board (OHPB), OHA, and other participants in Oregon's health system transformation. These services help Oregon Health Authority identify opportunities, articulate program options, implement policy, and assess its progress toward achieving the triple aim. The Office of Health Policy serves three key functions:

- Research, Analysis, and Policy Development
- Coordination & Tracking
- Partnerships

The **Office of Health Analytics** collects, stores, integrates and statistically analyzes utilization, quality, and financial data. It does this in order to:

- Evaluate OHA program performance.

Executive Summary

- Provide data to support health system and program planning and implementation.
- Analyze trends across all payers and claims data.

The **Office of Health Information Technology** is responsible for providing coordination across programs, departments, and agencies in developing policies and procedures that:

- Accelerate state and federal health reform goals through organized support for adoption, implementation and integration of health information technologies.
- Leverage health IT funding opportunities from federal agencies and the private sector to improve Oregon's health IT capacity.
- Increase collaboration and communication among state agencies and across programs for enhanced planning and shared decision making, leveraged IT purchases, and coordination of service delivery.

The **Public Employees' Benefit Board and the Oregon Educators Benefit Board** have made a priority of transforming the health care delivery system, advancing health care transformation with plans that coordinate care, and managing the cost of care. They accomplish this through offering value-added plans that provide high quality care and services, implementing measurable programs that support member health status improvement, encourage members to take responsibility for their own health outcomes, and capping annual per-member-per-month cost increases at 3.4 percent.

Both boards offer core benefit plans that include medical, dental, vision and life insurance. Additional benefits include short-term and long-term disability, flexible spending accounts, commuter savings accounts and supplemental life insurance.

PEBB and OEBB operating budgets are included in HPA's budget while the program budgets are kept separate.

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The **Oregon Health Insurance Marketplace** empowers Oregonians to improve their lives through local support, education, and access to affordable, high-quality health coverage by:

- Overseeing the health insurance products sold to Oregonians through HealthCare.gov.
- Providing free, local enrollment assistance to Oregonians.
- Raising awareness among consumers about health insurance options available in Oregon.
- Working with carriers, agents, community partners, and other stakeholders to get more people enrolled.
- Training and certifying community partners to be able to provide choice counseling services to Oregonians.
- Provided health insurance premium assistance and out-of-pocket subsidies for low-income COFA (Compact of Free Association) residents through June 2022.

The **Office of Business Operations** is responsible for all the division's operational functions. The office partners closely with various Shared Services offices and acts as a liaison to internal and external stakeholders related to operational functions. These operational functions include:

- Program contracts management
- Program staffing
- Program grants management
- Operational and project budget management
- Facilities management
- Program policy and rulemaking management
- Administrative and executive support
- Program technical support
- Project management
- Risk management

Executive Summary

Program justification and link to long-term outcomes

Health Policy and Analytics programs directly support the long-term outcomes of healthy people and health equity. Together, the offices help to establish the common vision, define the outcomes, measure fiscal accountability, measure the effects of investment in various health care strategies, and inform all aspects of Oregon's health care decision- and policy-making efforts. These offices recommend the policy direction, measure the results, and suggest strategies for improving all health-related outcomes. Recently, HPA has focused on monitoring and developing strategies around:

- Reducing per capita costs.
- Leveraging public purchasing power to drive value-based payments and coordinated care models.
- Reducing the number of uninsured Oregonians.
- Addressing social determinants of health, including individual health-related social needs.
- Improving specific health measures tracked by the CCOs.

Program performance

These offices provide technical and subject matter expertise, analytic capacity, technical assistance, and the ability to secure funding and support of federal and national agency partners. They do not deliver program-specific services.

Enabling legislation/program authorization

Program authorization legislation and applicable federal and state mandates are listed by office in the Program Unit narratives.

Funding streams

Health Policy and Analytics is supported primarily by General Fund matched with Medicaid administrative and Medicaid health information technology Federal Funds. The match rates vary depending on the type of work being

performed. The Primary Care Office also receives 100 percent Federal Funds from the Health Resources and Services Administration (HRSA) Primary Care Office grant and HRSA Oral Health Workforce grant. HPA receives Other Funds from fees (workforce, inpatient data, ambulatory surgical data, All Payer All Claim, J1 Visa, Oregon Prescription Drug Program and Health Care Market Oversight), Oregon Health Insurance Exchange, and the Health Care Incentive Fund. By statute (ORS 243.185), PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs. Oregon Revised Statute (ORS) 243.880 established the Oregon Educators Benefit Account to cover administration expenses.

Significant proposed program changes from 2021-23

HPA proposes several changes for the 2023-25 biennium in the policy packages listed below.

Policy Package 201 and Legislative Concept 475: Oregon received approval of a new Medicaid 1115 demonstration waiver for 2022–2027 on September 28, 2022. The new waiver includes first-in-the-nation changes to Oregon's Medicaid program and includes $1.1 billion in new Federal Funds to address inadequate food, housing and other root-cause issues that lead to poor health for people and families struggling to make ends meet. As part of the agreement, the federal government also approved expanded OHP coverage for young children, as well as extended eligibility for youth and adults.

Policy Package 202: House Bill 4035 (2022) funded federally mandated redetermination process to help maintain health care coverage when the Public Health Emergency expires by funding short-term coverage for people who earn too much for Medicaid but not enough to afford other coverage and authorize development of a sustainable long-term solution. This policy package supports ongoing development of both a temporary expansion to Medicaid eligibility and a Basic Health Plan.

Policy Package 416 and Legislative Concept 471 will transition the Oregon Health Insurance Marketplace away from the FFM to use of a state-based enrollment and eligibility platform and call center for operation and administration of Oregon's health insurance exchange.

Executive Summary

Policy Package 434: Marketplace Outreach & Operations uses existing Marketplace funds to further the Oregon Health Authority's (OHA) goals of 98 percent coverage by 2024 and elimination of health inequities by 2030. Priority populations face significant barriers to accessing health care due to systemic racism, oppression, discrimination, and bias. Specialized and dedicated efforts are needed to mitigate historical and contemporary injustices and either build or rebuild trust to ensure people are connected to the resources they need. With current staffing and due to the increasing demand from the community, the Marketplace needs additional resources to expand outreach and education initiatives to the communities it serves, including those who are and have been underserved and marginalized. With additional staff, these communities will have access to the most effective assistance available to gain access to potentially free or very low-cost health care.

There are additional policy packages that impact HPA, but those do not represent significant changes to the division's programs.

Office of Business Operations

The Governor’s Budget covers the Office of Business Operations’ current service level for the 2023-25 biennium.

Activities, programs and issues in the program unit base budget

The Office of Business Operations develops and maintains operational processes and procedures on behalf of the Health Policy and Analytics division. It acts as liaison with other parts of OHA, including business operations offices in other divisions, Central Services, the Director’s Office, and the Shared Services offices.

HPA's business operations are organized into three program units: Contracts and Project Management; Budget, Grants Management and Technology Management; and Staffing and Administrative Support.

Contracts and Project Management:

- Manages the division's portfolio of contracts.
- Administers the process of contract initiation, amendments and renewal including the use of interagency agreements and memos of understanding.
- Manages the division’s operational project portfolio and provides project management assistance to the division's programs.
- Manages the division's risk management function.

Budget, Grants Management and Technology Management:

- Leads the initial biennial budget build and projections process for the division and each of its offices.
- Provides rebalance and reshoot budget tracking for the division budget.
- Builds and maintains active operating budgets for each program area in the division.
- Builds, monitors and maintains project budgets for the division's high-level projects.
- Provides all accounts payable and receivable services for the division.

Office of Business Operations

- Supports the division's technology including SharePoint, Web development, deskside support, asset management, etc.
- Provides rule making and policy writing services for the division and tracks legislation during legislative sessions.
- Provides grant maintenance services including documentation and version control, carry-over process, operational setup and maintenance, and closeout.

Staffing and Administrative Support:

- Manages the hiring process for the human resources in the division.
- Manages HR issues related to position management concerns.
- Establishes and maintains a workforce strategy, succession plan and training plan for the division aligning with the agency diversity recruitment policy.
- Provides administrative support to the division's programs and executive support for the directors of each office.
- Provides support for all the division programs' committees.
- Manages and supports all inter-office moves.
- Maintains the division's record keeping and archiving.

Background information

The Office of Business Operations has focused on consolidating, identifying, documenting and maintaining the division's operational processes. The office is identifying meaningful metrics for each process, benchmarking the current state of the measures for those processes and setting goals for improvement. The focus will be incremental improvements using a maturity model and pinpointing the processes deemed to be of most importance by the collective input of the division.

Office of Business Operations

As the Office of Business Operations provides the foundational operating process structure, the office's workload mirrors the demands of the division's programs. As the workloads of individual programs grow the demands of the operational support structure expand as well.

Revenue sources and changes

Funding streams in support of the Office of Business Operations are allocated through a federally approved cost allocation plan. A grant allocation module aggregates costs monthly, as outlined in the federally approved plan, to its respective state and federal funding sources.

Proposed new laws that apply to the program unit

None.

Health Policy and Delivery Systems Innovation

The Governor's Budget covers the Health Policy and Delivery Systems Innovation's current service level for the 2023-25 biennium.

Activities, programs and issues in the program unit base budget

Health Policy Office

The Health Policy Office analyzes and develops policy options, facilitates stakeholder discussions, coordinates strategic and implementation planning efforts, and evaluates health services research and policy for the Governor's Office, the Legislature, the Oregon Health Policy Board (OHPB), OHA, and other participants in Oregon's health system transformation. These services help OHA identify opportunities, articulate program options, implement policy, and assess its progress toward achieving the triple aim. The Office of Health Policy serves three key functions:

1. Research, Analysis, and Policy Development
    - Track emerging national and state health policy trends and issues, and their impacts in Oregon.
    - Conduct research and analysis and develop policy.
    - Provide senior-level policy advice to Health Policy and Analytics (HPA) and OHA leadership.
    - Respond to priority incoming requests for research, analysis, presentations and talking points.

2. Coordination & Tracking
    - Track and coordinate, when needed, policy development and implementation across HPA and OHA to ensure alignment with strategic direction.
    - Coordinate and synthesize responses to proposed federal regulations and legislation, incorporating feedback from across HPA (and OHA when needed).
    - Coordinate development of legislative concepts; coordinate analysis on priority legislation; and track and support implementation of legislation.

- Staff OHPB, coordinate committees of OHPB, and provide staff and policy leadership to OHPB committees to ensure committee work is connected to OHPB vision and direction.
- Help maintain consistent strategic direction and vision between OHPB, HPA, and OHA.

3. Partnerships

- Support external partnerships and engagement, including developing and giving presentations and staffing convenings of health care leaders and other partners and stakeholders.
- Develop presentations or policy documents that help HPA and OHA leaders inform the public, media, and stakeholders about health policy.
- Partner with analysts across HPA to help translate technical information into clear, concise summaries of trends and their meaning to the public and policy makers.

The Office of Health Policy includes the Cost Growth Target Program, the Health Care Market Oversight Program, and the Policy Development Team.

Office of Delivery System Innovation

The purpose of the Office of Delivery System Innovation is to align and coordinate health delivery system policies and practices — including and beyond traditional medical care — across Oregon's health system, including coordinated care organizations (CCOs), the fee-for-service population, PEBB and OEBB, commercial plans and payers, and Oregon's providers. The goals of the Office of Delivery System Innovation are to:

- Integrate policies and resources focused on both clinical care and addressing health-related social needs to support the coordinated care model.
- Develop, support and implement strategies that ensure Oregon's delivery system is designed to eliminate health inequities.
- Align and coordinate strategies to improve health care delivery and systems throughout OHA.
- Support innovation and quality improvement within Oregon's health system transformation efforts.

Health Policy and Delivery Systems Innovation

- Establish and maintain effective working relationships with Oregon's providers and health care delivery system representatives.
- Coordinate quality improvement and transformation efforts across OHA, PEBB- and OEBB-contracted plans, CCOs, and other entities involved in quality improvement.

One goal of the Office of Delivery System Innovation is to focus the agency's clinical and delivery system knowledge and expertise on achieving transformation, quality, and cost-containment goals. The Director of the Delivery Systems Innovation Office directly supervises the following positions:

- Transformation Center director
- Health Evidence Review Commission (HERC) director
- Pharmacy Policy, Purchasing & Programs director
- Quality Improvement director
- Clinical Supports, Integration and Workforce Unit director

Significant cross-agency collaboration is involved in the work within the Delivery System Innovation Office. For example, the HERC partners with the Health System Division and Fiscal and Operations Division to implement coverage decisions. The Transformation Center coordinates with the Public Health, Health System, and Equity and Inclusion divisions to support innovation and health equity through OHA's clinical and delivery system policies and program strategies. The Clinical Supports, Integration and Workforce Unit partners with the Health System Division to support the behavioral health workforce.

Background information

The HERC conducts research into comparative effectiveness and benefit design to inform public and private sector transformation efforts; performs medical technology reviews; develops clinical and coverage guidelines; maintains the Oregon Health Plan's Prioritized List of Health Services; and disseminates information on the clinical- and cost-

effectiveness of medical treatments and technologies. A key strategy for the Office of Delivery System Innovation is applying HERC research to policy development, implementation, and evaluation for OHA, the CCOs, and PEBB- and OEBB-contracted plans.

The Office of Delivery System Innovation also sponsors performance improvement projects overseen by the Quality Improvement Director and houses the Transformation Center to coordinate and support health system transformation and quality improvement across Oregon's health system. The Transformation Center is a key lever in OHA's efforts to support and spread Oregon's health reform progress by sharing innovation at the system, community and practice levels. Since its inception in 2013, the Transformation Center has provided capacity-building support to over 21,000 representatives of CCOs and other payers, providers, and community partners through almost 750 individual technical assistance sessions and large convenings across the entire range of OHA key health priorities, from behavioral health to health equity.

The Office of Delivery Systems Innovation also includes the Clinical Supports, Integration and Workforce Unit, which brings together the Patient-centered Primary Care Home Program and the Primary Care Office, supporting high-quality care that minimizes health inequities through a robust primary care system and health workforce that meets patients' needs.

In addition, Pharmacy Policy, Purchasing & Programs houses the Pharmacy and Therapeutics Committee, Mental Health Clinical Advisory Group and Oregon Prescription Drug Program (which helps staff ArrayRx). The Office of Delivery System Innovation pharmacy role also includes but is not limited to evaluating and monitoring pharmacy benefits across Medicaid populations covered via CCOs and traditional fee-for-service. The office also leads development of strategies for fiscally sustainable administration of pharmacy benefits, including multi-state consortia and multi-agency collaboration.

Health Policy and Delivery Systems Innovation

Revenue sources and changes

Health Policy and Delivery Systems Innovation leverage Medicaid administrative match for eligible programs and activities including Medicaid-related health system transformation, the Medicaid Advisory Committee, research and evaluation, and staffing. The office receives Federal Funds from the Health Resources and Services Administration (HRSA) Primary Care grant and the HRSA Oral Health Workforce grant. Other Funds include a fee-supported program for the Conrad J-1 Visa Program (ORS 409.745) and the Health Care Provider Incentive Fund established January 2018 (House Bill 3396; ORS 676.450 and House Bill 3261), and Health Care Market Oversight fees (House Bill 2362; ORS 415.500) and an OHSU-funded partnership for the Healthy Oregon Workforce Training Opportunity Grant Program to administer a community-based funding program that aims to expand the supply of health care workforce providers in the state. The Oregon Prescription Drug Program generates nominal revenue from the ArrayRx discount card program, which is collected and purposed according to ORS 414.314 & 414.318.

Proposed new laws that apply to the program unit

Policy package #201/legislative concept #475: Agency-wide placeholder to support the anticipated approval of Oregon's Medicaid 1115 demonstration waiver renewal. The Office of Health Policy and the Office of Delivery Systems Innovation will contribute to, and lead aspects of, ongoing policy and program design, implementation, technical assistance and evaluation following approval of the Medicaid 1115 demonstration waiver by CMS in September 2022.

Policy package #202: The Office of Health Policy will lead ongoing efforts to understand and mitigate the churn of the Medicaid population, including through community engagement. This work sets the groundwork for eventual implementation of a Basic Health Plan or MAGI Adult Expanded Program in the state.

Office of Health Information Technology

The Governor's Budget covers the Office of Health Information Technology's current service level budget for the 2023-25 biennium. Policy package #201 funds Oregon's new 1115 Medicaid Demonstration Waiver, which includes resources for OHIT to support new efforts to streamline transitions between systems through defined benefit packages of social determinants of health services.

Activities, programs, and issues in the program unit base budget

OHA's Office of Health Information Technology (OHIT) develops and supports effective health IT policies, programs and partnerships that enable improved health for all Oregonians.

To be effective, Oregon's transformed health care system increasingly relies on access to patient information and the health information technology (IT) infrastructure to share and analyze data. Health IT affects nearly every aspect of coordinated care including care transitions and management; population health management; integration of physical, behavioral, and oral health; accountability, quality improvement and metrics; value-based payment methodologies; and patient engagement. Health IT tools are needed to share information, aggregate data effectively, and provide patients with tools and data. Health IT also supports OHA's goal of eliminating health inequities by 2030 by connecting health care organizations through information technology tools that provide reliable patient data when and where needed, as well as connecting health care and social services through systems that support addressing the social determinants of health. Health IT tools can help fill gaps in care and enhance the overall wellness of people and their communities within the state.

Health IT is computerized storage, retrieval, and sharing of clinical health information and other health-related data. Major examples of health IT include:

- Electronic health records (EHRs), which are used by hospitals and health care providers including physical, behavioral, and oral health providers and others.

Office of Health Information Technology

- Health information exchange (HIE), which is the electronic sharing of health information among health care providers, patients, or other users of health IT systems. This can include finding (query); sharing (send) and exchanging (receive) patient information. Health information exchange may also sometimes refer to an organization that provides HIE technology services.
- Community information exchange (CIE), which is a network of collaborative partners using a multidirectional technology platform to connect people to the services and supports they need. Partners may include human and social service, health care, and other organizations. Technology functions must include closed loop referrals, a shared resource directory, and informed consent. CIEs have rapidly been adopted in Oregon in recent years, with a primary focus on referrals to help address social determinants of health needs.

OHIT is working with Oregon's health care and social services partners to improve health, support health system transformation efforts, and address health inequities by supporting policies, programs, and public/private partnerships that bring tools for securely sharing individuals' information across providers, health plans, individuals, and other partners. These tools and programs provide critical infrastructure to make care more efficient and effective and are even more critical when responding to pandemic and other emergencies.

- In particular, health IT infrastructure is needed to connect systems, increase efficiencies, fill gaps in the data and infrastructure needed to support coordination in real time across hospitals, providers, coordinated care organizations (CCOs), and health plans.
- Health IT can also connect health care organizations to social service providers that can help vulnerable Oregonians when they need safety net programs and other supports, such as, to manage quarantine safely or to stay safe and healthy when displaced by wildfires or other events. This supports connecting Oregon Health Plan members to health-related social needs as outlined in the Medicaid 1115 demonstration waiver.
- Health IT is a critical component of OHA's efforts to eliminate health inequities across the state, including supporting provider and health plan collection of race, ethnicity, language, and disability (REALD) and sexual orientation and gender identity (SOGI) data, which are a core component of OHA's equity work.

Office of Health Information Technology

OHA is statutorily required to staff the Health IT Oversight Council (HITOC) and operate the Oregon Health IT Program, which includes health IT services and other supports needed to ensure our health system transformation efforts are successful. OHIT work is organized into two main areas:

- Health IT policy work, which includes staffing for HITOC and its' workgroups; health IT policy analysis including monitoring and responding to state and federal legislation and policy; exploration and development of new initiatives, such as CIE; and education; technical assistance; internal OHA/ODHS coordination including partnering with Medicaid, Behavioral Health, Oral Health, Public Health, and ODHS teams; and external coordination and convening. Staff are also engaged in data collection, analysis, evaluation, and reporting on the health IT landscape in Oregon.
- Health IT program and compliance work, which currently includes:
    - HIE programs: HIT Commons public/private partnership, Emergency Department Information Exchange (EDIE)/Collective Platform, and the Prescription Drug Monitoring Program Integration Initiative. These programs are operational and continue to evolve and enhance services, expanding use cases and functionality. Staff are engaged in program and contract management, as well as program and technology development, governance, internal and external coordination, technical assistance, outreach, and education.
    - CCO Health IT contractual compliance and reporting, including annual Health IT Roadmap and data reporting. Staff are engaged in developing guidance, coordinating with CCOs including convening quarterly Health IT Advisory Group (HITAG) meetings with all CCOs, reviewing annual Roadmap and data files, working with CCOs when revisions are necessary, providing technical assistance and cross-CCO learning opportunities, and producing CCO HIT Roadmap summaries.
    - Final audits for the Medicaid EHR Incentive Program (audits conclude in 2023).

Highlights of HITOC and OHA's health IT activities include:

- **Creation of a statewide health IT vision and goals, health IT strategic plans, environmental scans, and policy recommendations,** under HITOC and its workgroups and committees. HITOC reports regularly to the

Oregon Health Policy Board and oversees the Oregon Health IT Program. A 2022 HITOC Data Report[1] provided comprehensive information on EHR and HIE adoption and use in Oregon and support for HITOC's current work to update the 5-year Oregon Health IT Strategic Plan. In 2021-23, HITOC chartered a CIE Workgroup and HIE Workgroup. HITOC's 2023 work includes updating the Strategic Plan for Health IT, including identifying strategies to support social determinants of health, and using health IT to support OHA's goal of eliminating health inequities by 2030.

- **Support for connecting health care and social services to address social determinants of health**
  - OHA was statutorily required (by House Bill 4150 (2022)) to staff a group or groups convened by HITOC explore options to accelerate, support and improve secure, statewide CIE efforts that would allow the seamless coordination of health care and social services across all delivery systems, prioritizing health equity, confidentiality, and the security of information. A draft report to the Legislature was delivered in September of 2022 and a final report in January 2023. The CIE Workgroup began meeting in March of 2022 and concluded in November 2022.
  - OHA continues to monitor the CIE landscape, coordinate internally, and coordinate with the Oregon Department of Human Services (ODHS) to update leadership and explore opportunities to support Oregon Medicaid members and access to social services and resources.
  - A major component of Oregon's proposed 1115 Medicaid demonstration waiver includes a defined benefit packages of social determinants of health services to support members transitioning between systems such as corrections settings, foster care, Oregon State Hospital, etc. OHA's approved waiver package includes CIE components necessary to support screening Oregon Health Plan members and referring to health-related social needs.

[1] HITOC 2022 Data Report: https://www.oregon.gov/oha/HPA/OHIT-HITOC/HITOC%20Meeting%20Docs/20220609_HITOC_ReportOnOregonsHealthITLandscape.pdf

- **A successful public/private partnership to accelerate health IT use —** through Oregon's Health IT (HIT) Commons, jointly funded by OHA, all Oregon hospitals, all major health plans and CCOs, and co-sponsored by OHA and the Oregon Health Leadership Council. HIT Commons supports critical health IT initiatives and has the ability to target efforts on shared goals and bring key partners to the table, including recent work mobilizing support for COVID-19 response efforts. Current efforts and HIT projects have successfully:
    - **Connected real-time hospital data across hundreds of organizations** – Oregon's Emergency Department Information Exchange (EDIE)/Collective Platform is now used by all hospitals, CCOs, major health plans, and major swaths of primary care and behavioral health clinics, as well as the majority of skilled nursing facilities, and many others, including OHA and ODHS programs. This program provides real-time alerts about hospitalizations and emergency department use so that care can be coordinated, and individuals receive appropriate care and follow up.
    - **Reduced emergency department visits for high utilizers —** Broad use of EDIE/Collective Platform across Oregon has led to some astounding results. Emergency department visits by high utilizers decreased by 50 percent in the 90 days following the initial creation of a care guideline in EDIE/Collective Platform for 2021 compared to 2020. This program allows everyone working with a patient to know when they have been in the ED or hospital, and coordinate their care across primary care, CCO or health plan, behavioral health, dental care organizations, and hospitals.
    - **Helped reduce risky prescribing of opiates** by connecting Oregon prescribers to data on controlled substance prescriptions, through their EHR. The Prescription Drug Monitoring Program (PDMP) Integration initiative has been an important factor in sustained reduction of risky opioid prescribing patterns, including prescribing of high quantities or multiple types of controlled substances.[2] Integration of PDMP access into the prescriber's EHR removes the need to remember passwords and log into the PDMP portal. More than 19,000 prescribers at more than 332 organizations (health systems, clinics) and

[2] HITOC 2022 Data Report, page 27-28 https://www.oregon.gov/oha/HPA/OHIT-HITOC/HITOC%20Meeting%20Docs/20220609_HITOC_ReportOnOregonsHealthITLandscape.pdf

more than 650 pharmacies in Oregon actively benefit from “one-click” access to controlled substance prescription data in Oregon’s PDMP.

Background information

In 2009, the Legislature established HITOC and soon after, OHA established the Office of Health Information Technology to support HITOC and health IT policy work and leverage new federal funding to bring health IT infrastructure to Oregon. Major milestones include:

- 2009-2010: HITOC is established in House Bill 2009 (2009). The federal HITECH Act[3] passes, creating several programs including: federal EHR incentive programs, state HIE cooperative agreements (ended in 2014), and 90/10 match for state health IT efforts to support HITECH incentive program objectives. **HITOC** establishes the State Health IT Strategic and Operational plans as required for federal HITECH funding.
- 2011: Launch of federal EHR incentive programs (both Medicare and Medicaid programs). More than $542 million in federal Medicare and Medicaid incentive payments have been disbursed to all Oregon hospitals and nearly 8,500 Oregon providers. Included in that total, **Oregon’s Medicaid EHR Incentive Program** disbursed more than $213 million to eligible hospitals and health care providers. This program ended in December 2021, as planned by the federal Centers for Medicare & Medicaid Services (CMS).
- 2013: All CCOs agreed that OHA should leverage $3 million Transformation Fund (General Fund) investment to draw down 90/10 federal match and implement several statewide health IT programs/services.
- 2014: OHA partners with the Oregon Health Leadership Council to establish the **Emergency Department Information Exchange (EDIE) Utility**, a public/private partnership. The EDIE Utility officially launches in 2015, with financial support by OHA, all Oregon hospitals, and all major health plans.

[3] The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.

Office of Health Information Technology

- 2015: OHA establishes the **Oregon Health IT Program** mandated by House Bill 2294 (2015) to connect and support community and organizational health IT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have the means to participate in basic sharing of information needed to coordinate care.
    - Currently, the Oregon Health IT Program includes HIT Commons, EDIE/Collective Platform, and the PDMP Integration initiative.
    - Past programs include Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP); CareAccord, a HIPAA-compliant Direct secure messaging service; Oregon Provider Directory; Clinical Quality Metrics Registry; HIE Onboarding Program; the Flat File Directory; and the Medicaid EHR Incentive Program.[4]
- 2017: HITOC updates its **Strategic Plan for Health IT/HIE**[5], with approval from the Oregon Health Policy Board. The updated plan includes strategies to achieve statewide health information sharing, leveraging existing regional, statewide, and national HIE networks. HITOC is currently working to update the Strategic Plan for 2023-2027.
- 2018: OHA and the Oregon Health Leadership Council transition the EDIE Utility to a broader public/private partnership, the **HIT Commons**, to provide long-term sustainability for statewide health IT efforts. The HIT Commons governs two initiatives:
    - **EDIE/Collective Platform (formerly known as PreManage):** EDIE connects all Oregon hospitals and provides emergency rooms with critical, concise information about patients who are high utilizers of emergency department (ED) services and patients with complex care needs. The Collective Platform, a companion service to EDIE, brings real-time hospital event notifications from EDIE to participating CCOs, health plans, providers, and OHA/ODHS programs who subscribe to receive real-time

[4] For more information on past (and current) programs, see: https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx
[5] Strategic Plan for Health IT/HIE (2017-2020): https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OHA%209920%20Health%20IT%20Final.pdf

information when their patient, member, or client has a hospital event in any hospital in Oregon or Washington.

- All of Oregon's eligible hospitals have made their ED and inpatient data available in EDIE, adding Oregon's data to the data from Washington and other states. In 2019, Oregon's Skilled Nursing Facilities (SNFs) were able to join EDIE/Collective Platform, and today over 75 percent of SNFs in Oregon participate.
- Today, all CCOs and major health plans are subscribed to the Collective Platform, most of whom extend this service to their key contracted physical, behavioral, and oral health clinics. Today, a majority of Oregon's Patient-Centered Primary Care Home clinics, over one-third of licensed behavioral health agencies, and five of nine tribally operated clinics participate, as well as all of Oregon's Dental Care Organizations.
- OHA supports the **Medicaid Collective Platform program**, which supports CCOs, DCOs, Tribal clinics, Medicaid fee-for-service contractors and others. OHA/ODHS programs also use the Collective Platform – including Medicaid and behavioral health staff coordinating care, Oregon State Hospital teams, ODHS long-term services and supports program staff including all Type B Area Agency on Aging and Aging & People with Disability District offices, and ODHS Intellectual & Developmental Disability program staff and contractors.

- **The Oregon PDMP Integration Initiative,** launched in 2018, provides all Oregon prescribers, pharmacists, and their eligible delegates electronic access to PDMP data within their electronic workflows, to better inform prescribing of controlled substances including opioids.

- 2019: CCO 2.0 contracts include new **CCO Health IT Roadmaps** and other more specific health IT requirements to ensure CCO support of physical, behavioral, and oral health providers' health IT needs in four areas: EHR adoption, HIE for care coordination, hospital event notifications (e.g., through EDIE/Collective Platform), and health IT to support value-based payments. All CCOs have OHA-approved Health IT Roadmaps and annually update Roadmaps and report on progress. Starting in 2022, Roadmaps no longer include health IT to support value-based payments (as that component is covered in a different report) and

now include health IT to support social determinants of health. Also starting in 2022, CCOs provide OHA with annual data on EHR and HIE adoption for their contracted providers.

- 2019: OHA launched the **HIE Onboarding Program,** which aimed to increase Medicaid providers' capability to exchange health information. This program supported the costs to onboard high-priority physical, behavioral, and oral health Medicaid providers, and their major trading partners, to Reliance eHealth Collaborative, a community-based HIE. Seven CCOs participated in bringing this program to their clinics. This program ended in September 2021 with the conclusion of federal HITECH funding.
- 2019-2022: **Community Information Exchange (CIE)**:[6] CCOs and health plans led the way in Oregon communities to address social determinants of health through CIEs, which connect CCOs, health plans, hospitals, and health care providers to community-based organizations (CBOs) and others providing social services.
    - OHA partnered with HIT Commons to assess the Oregon landscape and convened a statewide advisory group focusing on common functions and the future of CIE, resulting in an advisory report on CIE in Oregon (December 2020).
    - CIE efforts developed rapidly in response to COVID-19 and the increased need to connect people to social services and resources more quickly, OHA tracked the landscape and developed educational information for partners, particularly community-based organizations.
    - OHA shared information on how CIE efforts, sponsored by CCOs and health plans, allowed for local public health authorities, COVID-19 CCBO Grantees, and Tribes to join CIEs at no cost to coordinate wraparound and social services support for isolation and quarantine.
    - House Bill 4150 (2022) passed and HITOC chartered a **CIE Workgroup** which met between March and November 2022 to provide legislative recommendations and other strategies to HITOC to accelerate, support, and improve statewide CIE. CBO perspectives were collected via interviews and a survey to inform this work. A final report was submitted to the Legislature on January 31, 2023, reflecting the CIE

[6] For more information about CIE: https://www.oregon.gov/oha/HPA/OHIT/Pages/CIE-Overview.aspx

Workgroup's recommendations, perspectives from CBOs, and HITOC comment. Major next steps recommended by all three groups included financial investment supports for CBOs and developing statewide governance.[7]

Revenue sources and changes

From 2009-2021, OHA's health IT efforts were almost exclusively funded by federal 90/10 Medicaid match, under the HITECH Act, as well as some funding from Medicaid Enterprise Systems (MES) federal (formerly MMIS) matching dollars, and state General Fund. Federal 90/10 HITECH funding ended for all states in 2021, as the funds were attached to the Medicaid EHR Incentive Program, which closed at the end of 2021. The exception includes audit work for the Medicaid EHR Incentive Program, which continues to leverage 90/10 HITECH funding through September 2023. OHIT anticipates all audits will be complete no later than June 30, 2023.

OHA's health IT systems-related work transitioned to ongoing 75/25 MES federal match. Federal MES match rates depend on several factors, including whether the money is spent on health IT system planning, implementation, or operations, and how much of the work directly supports the Medicaid enterprise. OHA's health IT policy, CCO compliance, program development, and data analysis work are not eligible for MES funds and instead utilize a 50/50 (for Medicaid specific work) or 39/61 match.

Proposed new laws that apply to the program unit

None.

[7] House Bill (HB) 4150 Final Report: Supporting Statewide CIE (Jan. 31, 2023): https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/HB4150FinalReport.SupportingStatewideCIE.pdf

Office of Health Analytics

The Governor's Budget covers the Office of Health Analytics' current service level for the 2023-25 biennium.

Activities, programs and issues in the program unit base budget

The Office of Health Analytics coordinates and produces financial, quality, and performance data about Oregon's health care system, and analyzes these data for the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB). The office supports OHA's and OHPB's policy and budget decisions and assesses the impact of these decisions.

The office collects and analyzes data on the performance of Oregon's health care system to support and inform sound policy development and decision making. Examples include hospital utilization, costs, financial and cost benefit data; licensed health care workforce; insurance coverage; administrative health insurance claims through the All Payer All Claims (APAC) database and the Medicaid Management Information System (MMIS); provider tax; and many others. The office also collects and analyzes OHA program performance data, including behavioral health services evaluation and coordinated care organization (CCO) incentive metrics.

The Office of Health Analytics is organized into five complementary work units. HA staff and contractors work together to accomplish the following:

The Behavioral Health Analytics Unit collects, analyzes and reports behavioral health data to other OHA programs through:

- Analysis and reporting for the Quality Metrics, Surveys and Evaluation Unit.
- Analysis, reporting, interpretation and development of dashboards for the Director's Office, Tribal Affairs, the Health Services Division's Behavioral Health Office and Medicaid Programs, and the Alcohol and Drug Policy Commission.

Office of Health Analytics

- Cross agency data integration, analysis, interpretation and reporting for Health Services Division's Behavioral Health Office and Medicaid Programs.
- Extraction and submission of client-level treatment episode data (TEDS) for the Substance Abuse and Mental Health Services Administrations' Behavioral Health Services Information System (BHSIS).
- Data extraction and summarized analyses for external research and evaluations.

The Behavioral Health Metrics Unit supports the Health Systems Division's Behavioral Health Committee through:

- Strategic planning, staffing, and general support for the committee (alongside HSD).
- Conducting research into nationally recognized metrics for behavioral health outcomes.
- Consulting with the committee on the process of developing metric concepts.
- (As the committee's work progresses) refining and validating metrics concepts into measurable, reportable outcome metrics and developing a reporting program for CCOs, counties, and other behavioral health providers.
- Supporting the coordination and tracking needs for other various behavioral health investments made in the 2021 legislative session.

The Medicaid Analytics and Data Integration Unit collects, analyzes and reports Medicaid operations data to other agency partners and interested parties. Provides technology, system and infrastructure support for the Office of Health Analytics through:

- Analysis, reporting, interpretation and development of dashboards for Health Services Division's Medicaid Programs
- Data governance, privacy and security
- Data request and data sharing process management
- Cross-agency data strategy, integration and coordination
- Data systems and infrastructure – data warehousing, server management, and documentation

Office of Health Analytics

The Quality Metrics Surveys & Evaluation Unit facilitates the use of data to understand the quality of health care through:

- Measuring CCOs' performance using the CCO incentive metrics, state quality metrics and CMS Adult and Child Core metrics, including pilots of REALD analyses of performance disparities and pandemic-related adaptations in benchmarking.
- Program evaluations, including the 1115 Oregon Health Plan Medicaid demonstration waiver.
- Member experience and other surveys, including the Consumer Assessment of Health Providers and Systems Survey (CAHPS) of Medicaid members, the Mental Health Services Improvement Program (MHSIP) surveys for Medicaid members receiving mental health services, and the Oregon Health Insurance Survey (OHIS) conducted among all people living in Oregon.
- Metrics development to track the most innovative aspects of the health care transformation, including health equity[1] and social determinants of health.[2]

The Research and Data Unit supplies data and analytics services to state government and external partners through:

- Maintenance of Oregon's APAC database – collecting, compiling, releasing to approved users and reporting claims and administrative data.
- Collection, analysis, reporting and development of dashboards of health care workforce data from licensees of 17 health care licensing boards.
- Collection, analysis, reporting and development of dashboards of hospital inpatient, outpatient data and emergency department data; hospital financial data including community benefit reporting; and other critical hospital information.

[1] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Health-Equity-Measurement-Workgroup.aspx
[2] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/sdoh-measure.aspx

Office of Health Analytics

Background information

The Office of Health Analytics provides reports and recommendations so that OHA leadership, the Governor, and the Legislature can better understand and improve the performance of OHA programs and the quality of Oregon's health system.

Health Analytics' primary roles are:

- To develop analyses, data strategies, and monitoring tools to assess the performance of Oregon's health care systems.
- To support OHA policy development, implementation, and evaluation.

During the 2021-23 biennium, Health Analytics supported numerous high-priority policy initiatives, including:

The Community Benefit Spending Floor Program. House Bill 3076 (2019) charged OHA with establishing minimum levels of community benefit spending for Oregon hospitals every two years. Community benefit investments include financial assistance for individual patients, Medicaid shortfalls, and, perhaps most significantly for OHA's equity goals, community-level investments in social determinants of health and health equity. House Bill 3076 contains the first statutory definition of the social determinants of health. The spending floor program seeks to encourage spending that meets community-identified needs and aligns with OHA priorities and calls on OHA to consider hospitals' alignment with CCOs' community needs assessments when setting minimum spending floors. Health Analytics will leverage the program's reporting requirements to tell the story of hospital community benefit spending in greater detail than has been previously possible.

Sustainable Health Care Cost Growth Target. Senate Bill 889 (2019) established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority (OHA). The cost of health care in Oregon has

grown and is projected to grow faster than both the state economy and Oregonians' wages. A health care cost growth target will serve as a target for the annual per capita rate of growth of total health care spending in the state. Cost increases of health insurance companies and health care providers will be compared to the growth target each year. The program will also evaluate and annually report on cost increases and drivers of health care costs. The Office of Health Analytics is supporting this program by developing data reporting templates, analyzing existing data sets to establish a common understanding of historical health care cost trends, and supporting the program's Implementation Committee tasked with making key programmatic decisions.

REALD data repository. This work is intended to create a systematic, aggregated repository of data to help fill in gaps in race, ethnicity, spoken and written language, and disability (REALD) demographic data collected pursuant to House Bill 2134 (2013). The legislation requires REALD data to be collected by OHA and the Oregon Department of Human Services (ODHS) for any data system that collects demographics. Implementation of House Bill 2134 has been slow and uneven due to factors such as cost to modify data systems and complexity of implementing the requirements correctly. This repository is intended as a temporary solution until OHA and ODHS data collection systems can implement REALD successfully.

APAC Data Vendor Transition. In January 2021, Health Analytics transitioned the state's legislatively-mandated All Payer All Claims database to a new vendor, the Human Services Research Institute (HSRI). HSRI's more robust technical infrastructure allows greater processing speeds for OHA's data analysts for improved productivity. This allows flexibility in use by other programs and agencies for timely use of APAC data in assessing costs and cost drivers, analyzing legislative bills, informing budgets and planning program activities. House Bill 3159 (2021) will enhance race and ethnicity data available from insurers, allowing APAC to be a stronger resource for assessing health inequities.

Drug Addiction Treatment and Recovery Act of 2020. The purpose of Ballot Measure 110 is to make screening, health assessment, treatment and recovery services for drug addiction available to all those who need and want

access to those services and to adopt a health approach to drug addiction by removing criminal penalties for low-level drug possession. This is a comprehensive approach that also addresses social determinants of health such as coexisting health problems, housing, employment and training, childcare and other services. The Office of Health Analytics is supporting this program by developing data collection and reporting protocols for the full spectrum of services and outcome measures of the impact of the Behavioral Health Resource Networks.

Behavioral Health Committee and Workforce Initiative. House Bills 2086 and 2949 were among several significant investments in behavioral health care during the 2021 session. These efforts aim to improve the quality of behavioral health services and create more opportunities for individuals from underrepresented communities to join the workforce. Health Analytics provides the data and analysis to pinpoint these investments and evaluate their effectiveness.

COVID-19 Emergency Outcome Tracking Measure Program. This program was implemented in 2021 to reward CCOs for making substantial progress in vaccinating their members, with a particular focus on ensuring CCOs reached higher vaccination rates across all race/ethnicity groups. A report of CCO performance will be published in summer 2022.

Examples of Health Analytics' reports:

- Medicaid Monthly Population Reports:[3] An interactive display containing eight separate tabs
- More Medicaid Enrollment reports can be found here[4]

[3] https://app.powerbigov.us/links/qdWQUdlHhc?ctid=658e63e8-8d39-499c-8f48-13adc9452f4c&pbi_source=linkShare&bookmarkGuid=ae3764b7-78ad-406b-b596-0ea861e485be
[4] https://www.oregon.gov/oha/hsd/ohp/pages/reports.aspx

Office of Health Analytics

CCO Metrics Reports

- Medicaid Quality Performance – Current[5] and Historical[6]
- Consumer Assessment of Health Plan Survey (Medicaid Experience)[7]
- Mental Health Statistical Improvement Program Survey (MHSIP-Consumer) - Overall and by CCO[8] and Historical[9]

Oregon Health Insurance Survey (OHIS) (general population insurance)

- Overview of OHIS and links to resources and past static reports[10]
- Tableau: Insurance Coverage[11]
- Tableau: The Uninsured[12]

Children's health complexity data

- State, County and CCO medical and social complexity scores[13]

[5] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-Annual-Report_FINAL.pdf
[6] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-CCO-Performance-Report.pdf
[7] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CAHPS.aspx
[8] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Mental-Health-Statistics-Improvement-Program-Survey.aspx
[9] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/MHSIP-Survey-Archives.aspx
[10] https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Insurance-Data.aspx
[11] https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHealthInsuranceCoverageRates/Overview?:iid=1&:isGuestRedirectFromVizportal=y&:embed=y
[12] https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonUninsuranceRates/Overview?:iid=2&:isGuestRedirectFromVizportal=y&:embed=y
[13] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx

Office of Health Analytics

Hospital financials (quarterly hospital financial and utilization data)

- Tableau dashboard[14] (updated quarterly)
- Tableau dashboard appendix with individual hospital data[15] (updated quarterly)
- Static report summaries of current trends and historical reports[16]

Hospital payment reports (annual report of median amounts paid by insurers for common hospital procedures)

- Tableau dashboard[17] (updated annually)
- Website with data files and historical reports[18]

Community benefits (annual report of hospital community benefit spending by category)

- Tableau dashboard: [Coming soon]
- Website with historical reports[19]

[14] https://visual-data.dhsoha.state.or.us/t/OHA/views/Databankdashboard/Mainpage?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no&:origin=viz_share_link

[15] https://visual-data.dhsoha.state.or.us/t/OHA/views/DatabankAppendix/Welcome?:isGuestRedirectFromVizportal=y&:embed=y%20%E2%80%A2Static%20report%20summaries%20of%20current%20trends%20and%20historical%20reports

[16] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

[17] https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHospitalPaymentReport2018/Welcome?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no&%3Aorigin=viz_share_link

[18] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

[19] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx

Office of Health Analytics

Health care workforce occupational profiles (annual report of licensed professionals; includes demographics, county-level details, hours worked per week, and other practice information)

- Tableau dashboard[20] (updated annually)
- Website with historical reports[21]

Health care workforce diversity reports

- 2020 report: [Coming soon]
- Tableau dashboard report appendix: [Coming soon]
- Website with historical reports[22]

Health care workforce supply reports

- 2020 report - coming soon
- Tableau dashboard report appendix: [Coming soon - not yet published]
- Website with historical reports[23]

Other reports

- Low Value Care Report[24]

[20] https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce/Overview?%3Aorigin=card_share_link&%3Aembed=y&%3AisGuestRedirectFromVizportal=y#1

[21] https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

[22] https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

[23] https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

[24] https://www.oregon.gov/oha/ERD/Pages/ReportIdentifiesLowValueCareInOregonHealthSystem.aspx#:~:text=There%20were%20772%2C094%20services%20found,in%202016%2C%202017%20and%202018

- Primary Care Spending Reports - 2021 report[25] and Historical[26] reports

Revenue sources and changes

The Office of Health Analytics leverages Medicaid administrative match for eligible programs and activities, including Medicaid-related health system transformation, research and evaluation, and staffing.

Several programs within Health Analytics, including the health care workforce reporting program, hospital reporting program, APAC and TEDS BHSIS data submissions are partially supported by Other Funds revenues.

Proposed new laws that apply to the program unit

Legislative concept #468: The HPA housekeeping bill includes technical fixes related to the Oregon All Payer All Claims (APAC) program (1) to align the APAC statute on collection of race and ethnicity data and (2) to authorize APAC to collect actuals cost for data requests for researchers and employers.

Policy Package #201/Legislative Concept #475: Policy package #201 contains staffing and funding for Office of Health Analytics to support the implementation of two components of the 1115 Medicaid demonstration waiver. The first body of work consists of redesigning the CCO Quality Incentive Program to incentivize equitable health outcomes and implementing the new structure. The second body of work consists of designing and implementing the CMS-required waiver evaluation so that it centers equity and community voice and produces evaluation results that are relevant and actionable for OHA.

[25] https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpendingDocs/2020-Oregon-Primary-Care-Spending-Report-Legislature.pdf
[26] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Primary-Care-Spending.aspx

Oregon Health Insurance Marketplace

The Governor's Budget covers the Oregon Health Insurance Marketplaces' current service level for the 2023-25 biennium. It also includes policy package #434, which provides position authority to expand outreach and education initiatives focusing on communities harmed by health inequities and most affected by social inequities.

Activities, programs, and issues in the program unit base budget

The Oregon Health Authority (OHA) administers the Oregon Health Insurance Marketplace, which helps Oregonians leverage federal subsidies and enroll in private health insurance plans that best fit their health and financial goals and needs.

Programs

The Program Administration Unit:

- Works with federal partners in ensuring eligibility and enrollment systems are available and accessible to Oregonians.
- Creates equity-centered outreach and education strategies to drive enrollment with a focus on identified communities harmed by health inequities and most affected by social inequities.
- Develops rules and policies to help eliminate health inequities and monitors the market for emerging trends.
- Engages partners from diverse communities in establishing and implementing policy and gathering feedback from community.
- Approves carriers and certifies qualified health plans (QHPs) to be offered through the Marketplace.
- Certifies on- and off-exchange and stand-alone dental plans for compliance with federal pediatric dental requirements.
- Provides data, information, and analyses to policymakers.
- Ensures compliance with federal and state regulations.
- Administered the Compact of Free Association (COFA) Premium Assistance Program through June 2022.

Oregon Health Insurance Marketplace

The Outreach and Education Unit:

- Conducts equity-centered outreach and education to Oregonians eligible for Marketplace coverage.
- Provides free, accessible, and objective local enrollment assistance.
- Connects consumers with insurance agents and community partners for one-on-one assistance.
- Educates consumers who have Marketplace coverage on post-enrollment health insurance literacy and plan utilization.
- Provides competitive grants for outreach and enrollment activities to community partners, insurance agents, and Tribal health clinics.
- Cultivates relationships with Oregon Tribal communities and provides outreach, education, Tribal health insurance policy, and operational direction services.
- Cultivates relationships and provides subject matter expertise support to Marketplace partners and community-based organizations.
- Provides English and Spanish training and certifies more than 1,000 community partners on Marketplace application assistance.
- Assists Oregonians with complex case resolution.
- Implements a mandated call center dedicated to answering questions from individuals seeking enrollment in a qualified health plan.

Activities

During the 2021-23 biennium, the Oregon Health Insurance Marketplace had numerous accomplishments, including:

Outreach and Policy:

- Achieved enrollment of 141,089 for the 2021 plan year, 146,602 for the 2022 plan year, and 141,963 for the 2023 plan year.

Oregon Health Insurance Marketplace

- Facilitated a competitive marketplace in the 2021, 2022, and 2023 plan years, with six medical carriers and six dental carriers. Four medical carriers and four dental carriers offered statewide coverage. Every Oregonian was offered at least 26 medical plans and 10 dental plans. Most Oregonians had access to at least 36 medical plans and 19 dental plans.
- Deployed an effective statewide mass education campaign through radio, television, digital, and social media.
- Received 12,617 calls from July 1, 2021, to December 31, 2022, through a state-based outreach center.
- Attended 313 outreach events in 2021 and 688 in 2022. These were both in in-person and virtual formats for a variety of audiences such as those for Tribal communities, LGBTQIA2S+ people, faith-based groups, and Latino, Latina, and Latinx individuals. Locations of in-person events included libraries, self-sufficiency offices, community-based organizations, and businesses.
- Provided grant and policy support to partner agents who, during the open enrollment period for the 2021 plan year, enrolled 9,557 consumers into Marketplace plans and for the open enrollment period for the 2022 plan year, enrolled 10,118 into Marketplace plans. For coverage year 2022, Oregonians made 50,565 total plan selections with an agent. With 829 active agents, Marketplace partners — even with the challenges presented by the pandemic — still accounted for 20 percent of total plan selections.
- Provided outreach, education, and private plan application assistance to Oregon Tribal Nations.
- Provided comprehensive Marketplace Assister Training to more than 1,400 community partners and Marketplace Overview Training to more than 743 certified application assisters and community partners. Many of the community partners specialize in providing equity-centered outreach to communities of focus harmed by health inequities and most affected by social inequities. Furthermore, many of these assisters and community partners are trained in assisting people in special situations, including survivors of domestic violence, people with seasonal income, and refugees. In 2022, the Marketplace increased the number of overall assisters who completed Marketplace training by 8 percent. Accessibility of the training program was improved by launching all levels of training in English and Spanish, providing closed captions and an accessibility menu, and making the training available online on-demand. Cultural humility training was added on all levels to help community partners

provide more equitable service to Oregonians. A robust multi-level training on diversity and equity was made available for assisters and community partners who may not have the training resources within their own organization. For organization leaders and managers, an optional training that addresses the importance of diversity in the workplace was made available.

- Achieved 17,990,388 community partner outreach contacts and provided 108,372 instances of application assistance resulting in 3,167 Marketplace applications and 13,619 Oregon Health Plan applications since January 1, 2021.
- Increased the number of community partner grantees to address service equity gaps in Southern Oregon, Central Oregon, and Oregon's Latino, Latina, and Latinx communities.
- Resolved 98 cases between July 1, 2021, and June 30, 2022. The nationally declared public health emergency likely resulted in roughly a 21 percent increase in cases from the prior 12 months, with more consumers having overlapping coverage with Medicaid. This type of issue can only be resolved at the state level. Complex customer support requires case resolution for urgent issues when consumers believe they did not receive adequate or effective help from the HealthCare.gov call center.
- Participated in the staffing of the House Bill 4035 (2022) task force and work group working on issues related to the end of the federal public health emergency (PHE).
- Developed and implemented outreach and education and operational strategies to transition individuals no longer eligible for the Oregon Health Plan to coverage through the Marketplace.
- Participated in multiple OHA agency coverage and policy initiatives, including Healthier Oregon.

COFA Premium Assistance Program:

- Provided premium assistance and cost-sharing reimbursements to 802 COFA members during the 2022 plan year.
- Helped to successfully transition COFA Premium Assistance Program enrollees to the Oregon Health Plan.
- Closed the program on June 2022, reconciling final premium payments and cost-sharing reimbursements.

Oregon Health Insurance Marketplace

COVID-19:

- Achieved Marketplace enrollment of 22,743 Oregonians during the COVID-19 special enrollment period that ended on August 15, 2021.

Background information

The Oregon Health Insurance Marketplace was a division of the Department of Consumer and Business Services from its inception in 2015 through June 30, 2021. On July 1, 2021, the Oregon Health Insurance Marketplace was transferred to the Oregon Health Authority, where it remains as an office of the Health Policy and Analytics Division.

Enabling legislation/program authorization

The Oregon Health Insurance Marketplace is governed by the following chapters of the Oregon Revised Statutes:

- ORS 741 – Oregon Health Insurance Exchange
- ORS 413 (ORS 413.610 – 413.613) – COFA Premium Assistance Program

Revenue sources and changes

Health Insurance Marketplace Fees

The Oregon Health Insurance Marketplace is funded through a per-member-per-month (PMPM) fee charged to insurance companies for medical plans and dental plans purchased through the marketplace.

Statute provides that the assessment rates be set annually by the director of OHA after consultation with the Health Insurance Marketplace Advisory Committee and a public hearing. The PMPM rate is included in the health insurance premiums of individuals, so is set in the spring of the year prior to its implementation.

Oregon Health Insurance Marketplace

Proposed new laws that apply to the program unit

Policy package #416 and legislative concept #471 would transition the Oregon Health Insurance Marketplace away from the federally facilitated marketplace (FFM) to a state-based enrollment and eligibility platform and call center for operation and administration of Oregon's health insurance exchange. OHA envisions that funding will be in two phases. Phase I funds would be used for research and planning purposes through the request for proposals (RFP) stage, completion of the Department of Administrative Services' (DAS) Stage Gate process and drafting of the required federal blueprint to transition from a state-based marketplace on the federal platform (SBM-FP) to a full state-based marketplace (SBM). Phase II funds would be used for purchase and operation of the platform, call center implementation, and any additional staff necessary for operation of the new platform.

Public Employees' Benefit Board

The Governor's Budget covers the Public Employees' Benefit Board's current service level for the 2023-25 biennium. The budget also includes funding in policy package #435 to continue the Benefits Management System replacement project to improve user experience and customer care as well as policy package #438 for Affordable Care Act 1095 mandatory reporting.

Activities, programs and issues in the program unit base budget

PEBB's authority lies in ORS 243.061 through ORS 243.302. House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts. As directed by the 1997 Legislature, the Public Employees' Benefit Board (PEBB) was established in 1998 to merge the State Employees' Benefit Board (SEBB) and the Bargaining Unit Benefits Board (BUBB) programs into one program. PEBB's mission is to provide a high-quality plan of health and other benefits for state employees at a cost that is affordable to both the employees and the state. Its statutes create an eight-member board whose members are appointed by the Governor and confirmed by the Senate. PEBB serves broadly diverse constituencies, including the State of Oregon (as an employer), employees who live and work in every county of Oregon and in every state across the nation, the Legislature, taxpayers, labor unions and health policy groups.

The PEBB Board works to achieve its goals by adhering to the following values:

- Offering employee choice among high quality plans
- Creating a competitive marketplace
- Closely managing plan performance and monitoring quality data
- Innovative, flexible plan designs
- Delivering high quality customer service
- Advancing health equity and eliminating disparities in priority populations
- Commitment to improving employee health

Public Employees' Benefit Board

Background information

The Public Employees' Benefit Board (PEBB) designs, contracts for, and administers health plans, group insurance policies, and flexible spending accounts for state and university employees and their dependents. The board provides medical and dental insurance programs representing about 140,000 Oregonians. The board also selects and administers life and disability insurance coverage for eligible state and university employees. A major part of the board's responsibility is developing benefit packages to meet the needs of state government and its employees, preparing benefits information for communication materials, and answering inquiries from employees and their dependents about coverage.

PEBB members include active agency and university employees and their dependents; active semi-independent agency employers and their employees; early retirees and other self-pay members and their dependents; and COBRA subscribers. The program is administered by staff, with actuarial services and third-party administrator services provided through contract.

PEBB Operations is funded entirely with Other Funds. PEBB collects premiums for all insured individuals, and then purchases insurance with those revenues. The resources to pay for employee health insurance are budgeted in each state agency for that agency's employees. The resources may be General Fund, Lottery Funds, Other Funds, or Federal Funds. Once the resources are transferred to PEBB, they are shown as Other Funds.

For fully-insured plans, the premiums PEBB collects are passed through to the appropriate insurance carrier who carry the risk on those plans. For self-insured plans, PEBB carries the risk and must maintain a Stabilization Fund, which requires a sufficient balance to cover large claims risk.

Public Employees' Benefit Board

Operational costs are funded through an administrative charge (assessment) added to medical and dental insurance premiums and premium equivalents. By statute, the assessment cannot exceed 2 percent of monthly contributions from employees and employers.

The Operations Budget is approximately 1 percent of the Total Funds budget for PEBB. The core functions of PEBB Operations include administrative areas: communications, financial services, contracts, health policy, employee wellness, regulatory, IT systems and data management, and member services. In 2017, Senate Bill 1067 directed the merger of the administrative functions of PEBB and the Oregon Educators Benefit Board (OEBB) under one executive director and leadership team. The boards have engaged in many joint initiatives since then and are currently building a joint eligibility and enrollment system. The board delegates many important functions to operations staff including:

- Operational and administrative actions required to administer services to members and implement benefits (for example, rule-making authority)
- Other activities as determined by the chair and vice-chair
- Directing rate negotiations with vendors through PEBB's contracted consultant
- Directing contract negotiations for implementation and renewal of PEBB programs and benefits once the board has awarded contracts to successful vendors or has approved renewals of existing program contracts
- Authority to initiate contracts for specific services that fall under the not-to-exceed dollar amount threshold established in state procurement laws for direct contracting and informal procurements
- Authority to initiate transfer of excess reserve funds held by contracted carriers or refunds from contracted vendors to PEBB Stabilization Fund
- Authority to pay claims, invoices, purchase orders, travel expenses, maintenance agreements and personal service agreements

<u>Annual Renewal Process</u>

Public Employees' Benefit Board

Each year, the board begins an annual plan renewal process where benefit offerings are examined, premium rates are re-negotiated with carriers, administrative fees are projected, and final decisions are made by the board for the following plan year. Once the board finalizes renewal decisions and they are captured in renewal letters to carriers, the PEBB administrative team gets to work operationalizing their decisions:

- The Contracts team begins working to update contracts
- IT Systems staff begin work with contractors to implement changes in the PEBB benefits system (PDB)
- The Communications team begins updating open enrollment materials with rates and benefit changes
- Member Services staff readies for open enrollment October 1st through October 30th.

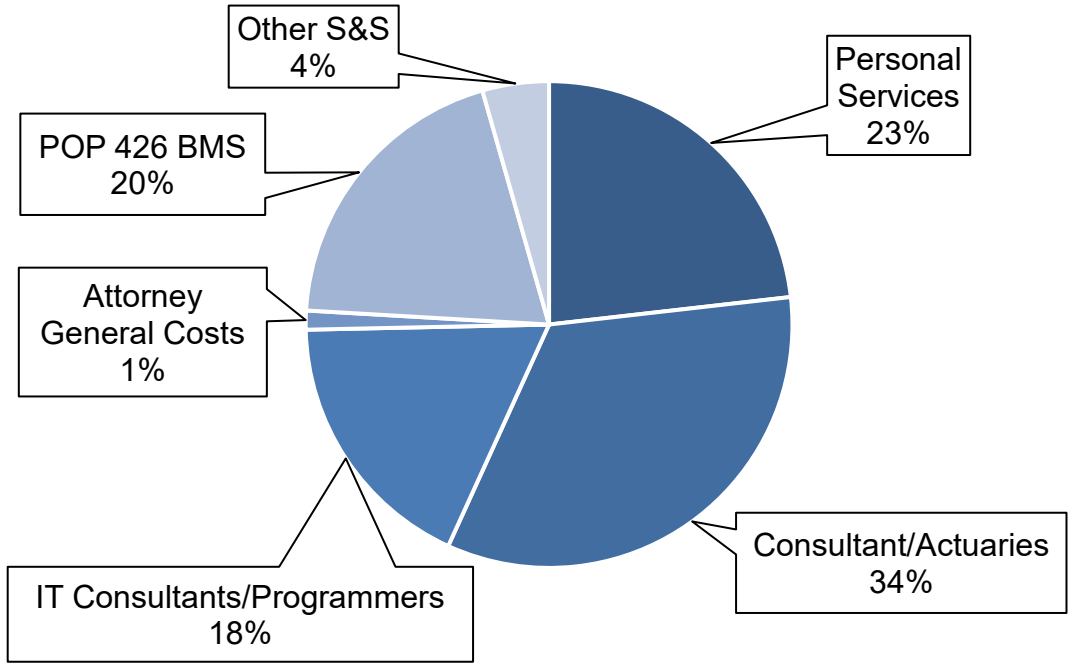
Operating expenditures are mainly driven by personal services, consultant actuary costs, IT consultant/programming costs, attorney general costs and open enrollment and wellness costs.

Public Employees' Benefit Board

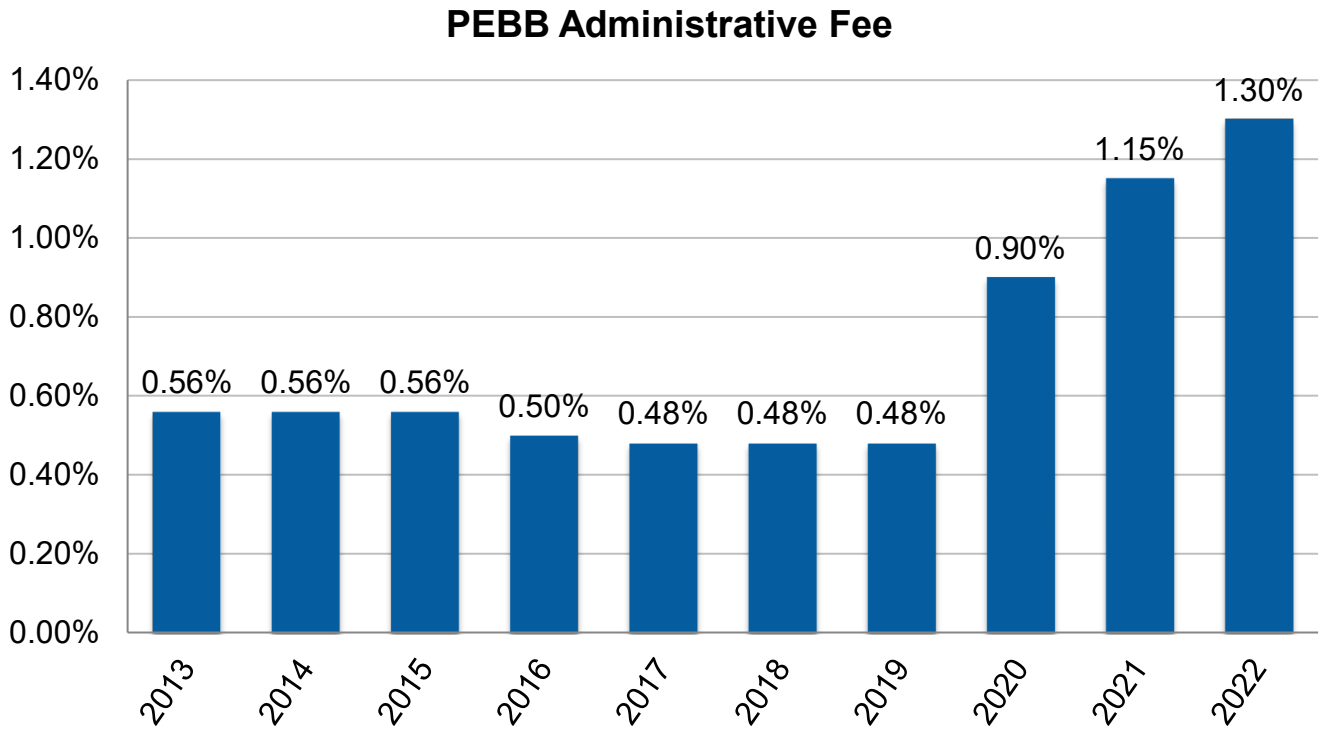
Revenue sources and changes

Other Funds revenue pays for PEBB administration through an administrative assessment added to medical and dental insurance premiums and premium equivalents. By statute (ORS 243.185), PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs.

PEBB Operating Budget



In recent years, the administrative fee was not an adequate source of revenue to cover the development of the Benefit Management System (BMS) project and the increase in system programming costs. A main goal of the boards was to construct the new BMS without having to borrow the funds to do it. Consultant costs have also increased from prior years driven by the passage of Senate Bill 1067 (2017) and funding the work of the joint PEBB/OEBB Innovation Work Group (IWG) and joint Health Equity Work Group. These investments will end up saving the state money over the long term by becoming more efficient and having better data to make better decisions. As the new system development project ends and the old system is phased out, the administrative fee is likely to decrease back to under 1 percent.



Proposed new laws that apply to the program unit

None.

Oregon Educators Benefit Board

The Governor's Budget covers the Oregon Educators Benefits Board's current service level for the 2023-25 biennium and includes funding in policy package #435 to continue the Benefits Management System replacement project to improve user experience and customer care.

Activities, programs and issues in the program unit base budget

The Oregon Educators Benefit Board (OEBB) was established by the 2007 Legislature. OEBB provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments across the state. OEBB offers a multitude of plans that resemble an "exchange." OEBB started offering medical, dental, and vision coverage in 2008 and has since added a broad range of additional benefits including life, accidental death and dismemberment (AD&D), short-term and long-term disability and long-term care insurance, as well as an employee assistance program (EAP), a health savings account (HSA), flexible spending accounts (FSAs), and commuter savings accounts. Each of the 256 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing with employees, and diverse populations. The law prohibits those entities, with certain exceptions, from offering benefit plans other than those offered by the Board. Unlike PEBB, all plans are fully insured. OEBB has prioritized choice in plan options for employers and employees, and consequently offer a large number of different plans.

The board and staff have been focused on coming out of the pandemic with an improved overall health status of its members and a moderate impact to cost trends. The Oregon Health Policy Board has worked on coordinated care model alignment, looking for ways to utilize a model with coordinated care attributes in programs such as OEBB. Over the last few years, OEBB has implemented a number of programs that fit within this model. This includes increasing the percentage of OEBB members in patient-centered primary care homes, implementing additional cost tiers to promote value-based benefits, full coverage for preventive services, coverage for weight management and tobacco cessation programs, and implementing benefit design to reduce barriers to care for members with chronic

diseases. The Board implemented the Healthy Futures program to promote member participation in reducing health risks and improving overall health status.

Background information

OEBB Operational costs are funded entirely with Other Funds revenue through an administrative charge (assessment) added to medical and dental insurance premiums and premium equivalents. By statute, the assessment cannot exceed 2 percent of monthly contributions from employees and employers. Each month OEBB invoices its participating entities after reconciling eligibility, collecting premiums for all insured individuals. OEBB withholds the administrative assessment revenue and then purchases insurance with the remaining premium revenues. The resources to pay for employee health insurance is included in the State School Fund distribution. Once the premiums are collected by OEBB, they are shown as 100 percent Other Funds in OEBB's budget.

The Operations Budget is approximately 1 percent of the Total Funds budget for OEBB. The core functions of OEBB Operations include administrative areas: communications, financial services, contracts, health policy, employee wellness, regulatory, IT systems and data management, and member services. In 2017, Senate Bill 1067 directed the merger of the administrative functions of OEBB and the Public Employees' Benefit Board (PEBB) under one executive director and leadership team. The boards have engaged in many joint initiatives since then and are currently building a joint eligibility and enrollment system. The board delegates many important functions to operations staff including:

- Operational and administrative actions required to administer services to members and implement benefits (for example, rule-making authority)
- Other activities as determined by the chair and vice-chair
- Directing rate negotiations with vendors through OEBB's contracted consultant
- Directing contract negotiations for implementation and renewal of OEBB programs and benefits once the board has awarded contracts to successful vendors or has approved renewals of existing program contracts

Oregon Educators Benefit Board

- Authority to initiate contracts for specific services that fall under the not-to-exceed dollar amount threshold established in state procurement laws for direct contracting and informal procurements
- Authority to initiate transfer of excess reserve funds held by contracted carriers or refunds from contracted vendors to the OEBB Stabilization Fund
- Authority to pay claims, invoices, purchase orders, travel expenses, maintenance agreements and personal service agreements

Annual Renewal Process

Each year, the board begins an annual plan renewal process where benefit offerings are examined, premium rates are re-negotiated with carriers, administrative fees are projected, and final decisions are made by the board for the following plan year. Once the board finalizes renewal decisions and they are captured in renewal letters to carriers, the OEBB administrative team gets to work operationalizing their decisions:

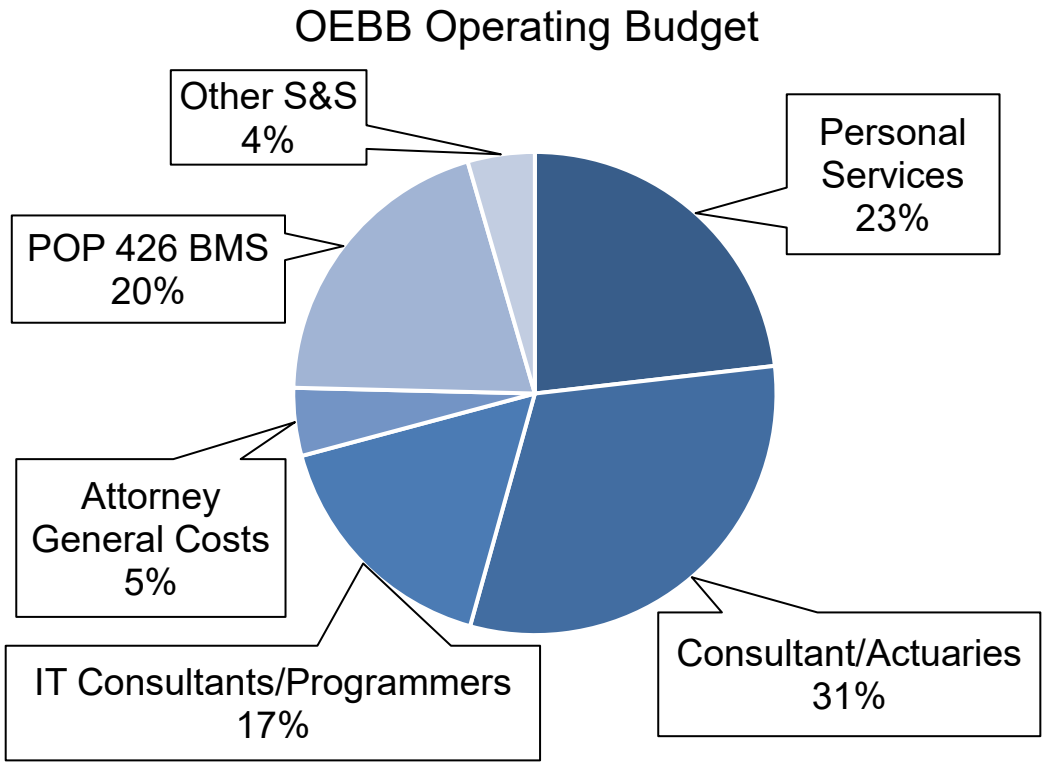
- The Contracts team starts updating contracts.
- IT Systems staff begin work with contractors to implement changes in the OEBB benefits system (MyOEBB).
- The Communications team begins updating open enrollment materials with rates and benefit changes.
- Member Services staff readies for open enrollment, which is from August 15 to September 30.

Operating expenditures are mainly driven by personal services, consultant actuary costs, IT consultant/programming costs, attorney general costs and open enrollment and other costs.

Oregon Educators Benefit Board

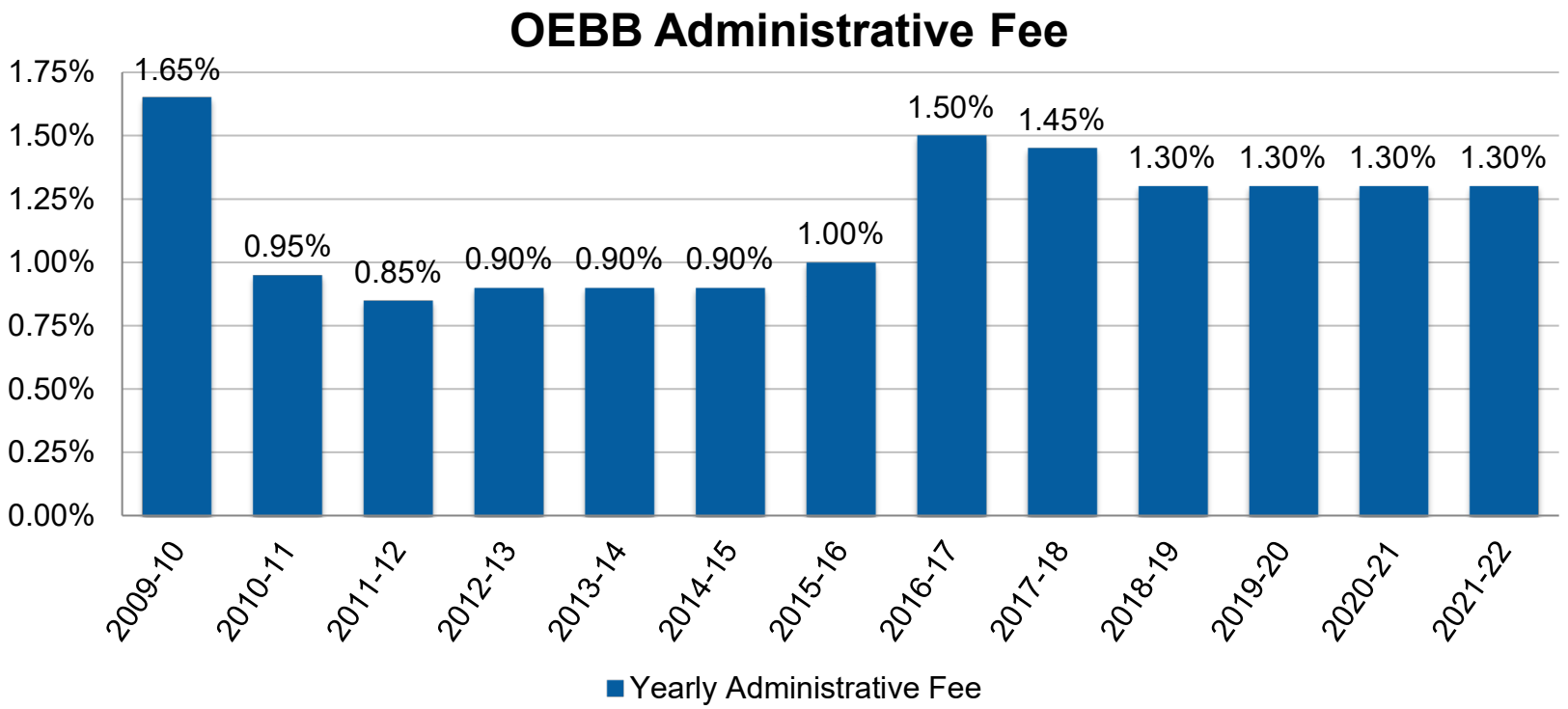
Revenue sources and changes

Oregon Revised Statute (ORS) 243.880 established the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated through an administrative fee included in premiums for OEBB medical, dental and vision benefits, which is considered Other Funds revenue. By statute, the administrative fee cannot exceed 2 percent of total monthly premiums. ORS 243.882 prohibits the balance in the account from exceeding 5 percent of the monthly total of employer and employee contributions for more than 120 days.



In recent years, the administrative fee was not an adequate source of revenue to cover the development of the Benefit Management System (BMS) project and the increase in system programming costs. A main goal of the boards was to construct the new BMS without having to borrow the funds to do it. Consultant costs have also increased from prior years driven by the passage of Senate Bill 1067 (2017) and funding the work of the joint PEBB/OEBB Innovation Work Group (IWG) and joint Health Equity Work Group. These investments will end up saving the state money over the long term by becoming more efficient and having better data to make more informed decisions. As the new system development project ends and the old system is phased out, the administrative fee is likely to decrease back closer to 1 percent.

Oregon Educators Benefit Board



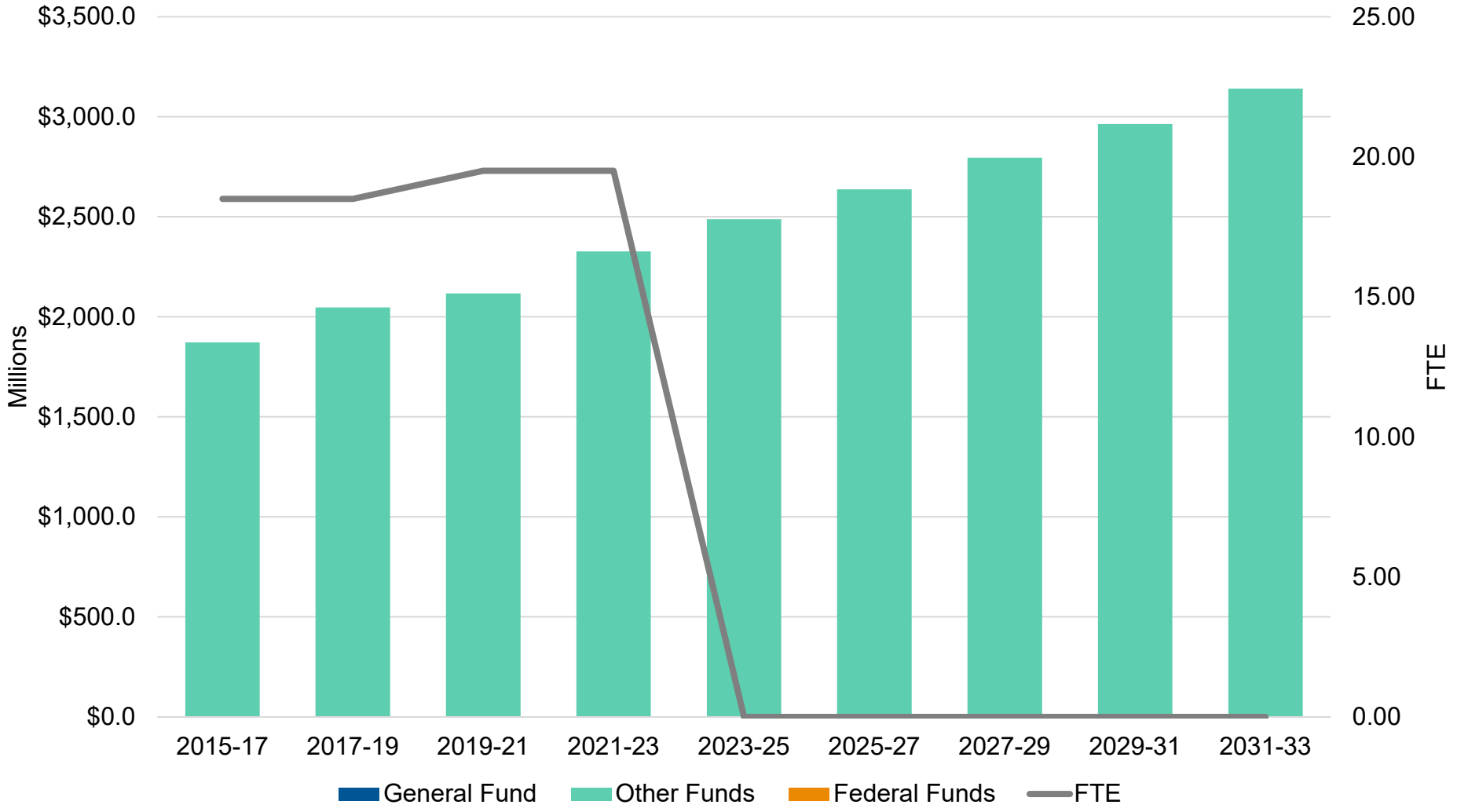
Proposed new laws that apply to the program unit

None.

Oregon Health Authority: Public Employees' Benefit Board

Executive Summary

Program Contact: Ali Hassoun, Director
503-378-2798



Executive Summary

Division overview

The Public Employees' Benefit Board (PEBB) is a division of the Oregon Health Authority (OHA). PEBB supports the goals of transforming the health care system in Oregon and fundamentally improving how care is paid for and delivered. The PEBB board's mission is to provide high-quality health plans and other benefits for state employees at a cost that is affordable to both the employees and the state.

Funding request

The Governor's Budget for PEBB for the 2023-25 biennium to continue current service levels, which includes cost growth for PEBB medical premiums, both self-insured and fully insured, at 3.4 percent. It also includes the cost to PEBB to implement payer parity in the behavioral health crisis system in policy package #429. All PEBB expenditures are categorized as Other Funds.

Program descriptions

PEBB designs, contracts for and administers medical, dental, vision, life, disability, and accidental death and dismemberment plans and flexible spending accounts for PEBB members. More than 140,000 members are enrolled in PEBB coverage. They include active employees, retirees, spouse and domestic partner dependents, child dependents up to age 26, and adult children with disabilities over age 26. They are drawn from state agencies, universities, Lottery and semi-independent agencies, and local governments and special districts.

PEBB's major cost driver is rising health care costs, which is mainly driven by unit health care cost inflation which makes controlling premium costs a major challenge. PEBB has always sought ways to manage costs through innovative plan designs and payment strategies. PEBB has incorporated "value-based" payments into plan design and aligned VBP targets with CCO goals to drive use of high-value services with aspirational goals.

Executive Summary

Program justification and link to long-term outcomes

Transforming health care and advancing health equity

The PEBB board has made transforming the health care delivery system a priority and advances transformation with plans that coordinate care. PEBB has partnered with its "sister program" the Oregon Educators Benefit Board (OEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. Both boards are continuing to expand these systems of care throughout the state with a focus on integrated care and reducing health care costs and identifying and addressing health disparities. In 2021, PEBB and OEBB formed a joint subgroup of the boards focused on advancing and ensuring health equity, called the "Joint Subcommittee on Health Equity". The committee consists of two board members from each board, expert consultants, and staff. The committee supports OHA's goal of eliminating health inequities by 2030.

PEBB and OEBB are fully committed to working together to leverage their purchasing power across the state and have started working with the Insurance Marketplace to further leverage the state's healthcare purchasing power. The "Joint PEBB and OEBB Innovation Workgroup" was formed in 2018 with board members from each board and legislators to develop strategies on cost containment, how to best leverage claims data stores for analysis of quality and cost performance, and developing payment initiatives to ensure meeting the 3.4 percent cap every year.

Value-based benefits

Traditional fee-for-service models provide payment for each health care visit, service, or test. Value-based payments shift focus from volume to value by rewarding providers for delivering high quality care that supports improved outcomes and slower cost growth. As shown in the table below, OEBB and PEBB health plans currently incorporate a variety of value-based payment strategies to incentivize provider quality and efficiency. Many of the general strategies used align with value-based payment approaches also used by coordinated care organizations (CCOs) serving Oregon's Medicaid population.

Executive Summary

Many of the strategies used by PEBB & OEBB align with value-based payment approaches also used by Coordinated Care Organizations (CCOs) serving Oregon's Medicaid population.

	OEBB	PEBB	CCO
Infrastructure payments	■	■	■
Pay for reporting	■	■	■
Pay for performance	■	■	■
Shared savings with upside risk	■	■	■
Shared savings upside and downside risk	■	■	■
Condition-specific population-based payment			■
Comprehensive population-based payment	■	■	■
Integrated finance and delivery system	■	■	■

PEBB and OEBB continue to work toward increasing the percentage of total health care payments that use value-based approaches and have identified future year targets that closely align with those established for CCOs. PEBB and OEBB currently have approximately 47 percent of total medical expenditures in a VBP arrangement with a goal of 70 percent by 2024, thereby matching the goals as defined in CCO 2.0.

<u>Wellness initiatives and promoting member health</u>

In 2020 many PEBB members began working remotely due to the COVID-19 pandemic. Flexible work schedules continue to be the norm. As a result, PEBB's employee wellness efforts shifted away from a focus on environmental approaches and toward increasing communications directly to members to promote PEBB wellness programs, and to help them understand and access their benefits.

The Worksite Wellness Coordinating Council and the PEBB Member Advisory Committee (PMAC) developed and began implementing a Member Wellbeing Strategy aimed at addressing needs identified by both groups. Specifically,

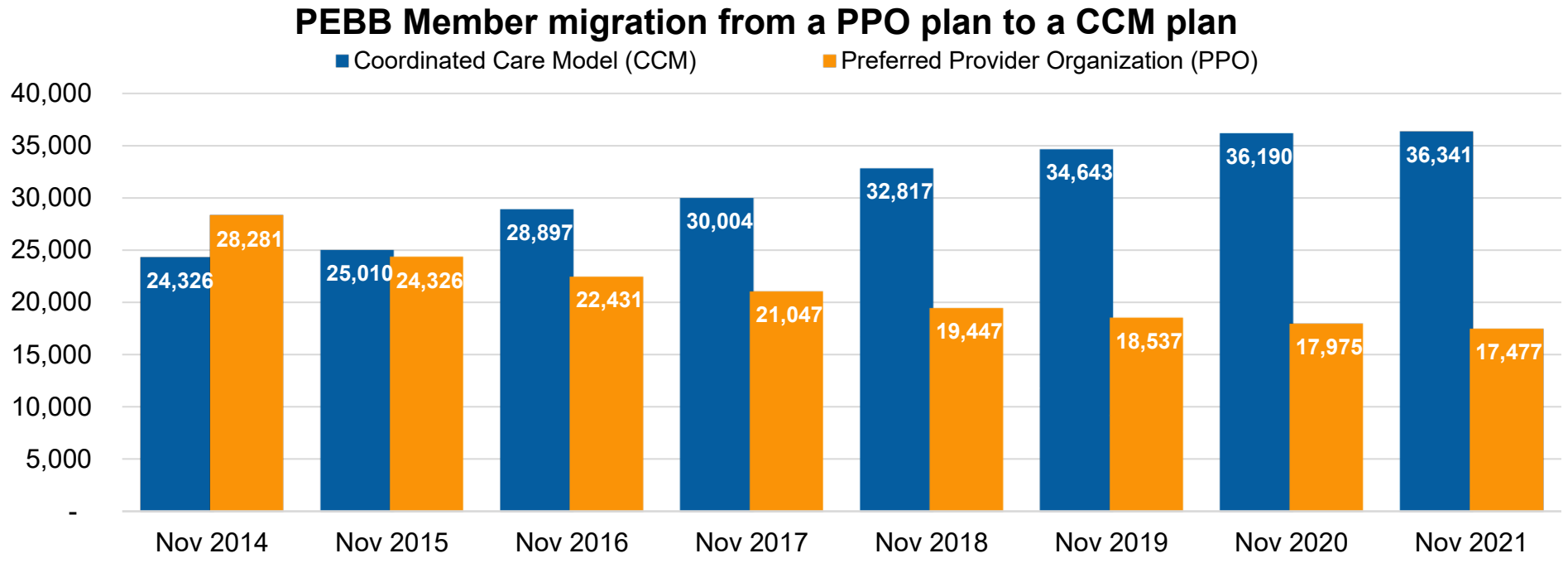
- Challenges with supporting employees in a remote and COVID-19 environment
- How "worksite" wellness will be defined in the future
- Need to support employees with current resources in the meantime, while a long-term well-being strategy is developed

Executive Summary

The goals include:

- Improve awareness and promote utilization of existing well-being resources & specify well-being roles of the Council and PMAC
- Develop multi-year well-being strategy
- Execute strategy in concert with HEM and appropriate partner groups (PMAC, Uplift Oregon, etc.)

PEBB supports prevention and member wellness by offering members access to no-cost wellness programs. Wellness programs help members living with chronic conditions build self-management skills; provide emotional, social and financial health services; support development of healthier behaviors; help members overcome tobacco use; and help members develop healthy eating habits and achieve weight-loss goals.



Executive Summary

PEBB also offers members opportunities to improve their health and contain costs through participation in the Health Engagement Model (HEM) program. The HEM program allows participants the opportunity to learn more about their own personal health risks and take actions to reduce them. Participants earn financial incentives by annually completing a private health assessment on their medical plan's secure website and completing two health-related activities.

Over the past four years increasing numbers of PEBB members have moved from less-coordinated PPO medical coverage to Coordinated Care Model plans.

PEBB quality measures and fees-at-risk
In the 2023-25 biennium, PEBB will continue to add quality measures and performance targets in health plan contracts to support movement toward better health, better care, and lower costs. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for coordinated care organizations (CCO), PEBB and OEBB plans, and the Oregon Health Insurance Marketplace.

Program performance

PEBB has met the 3.4 percent overall expenditure increase and annual premium increase "test" nearly every year since 2012 (see below). Fulfilling the growth cap has been done by executing on cost containment strategies and promoting program efficiencies. PEBB face challenges in meeting the 3.4 percent tests as a payer in the commercial market in battling trend, provider market leveraging and the timing of the annual growth cap. From 2020-2022, the global pandemic heavily impacted utilization levels. The "bounce-back" of deferred care and quantifying the impact on the health of PEBB members will be better known in 2023.

PEBB offers members in all 36 Oregon counties choice between the statewide Preferred Provider Organization (PPO) plan and at least one regional Coordinated Care Model plan. Coordinated Care Model plan choices are available at a lower cost to both members and the state.

Executive Summary

PEBB medical benefit design did not change significantly between 2021 and 2022. PEBB still continues to cover:

- The first four visits to primary care, with no deductible
- The full cost of certain chronic condition and substance abuse visits, with no deductible, copayment or coinsurance
- Nationally recommended preventive services
- No-cost outpatient mental health services when provided in network
- Alternative care including massage therapy
- Added infertility benefit in 2022

PEBB also offers non-traditional and culturally responsive benefits and services, e.g., the use of doulas and other traditional health workers, Christian Science and Native American healers and alternative care such as acupuncture, massage, naturopathic and spinal manipulation services.

Year	Composite Rate Using Prior Year's March Census	% Change	Composite Rate Using Plan Year's March Census	% Change from Prior Composite
2014	$1,333.58		$1,327.47	
2015	$1,321.53	-0.9%	$1,313.06	-1.5%
2016	$1.356.47	2.6%	$1,347.31	2.0%
2017	$1,416.93	4.5%	$1,405.13	3.6%
2018	$1,464.20	3.3%	$1,452.68	2.5%
2019	$1,513.98	3.4%	$1,495.83	2.2%
2020 (w/ Premium Tax and 2.676% funding assessment)	$1,594.86	5.3%	$1,588.17	4.9%
2021 (prior to potential funding assessment)	$1,611.97	1.1%		
2021 with PEBB Admin increase (prior to potential funding assessment)	$1,618.71	1.5%		

Executive Summary

Enabling legislation/program authorization

The Public Employees' Benefit Board authority lies in ORS 243.061 through ORS 243.302.

Funding streams

Other Funds revenue pays for PEBB administration through an administrative assessment added to medical and insurance premiums and premium equivalents. By statute (ORS 243.185), PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs.

PEBB maintains two accounts within its **Revolving Fund**.

- Stabilization Account: PEBB has authority to use this account to control costs, subsidize premiums and self-insure. The primary source of Other Funds revenue is unused employer contributions for employee benefits. This account also holds proceeds generated when PEBB's life insurance carrier changed from a mutual organization to a public corporation.
- Flexible Spending Account: PEBB operates two flexible-spending-account programs and two commuter programs for employees and maintains an account for their administrative costs. The primary Other Funds revenue source for these programs is forfeitures from participants.

Significant proposed program changes from 2021-23

Changes from the 2021-23 biennium include two policy packages: #435 for PEBB OEBB Benefit Management System (BMS) Replacement and #438 for Affordable Care Act (ACA) Employer Reporting.

Policy package #435 BMS would allow PEBB and OEBB to combine enrollment systems, enhance and modernize member and administrator experience, and update security measures to safeguard data. Top modernization goals include:

- The ability to implement and maintain latest security best practices
- Mobile app compatibility

Executive Summary

- Compatibility with commonly used browsers, operating systems and devices
- Flexibility to accommodate business partners' and customers' needs
- Expanded automated error checking and data validation
- Availability of on-demand enrollment and training tools for members and administrators
- Self-service tools and features for members and administrators
- Automated dependent eligibility verification among and between PEBB and OEBB member groups

OEBB and PEBB are in the initial stages of the replacement BMS implementation with their contracted vendor utilizing POP funding from the current biennium. This policy package would fund the remaining implementation activities including additional project staffing, vendor implementation costs, hosting and licensing fees, oversight fees for quality assurance, and contingency allowances.[1] The implementation plan outlined by the selected vendor, LifeWorks, has a go live date in the first quarter of 2025.

Policy package #438 ACA Employer Reporting would allow PEBB to seek the services of a vendor for comprehensive ACA reporting that includes evaluation of data needs, data gaps, coordination of employer data gathering, evaluation and coding of offers of coverage, employee share, enrollment codes, mailing of 1095 forms, filings with IRS, correction filing, and responses to IRS inquiries..

ACA reporting is an employer responsibility. The complexity of ACA reporting is primarily related to the tracking of hours worked and tracking measurement periods to determine if offers of coverage must be made. This data is owned by HR systems. HR and Payroll systems do not have the capability currently to complete ACA reporting or enhance the data it provides to PEBB to complete ACA reporting on their behalf. The Chief Human Resource Office (CHRO) has not given an indication of any efforts to secure a position within their office to ensure required ACA data

[1] The funding for the BMS replacement project sits in the PEBB Operations and OEBB Operations budgets in the Health Policy and Analytics division.

Executive Summary

is captured. At this time, PEBB has not received an estimated timeline as to when HRIS will be able to include essential ACA data elements into its system.

If PEBB is not able to procure a vendor, additional positions would need to be added to fill expertise in ACA rules and regulations and changes, including 1095 coding requirements based on data available. Additional positions would be needed to address data needs, data gaps, compile IRS compliant files, mail 1095 forms to member and track mailings, corrections for compliance. While PEBB is designated to conduct reporting on CHRO's behalf, other participating employers can utilize the same services. Universities, local governments that participate in PEBB would benefit from the professional services of an ACA vendor.

At such time that the state CHRO and payroll systems have incorporated their responsibility for ACA reporting in scope of their systems, PEBB would reassess the scope of vendor services needed, and also give universities and local governments who currently elect to use PEBB at least one year notice so they can find an alternative for ACA reporting.

Oregon Health Authority: Health Policy and Analytics

Public Employees' Benefit Board

The Governor's Budget includes funding for the 2023-25 biennium to continue current service levels, which includes cost growth for PEBB medical premiums, both self-insured and fully insured, at 3.4 percent. It also includes policy package #435 for PEBB's portion of replacement costs for both the OEBB and PEBB benefits management systems and policy package #438 for Affordable Care Act 1095 mandatory reporting.

Activities, programs and issues in the program unit base budget

The Public Employees' Benefit Board (PEBB) is a division of the Oregon Health Authority (OHA). PEBB supports the goal of transforming the health care system in Oregon and fundamentally improving how care is paid for and delivered and achieving OHA's strategic goal to end health inequities in Oregon by 2030. PEBB's mission is to provide high-quality health plans and other benefits for state and university employees at a cost that is affordable to both the employees and the state. Oregon Revised Statutes create an eight-member board whose members are appointed by the Governor and confirmed by the Senate. PEBB serves broadly diverse constituencies including the State of Oregon (as an employer), public universities, employees who live and work in every county of the state, the Legislature, taxpayers, labor unions and health policy groups.

PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. Approximately 140,000 Oregonians are enrolled as PEBB members. They include active and retired employees, spouse and domestic partner dependents, child dependents up to age 26, and adult children with disabilities over age 26, from state agencies, universities, Lottery and semi-independent agencies, and local governments and special districts.

The PEBB Board serves diverse populations and provides a critical public service to Oregonians. The board offers medical, dental, vision, life, disability and accidental death and dismemberment benefit plans. PEBB is a federal IRS Section 125 Cafeteria Plan benefits program that is required to offer the same benefits to all members to enable pretax benefit payment.

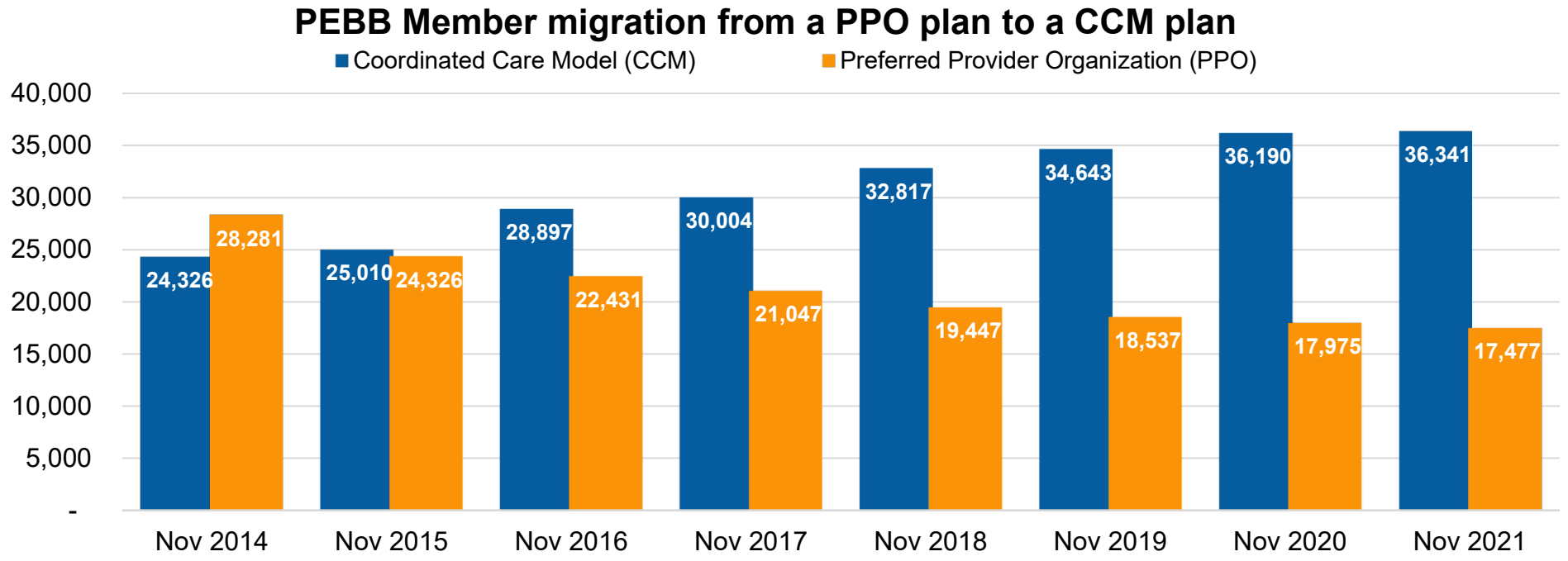
Public Employees' Benefit Board

Transforming health care

The Public Employees' Benefit Board (PEBB) is mandated to redesign the health care delivery system so public employees have access to high quality plans at a lower price, defined in Senate Bill 1067 (2017) as no more than 3.4 percent growth annually. How to stay at or under a 3.4 percent annual growth trend when the Oregon commercial insurance market trend averages 6-7 percent is without a doubt PEBB's biggest challenge and consumes most of the board's attention.

The PEBB Board has made transforming the health care delivery system a key priority and advances transformation with plans that coordinate care. PEBB has partnered with its "sister program" the Oregon Educators Benefit Board (OEBB) to mostly offer "Coordinated Care Model" plans and have developed incentives to increase enrollment in the more efficient, managed plans. Both boards believe the coordinated care model (CCM) is essential for achieving a sustainable 3.4% budget target and in managing overall costs. PEBB offers coordinated care model health plans that use patient-centered medical homes to improve quality, enhance member experience, and contain costs. Both boards continue to add these systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities. The boards would like to further pursue plans and providers that use creative and innovative evidence-based practices that contribute value.

Public Employees' Benefit Board



PEBB's coordinated care model plans enable the board to execute on strategies such as:

- Promoting alternative payment methodologies such as risk sharing and global value-based payments.
- Integrating behavioral and physical health delivery.
- Supporting the use of medical homes.
- Increasing payments for primary care.
- Putting fees at risk in contracts for meeting agreed-upon administrative and clinical performance metrics.
- Managing costs to a 3.4 percent annual increase.

Public Employees' Benefit Board

PEBB cost containment programs

Premium costs are affected by external drivers such as member utilization; lack of care coordination; inflation in health care costs, such as high prescriptions costs; and sedentary occupations that lead to long-term health risks and chronic conditions.

The traditional method of controlling premium increases is to increase costs to members through higher deductibles, higher copayment or coinsurance, or increased premium share. PEBB has always sought ways to reduce costs through innovative plan designs. Both PEBB and OEBB have incorporated "value-based" benefit attributes into plan design to encourage use of high-value services including:

- Value prescription drug formularies
- Waived copayments for office visits related to certain chronic conditions
- Self-management programs for weight and diabetes prevention available at no out-of-pocket cost to members
- No-cost tobacco use cessation support

Value-based benefits

Both OEBB and PEBB have implemented value-based benefit plans. Services that have been shown to reduce health care costs have a lower copayment or coinsurance. Members pay more for services that have less-expensive alternatives. Members are encouraged to talk to their medical providers about alternatives to these higher-cost options. Examples of these benefits include:

- No or lowered costs for visits for diabetes, coronary artery disease, asthma and chronic obstructive pulmonary disease. Regular office visits keep people with these diagnoses out of the emergency room and hospital.
- No or lowered costs for medications that help prevent or manage chronic diseases such as statins for cholesterol, asthma inhalers and depression medications.
- Additional copayment for endoscopies, sleep studies and advanced imaging technologies (CT, MRI, PET scans).

- Additional copayment for shoulder and knee arthroscopic surgery, total knee and total hip joint replacement surgery.
- PEBB and OEBB continue to work toward increasing the percentage of total health care payments that use value-based approaches and have identified future year targets that generally align with those established for Coordinated Care Organizations. PEBB and OEBB currently have approximately 47 percent of total medical expenditures in a VBP arrangement with a goal of 70 percent by 2024, thereby matching the goals as defined in CCO 2.0.

Wellness initiatives and promoting member health

PEBB supports prevention and member wellness by offering members no-cost programs through carrier contracts and direct vendor contracting.

- Better Choices Better Health helps people living with a chronic condition to live healthier lives.
- The Employee Assistance Program (EAP) provides emotional, social and financial health services.
- Healthy Team Healthy U offers members a foundation of knowledge and skills to help members live a healthier lifestyle.
- Quit For Life and other tobacco cessation resources help members overcome tobacco use.
- Weight Watchers is designed to help members achieve and maintain weight-loss goals.

Providing direct incentives to members outside of plan benefits comes with upfront costs to fund and administer. This appears as a direct cost to the program for each year the incentive is provided. Several years of claims data are needed to analyze whether the incentive has a measurable, sustained impact on participant health care claims costs. This type of analysis is possible and may show an impact on costs. However, any potential savings would not be realized until future years after the upfront costs of the incentive have been incurred.

PEBB also offers members opportunities to improve their health and contain costs through participation in the Health Engagement Model (HEM) program. The HEM allows program participants to learn more about their own personal health risks and how to reduce them. Participants earn financial incentives by annually completing a private health assessment on their carrier's secure website and completing two health-related activities.

The COVID-19 pandemic has greatly influenced PEBB's wellness efforts. Flexible work schedules continue to be the norm. As a result, PEBB's employee wellness efforts shifted away from a focus on environmental approaches and toward increasing communications directly to members to promote PEBB wellness programs, and to help them understand and access their benefits.

The Worksite Wellness Coordinating Council and the PEBB Member Advisory Committee (PMAC) were developed and began implementing a Member Wellbeing Strategy aimed at addressing needs identified by both groups. They work in coordination with the board to develop a near-term RFP for wellness benefits.

PEBB quality measures and fees-at-risk

PEBB has made significant progress on the implementation of quality and cost performance measures with fees at risk in benefit contracts. PEBB continues to include quality measures and performance targets in health plan contracts to support better health, better care, and lower cost. The specific quality measures selected are based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for CCOs, PEBB and OEBB plans, and the Oregon Health Insurance Marketplace. PEBB and OEBB contracts now include performance improvement targets on each measure and require that health plans put at risk a portion of administrative fees or premiums paid to them, with retention of at-risk dollars contingent on the plan achieving its targets. Performance improvement targets established for each measure considers the health plan's current performance in comparison to national benchmarks, gold standard performance rates, and organizational priorities to achieve identified rates of improvement in specific areas of health care quality. The categories of Performance

Public Employees' Benefit Board

Guarantees are: Administrative/Operational, Financial Trend, Clinical Quality, Clinical Management programs, Account Management, and Transparency.

Additional budget drivers

- Legislative cap on premium rate increases: The PEBB Board will continue to work with carriers to explore strategies to keep renewal rate increases at or below the Legislature's 3.4 percent growth cap.
- Implementing benefit mandates as required.

Joint PEBB and OEBB Innovation Workgroup

PEBB and OEBB formed the joint Innovation Workgroup (IWG), made up of PEBB and OEBB board members and legislators to analyze cost drivers, measure access and quality, and explore joint alternative payment models that bring true value and the potential for tremendous savings. The IWG looks to leverage the purchasing power and data to its maximum value and will look to include joint ventures with other OHA programs in the future such as the Marketplace to further leverage purchasing power. Key initiatives the IWG has worked on most recently include:

- Development of a Centers of Excellence program across the state
- Addressing Behavioral Health provider access issues and payment strategies
- Advancing Value-based payments in PEBB and OEBB

Joint PEBB and OEBB Health Equity Workgroup

In 2021, the boards determined that to fully engage in advancing health equity in all aspects of their benefit programs, a special workgroup must be formed that focused on this goal. The Joint PEBB OEBB Health Equity Workgroup has set five initial goals:

- To intentionally increase the diversity on the boards
- Develop and apply a health equity lens tool to all board policy decisions

- Develop a Diversity Equity and Inclusion assessment tool that audited PEBB and OEBB benefit vendors and ensured their business practices met the standards the boards have set
- Amplify the commitment to Health Equity by the boards and communicate it in all areas
- Incorporate Health Equity into governance, quality metrics and clinical protocols

The workgroup has developed a health equity lens tool and has incorporated it in several policy decisions. It has also developed a DEI tool and used it to audit PEBB and OEBB business partners, providing reports for areas needed for improvement. The workgroup continues to move this work forward.

Policy Package 426 OEBB-PEBB Benefit Management Replacement System
This POP will allow OEBB and PEBB to combine enrollment system, enhance and modernize members and administrator experience. Top modernization goals include:

- The ability to implement and maintain latest security best practices.
- Mobile app compatibility.
- Compatibility with commonly used browsers, operating systems and devices.
- Flexibility to accommodate business partners' and customers' needs.
- Expanded automated error checking and data validation.
- Availability of on-demand enrollment and training tools for members and administrators.
- Self-service tools and features for members and administrators.
- Automated dependent eligibility verification among and between OEBB and PEBB member groups.

OEBB and PEBB are in the initial stages of the replacement BMS implementation with their contracted vendor utilizing POP funding from the current biennium. This policy package will fund the remaining implementation activities including additional project staffing, vendor implementation costs, hosting and licensing fees,

oversight fees for quality assurance, and contingency allowances. The implementation plan outlined by the selected vendor, LifeWorks, has a go live date in the first quarter of 2025.

Policy Package 438 Affordable Care Act (ACA) Employer Reporting
This POP will allow PEBB to seek the services of a vendor for comprehensive ACA reporting that includes evaluation of data needs, data gaps, coordination of employer data gathering, evaluation and coding of offers of coverage, employee share, enrollment codes, mailing of 1095 forms, filings with IRS, correction filing, and responses to IRS inquiries.

ACA reporting is an employer responsibility. The complexity of ACA reporting is primarily related to the tracking of hours worked and tracking measurement periods to determine if offers of coverage must be made. This data is owned by HR systems. HR and Payroll systems do not have the capability currently to complete ACA reporting or enhance the data it provides to PEBB to complete ACA reporting on their behalf. The Chief Human Resource Office (CHRO) has not given an indication of any efforts to secure a position within their office to ensure required ACA data is captured. At this time, PEBB has not received an estimated timeline as to when HRIS will be able to include essential ACA data elements into its system.

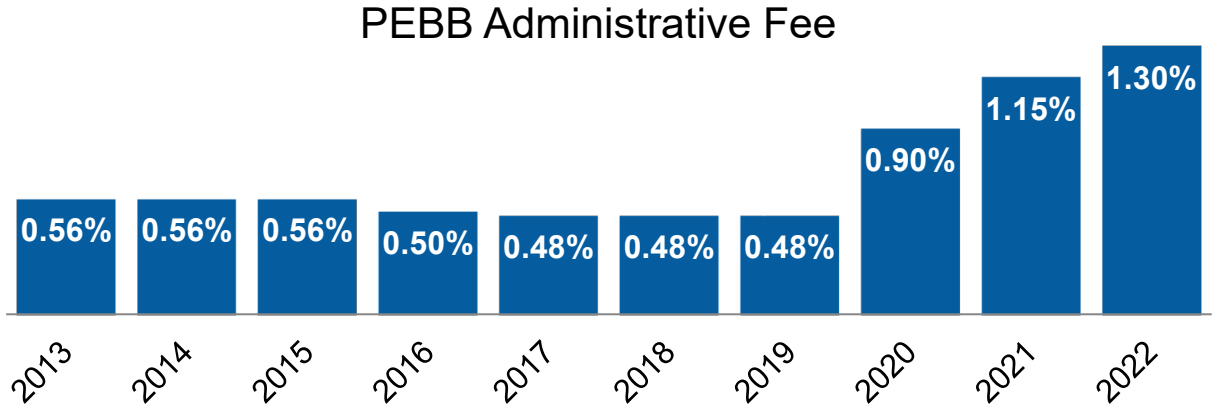
If PEBB is not able to procure a vendor, additional positions would need to be added to fill expertise in ACA rules and regulations and changes, including 1095 coding requirements based on data available. Additional positions would be needed to address data needs, data gaps, compile IRS compliant files, mail 1095 forms to member and track mailings, corrections for compliance. While PEBB is designated to conduct reporting on CHRO's behalf, other participating employers can utilize the same services. Universities, local governments that participate in PEBB will benefit from the professional services of an ACA vendor.

At such time that the state CHRO and payroll systems have incorporated their responsibility for ACA reporting in scope of their systems, PEBB will reassess the scope of vendor services needed, and also give universities and

local governments who currently elect to use PEBB at least one year notice so they can find an alternative for ACA reporting.

Revenue sources and changes

Other Funds revenue pays for PEBB administration through an administrative assessment added to medical and dental insurance premiums and premium equivalents. By statute (ORS 243.185), PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs.



In recent years, the administrative fee was not an adequate source of revenue to cover the development of the Benefit Management System (BMS) project and the increase in system programming costs. A main goal of the boards was to construct the new BMS without having to borrow the funds to do it. Consultant costs have also increased from prior years driven by the passage of Senate Bill 1067 and funding the work of the joint PEBB/OEBB Innovation Work Group (IWG) and joint Health Equity Work Group. These investments will end up saving the state money over the long term by becoming more efficient and having better data to make better decisions. As the new system development project ends and the old system is phased out. The administrative fee is likely to decrease back to under 1 percent.

PEBB maintains two accounts in its **Revolving Fund**.

- Stabilization Account: PEBB has authority to use this account to control costs, subsidize premiums and self-insure. The primary source of Other Funds revenue is unused employer contributions for employee benefits. This account also holds proceeds generated when PEBB's life insurance carrier changed from a mutual organization to a public corporation.
- Flexible Spending Account: PEBB operates two flexible-spending-account programs and two commuter programs for employees and maintains an account for their administrative costs. The primary Other Funds revenue source for these programs is forfeitures from participants.

Proposed new laws that apply to the program unit

None.

Oregon Health Authority: Oregon Educators Benefit Board

Executive Summary

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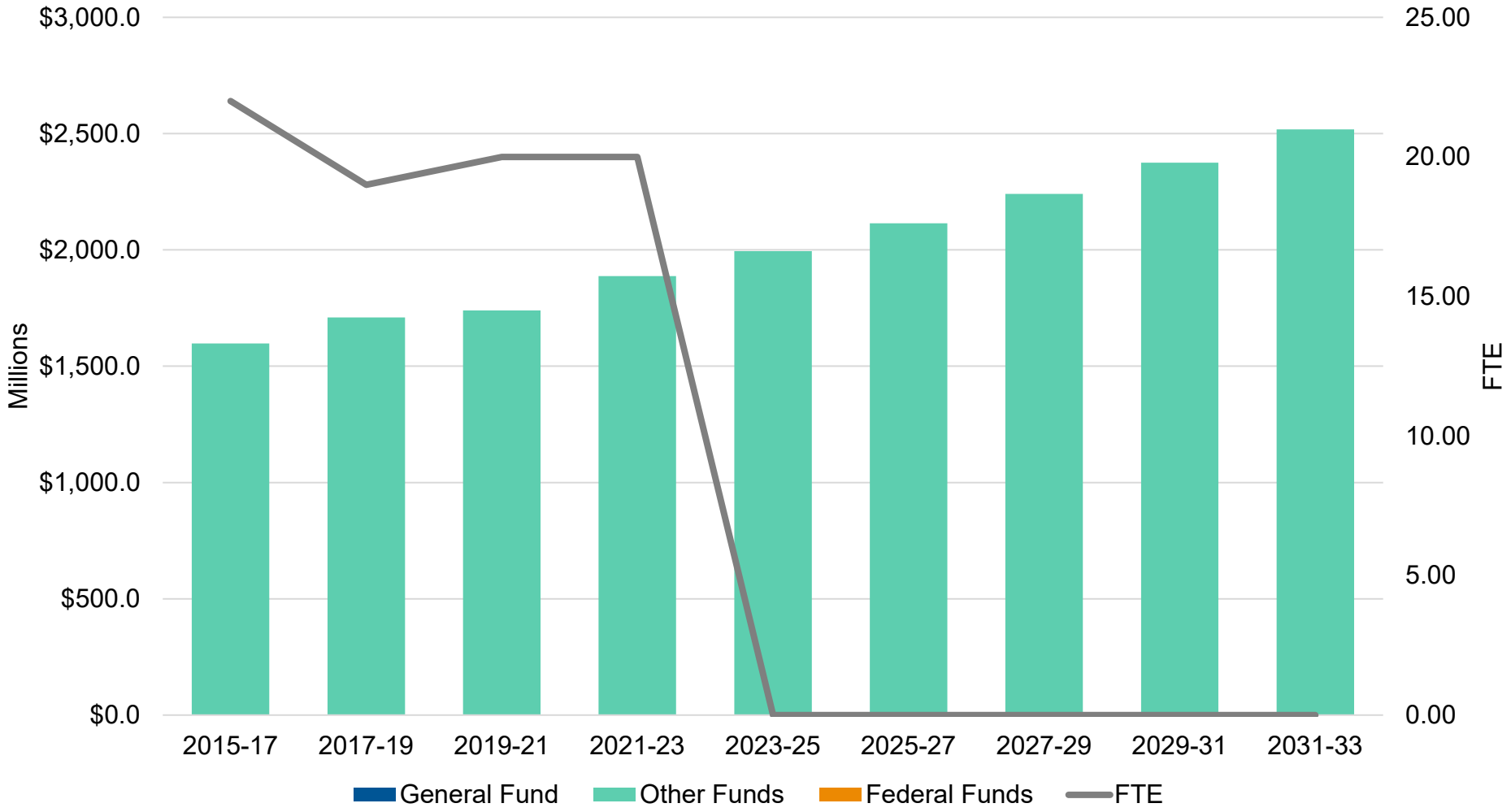


Executive Summary

Division overview

The Oregon Educators Benefit Board (OEBB) is a division of the Oregon Health Authority (OHA). OEBB supports the goals of transforming the health care system in Oregon and fundamentally improving how care is paid for and delivered. The OEBB board's mission is to provide a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and some special districts and local governments. OEBB's benefit plans are designed to be flexible and accommodate the needs of employers and members.

Funding request

The Governor's Budget for OEBB for the 2023-25 biennium continues current service levels, which includes cost growth for OEBB core benefits at 3.4 percent for both the 2023-2024 and 2024-2025 plan years. It also includes the cost to OEBB to implement payer parity in the behavioral health crisis system in policy package #429. All OEBB expenditures are categorized as Other Funds.

Program descriptions

OEBB serves entity employees, early retirees, COBRA enrollees and their family members, in more than 256 publicly funded entities throughout Oregon. OEBB serves its members and entities year-round.

The OEBB board designs and maintains a full range of benefit plans for eligible publicly funded entities to offer to their employees, early retirees and COBRA enrollees Plans include medical, dental, vision, life, disability, accidental death and dismemberment, long term care, an employee assistance program, a health savings account and flexible spending accounts.

Rising health care costs are a primary cost driver for OEBB. OEBB has recognized and taken steps to provide incentives for appropriate care and condition management through benefit plan design with the goal of containing costs and using alternative payment models to control costs. OEBB strives to keep benefit plans affordable and

stable while providing quality care to members. OEBB has managed benefit costs to well below national trend throughout its history and continues to meet a legislatively capped annual 3.4 percent increase on premiums and costs on behalf of members.

Program justification and link to long-term outcomes

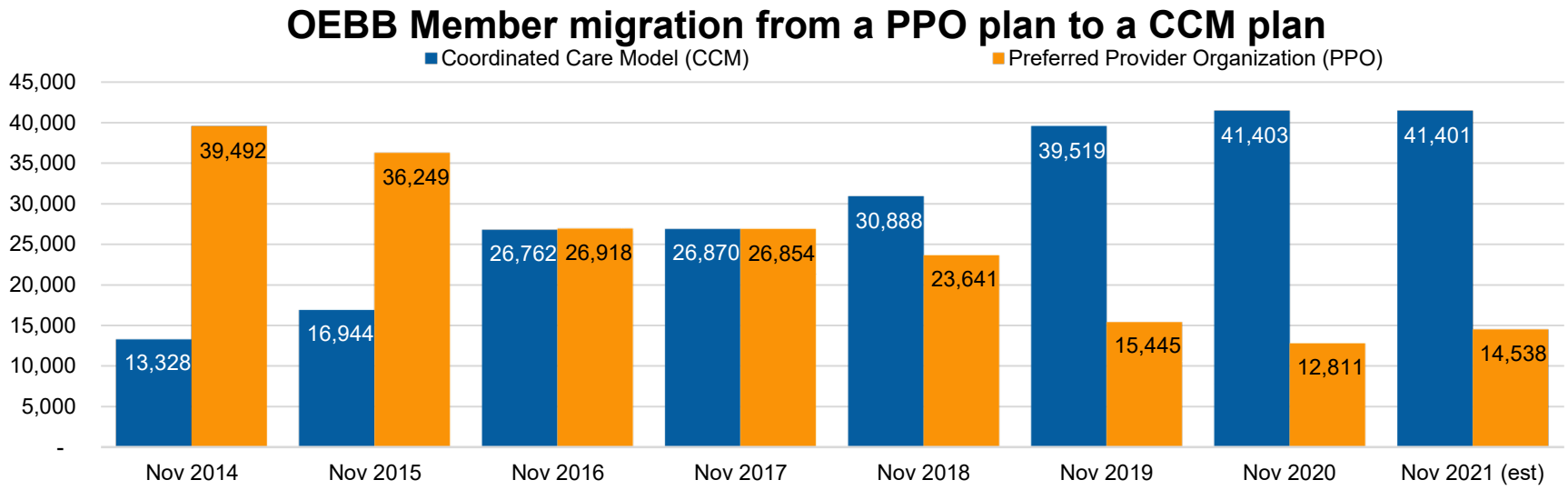
OEBB was established to eliminate the wide-ranging disparities among health plans offered by educational entities and for responding to the rapidly rising costs of health care. A statewide pool such as OEBB creates purchasing power and avoids unstable premium swings. Streamlining administration and eliminating third-party fees and duplication of work were also large cost savers upon the formation of OEBB. Educational entities benefit from cost predictability and controlling of expenditures year-over-year.

Transforming health care and advancing health equity

The OEBB board has made transforming the health care delivery system a priority and envisions advancing health care transformation with plans that coordinate care. OEBB has partnered with its “sister program” the Public Employees’ Benefit Board (PEBB) in the shared innovation strategy referred to as the “Coordinated Care Model” (CCM). Both boards are continuing to add these systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities. In 2021, PEBB and OEBB formed a joint subgroup of the boards focused on ensuring health equity, called the “Joint Subcommittee on Health Equity.” The committee consists of two board members from each board, expert consultants, and staff. The committee supports OHA’s goal of eliminating health inequities by 2030.

OEBB and PEBB are fully committed to working together to leverage their purchasing power across the state and have started working with the Insurance Marketplace to further leverage the state’s healthcare purchasing power. The “Joint PEBB and OEBB Innovation Workgroup” was formed in 2018 with board members from each board and legislators to develop strategies on cost containment, how to best leverage claims data stores for analysis of quality and cost performance, and developing payment initiatives to ensure meeting the 3.4 percent cap every year.

Executive Summary



Value-based benefits

Traditional fee-for-service models provide payment for each health care visit, service, or test. Value-based payments shift focus from volume to value by rewarding providers for delivering high quality care that supports improved outcomes and slower cost growth. As shown in the table below, OEBB and PEBB health plans currently incorporate a variety of value-based payment strategies to incentivize provider quality and efficiency. Many of the general strategies used align with value-based payment approaches also used by coordinated care organizations (CCOs) serving Oregon's Medicaid population.

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Many of the strategies used by PEBB & OEBB align with value-based payment approaches also used by coordinated care organizations (CCOs) serving Oregon's Medicaid population.

	OEBB	PEBB	CCO
Infrastructure payments			
Pay for reporting			
Pay for performance			
Shared savings with upside risk			
Shared savings upside and downside risk			
Condition-specific population-based payment			
Comprehensive population-based payment			
Integrated finance and delivery system			

OEBB and PEBB continue to work toward increasing the percentage of total health care payments that use value-based approaches and have identified future year targets that closely align with those established for CCOs. OEBB and PEBB currently have approximately 47 percent of total medical expenditures in a VBP arrangement with a goal of 70 percent by 2024, thereby matching the goals as defined in CCO 2.0.

OEBB quality measures and fees at risk

In the 2023-25 biennium, OEBB will continue to include quality measures and performance targets in health plan contracts to support better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for coordinated care organizations (CCOs), PEBB and OEBB plans, and the Oregon Health Insurance Marketplace.

Wellness initiatives and promoting member health

OEBB supports prevention and member wellness by offering members access to no-cost wellness programs. Wellness programs help members in a variety of ways, including helping people with chronic conditions live healthier lives, helping prevent the onset of diabetes; providing emotional, social and financial health services; helping overcome tobacco use; and helping achieve and maintain weight loss goals.

Executive Summary

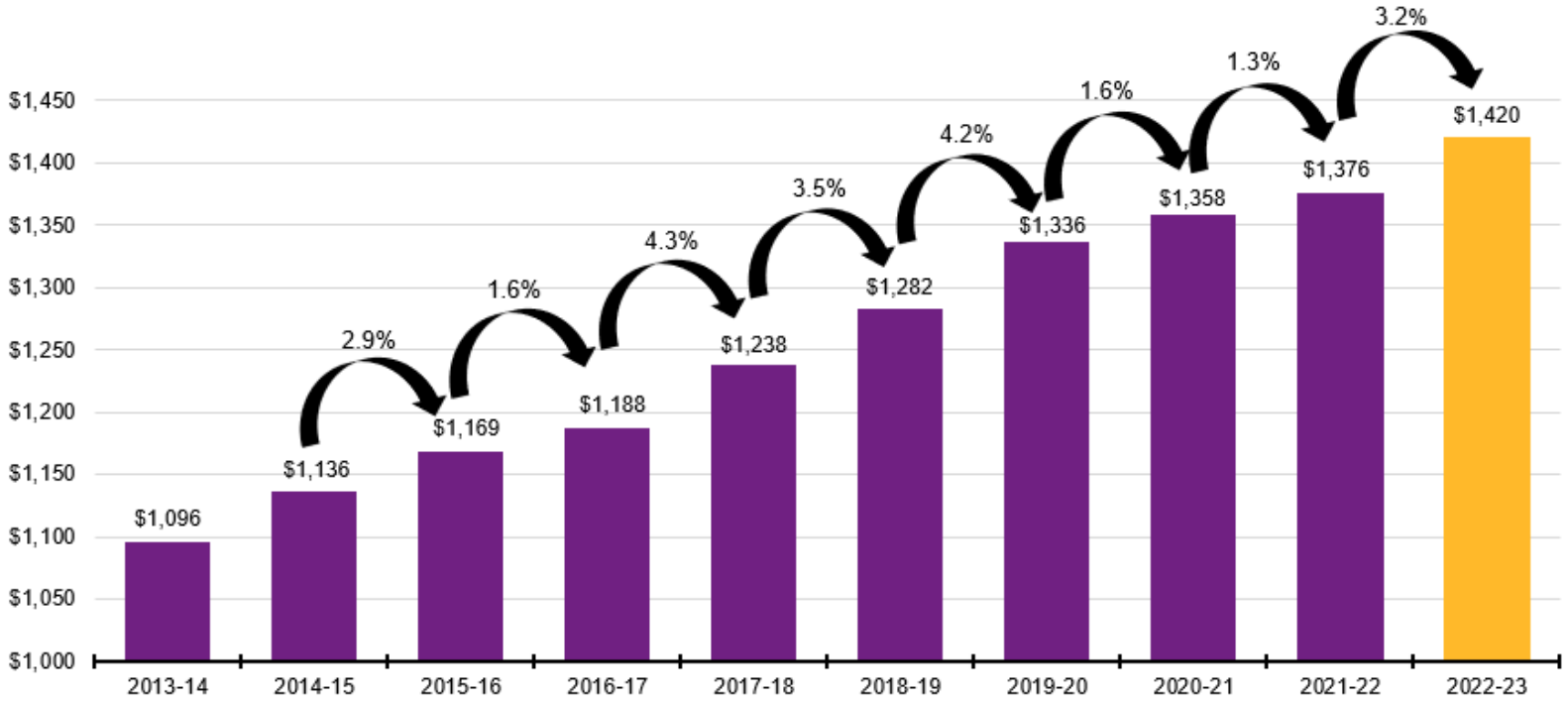
Program performance

OEBB has met the 3.4 percent overall expenditure increase and annual premium increase “test” nearly every year since 2012 (see below). Fulfilling the growth cap has been done by executing on cost containment strategies and promoting program efficiencies. OEBB faces challenges in meeting the 3.4 percent tests as a payer in the commercial market in battling trend, provider market leveraging and the timing of the annual growth cap. From 2020-2022, the global pandemic heavily impacted utilization levels. The “bounce-back” of deferred care and quantifying the impact on the health of OEBB members will be better understood in upcoming claims cycles.

Executive Summary

Actual per employee per month (PEPM) costs with projected 2022-23

- Historical Increase in Medical, Dental, and Vision PEPM, excluding the change in insurance taxes/fees



Strategies for success

OEBB is incorporating key elements of the coordinated care model into all OEBB medical plans. They are particularly evident in the structure of the Moda Health PCP 360 plans, as well as the fully integrated health care delivery system inherent in the Kaiser Permanente plans.

Executive Summary

The OEBB board and staff are committed to our mission and guiding principles and have developed strategies to achieve long-term results:

- Offer high-quality, affordable health plans.
- Support member wellness and population health.
- Create streamlined operations and organization effectiveness.
- Provide enhanced member outreach and communications.
- Create a financially sustainable organization.

Benefit highlights for the 2021-22 plan year

- OEBB will continue to offer the same medical, dental and vision plans through Moda, Kaiser, Willamette Dental and VSP for the 2022-23 Plan Year. All deductible levels, copayments, coinsurance levels and out-of-pocket maximums will continue.
- All medical plans will include an enhanced virtual telehealth service.
- Moda plans will see continued innovation with its member concierge service, Moda360. Moda360 provides OEBB members with specialized service navigators to provide extra assistance to get the care they need, find quality providers, resolve claims or billing issues, schedule appointments or find health care resources. Moda360 includes additional services such as expanded telemedicine, diabetes care programs and enhanced behavioral health services.

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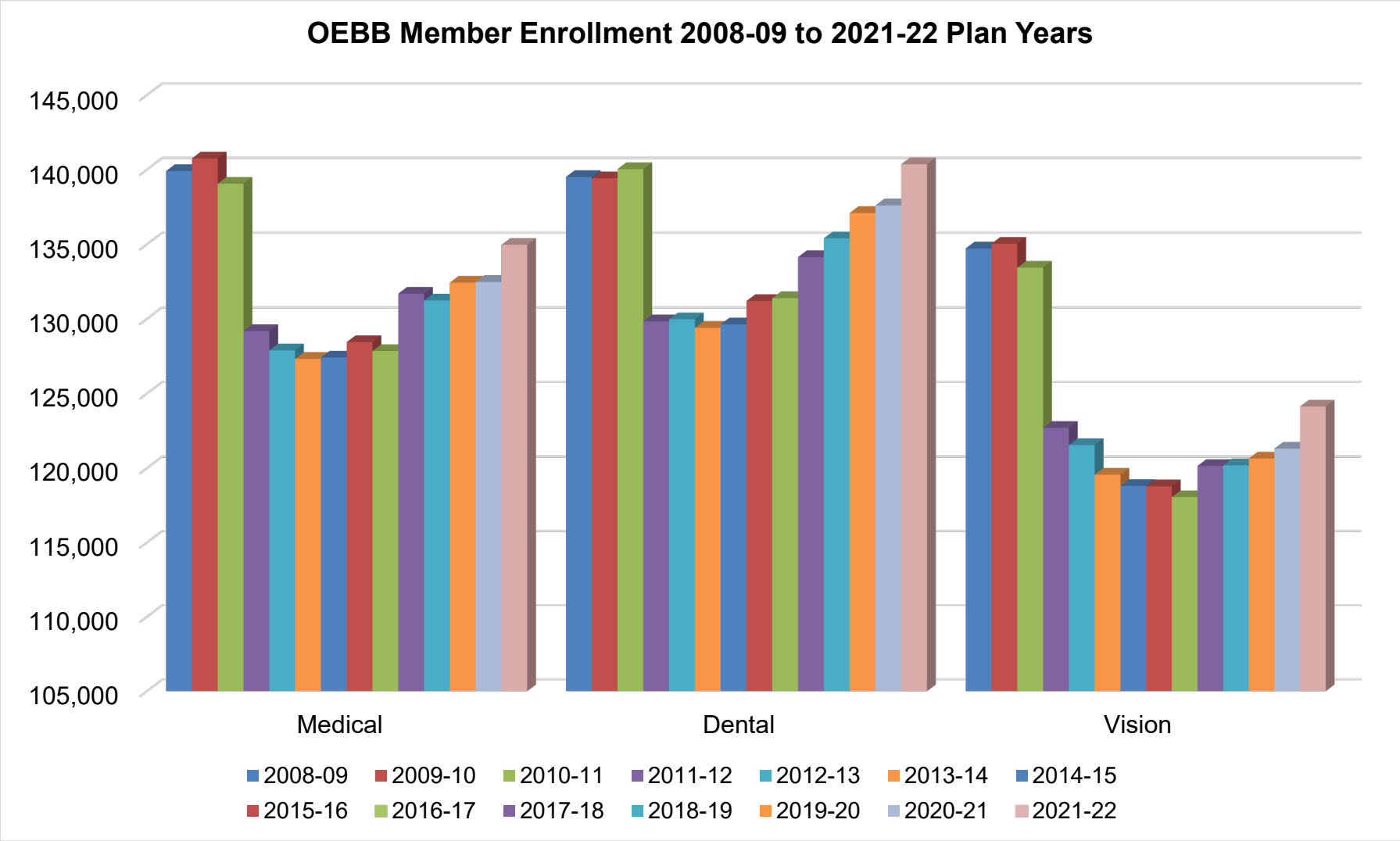


*drop in enrollments in plan year 2011-12 was due to a recession.

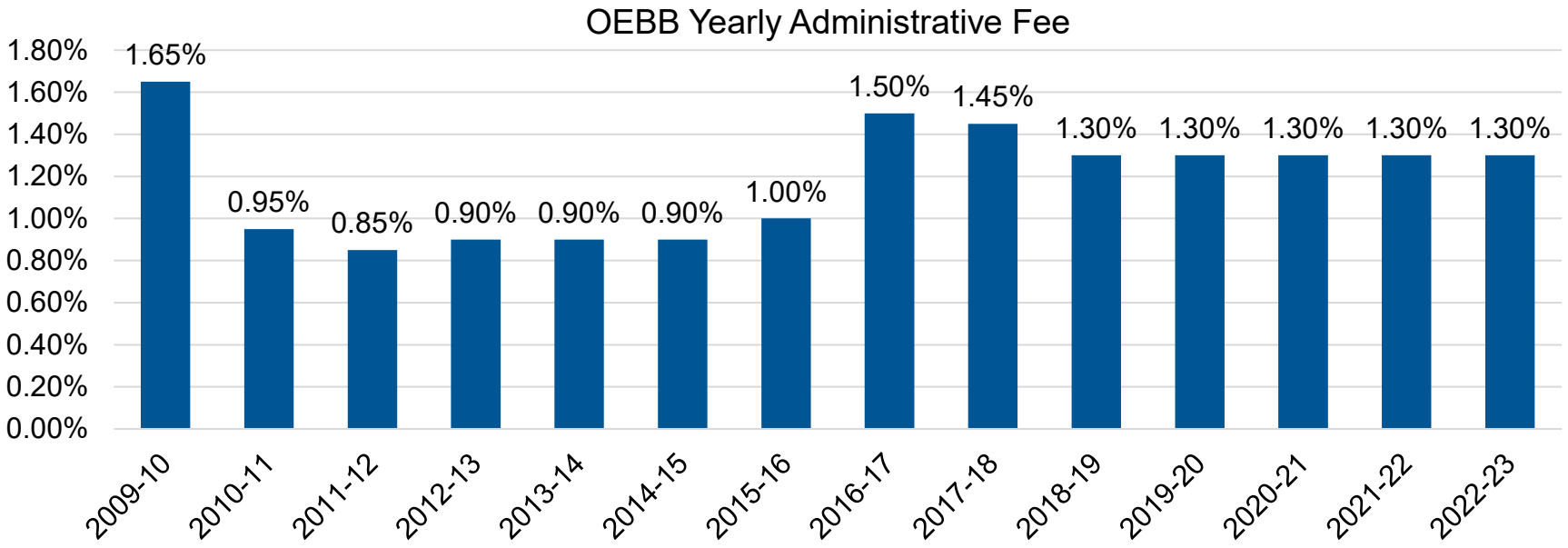
Executive Summary

Enabling legislation/program authorization

OEBB was established by Senate Bill 426 (2007). House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts. The OEBB board functions and responsibilities are authorized by ORS 243.860 to 243.886.

Funding streams

OEBB is funded entirely with Other Funds. ORS 243.880 authorizes the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated by an administrative assessment paid by members along with their premiums. The administrative assessment cannot exceed 2 percent of total monthly premiums. The administrative fee is the sole source of revenue for the OEBB benefits program.



Executive Summary

ORS 243.884 authorizes the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and stabilize premiums.

Significant proposed program changes from 2021-23

Changes from the 2021-23 biennium include one policy package: #426 OEBB-PEBB Benefit Management System (BMS).

Policy package #426 BMS will allow OEBB and PEBB to combine enrollment system, enhance and modernize members and administrator experience. Top modernization goals include:

- The ability to implement and maintain latest security best practices.
- Mobile app compatibility.
- Compatibility with commonly used browsers, operating systems and devices.
- Flexibility to accommodate business partners' and customers' needs.
- Expanded automated error checking and data validation.
- Availability of on-demand enrollment and training tools for members and administrators.
- Self-service tools and features for members and administrators.
- Automated dependent eligibility verification among and between OEBB and PEBB member groups.

OEBB and PEBB are in the initial stages of the replacement BMS implementation with their contracted vendor utilizing policy package funding from the current biennium. This policy package will fund the remaining implementation activities including additional project staffing, vendor implementation costs, hosting and licensing fees, oversight fees for quality assurance, and contingency allowances.[1] The implementation plan outlined by the selected vendor, LifeWorks, has a go live date in the first quarter of 2025.

[1] The funding for the BMS replacement project sits in the PEBB Operations and OEBB Operations budgets in the Health Policy and Analytics division.

Oregon Educators Benefit Board

The Governor's Budget includes funding for the 2023-25 biennium to continue current service levels, which includes cost growth for OEBB medical premiums, both self-insured and fully insured, at 3.4 percent. It also includes policy package #435 for OEBB's portion of replacement costs for both the OEBB and PEBB benefits management systems.

Activities, programs and issues in the program unit base budget

The Oregon Educators Benefit Board (OEBB) was established by the 2007 Legislature. OEBB provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments across the state. OEBB offers a multitude of plans that resemble an "exchange." OEBB started offering medical, dental, and vision coverage in 2008 and has since added a broad range of additional benefits including life, accidental death and dismemberment (AD&D), short-term and long-term disability and long-term care insurance, as well as an employee assistance program (EAP), a health savings account (HSA), flexible spending accounts (FSAs), and commuter savings accounts. Each of the 256 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing with employees, and diverse populations. The law prohibits those entities, with certain exceptions, from offering benefit plans other than those offered by the Board. Unlike PEBB, all plans are fully insured. OEBB has prioritized choice in plan options for employers and employees, and consequently offer a large number of different plans.

OEBB was created to eliminate the wide-ranging disparities between health plans offered by school districts and to respond to the rapidly rising costs of health care. House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts. A statewide pool, such as OEBB, creates purchasing power and avoids unstable premium swings experienced by school districts with volatile claims experience. Streamlining administration and eliminating third-party fees and duplication of work were also large cost savers upon the formation of OEBB. School districts benefit from cost predictability and controlling of expenditures year-over-year. In addition to OEBB's cost goals, OEBB plans emphasize coordinated care model features. Coordinated care means

the member's primary care physician works with specialists, hospitals and other providers in a coordinated fashion to ensure optimal and efficient care for members. All the plan design changes implemented since the 2020-21 Plan Year have focused on advancing preventive care and coordinated care principles.

Key components of the OEBB program include:

- Value-added plans that provide high-quality care and services at an affordable cost to members.
- Collaboration with districts, members, carriers and providers that ensures a focused approach on the design and delivery of benefit plans and services.
- Support of improvement in members' health status through a variety of measurable programs and services.
- Implementing measurable goals and programs that hold carriers and providers accountable for health outcomes.
- Encouraging members to take responsibility for their own health outcomes.
- Top-of-class customer service.

Transforming Health Care

The OEBB board has made transforming the health care delivery system a priority and envisions advancing health care transformation with plans that coordinate care. OEBB has partnered with its "sister program" the Public Employees' Benefit Board (PEBB) in the shared innovation strategy referred to as "Coordinated Care Model" plans. OEBB and PEBB believe the coordinated care model (CCM) is essential for achieving success in managing overall costs. For the 2022-23 plan year, OEBB continued its further enhancement the CCM offerings with more duties for the health navigators. Health navigators are personal health coaches that provide members with assistance in scheduling appointments, billing questions, claims and appeals, care programs and prior authorizations allowing members to better coordinate their health care. Both boards continue to add these systems of care throughout Oregon with a focus on integrated care and reducing health care costs and eliminating health disparities. The boards would like to further pursue plans and providers that use creative and innovative evidence-based practices, specifically in social determinants of health.

As the board evaluates plan offerings in an annual contract renewal with plans, it focuses on maintaining sustainable, affordable, equitable and high-quality benefit plan options across the entire state. Strategies include:

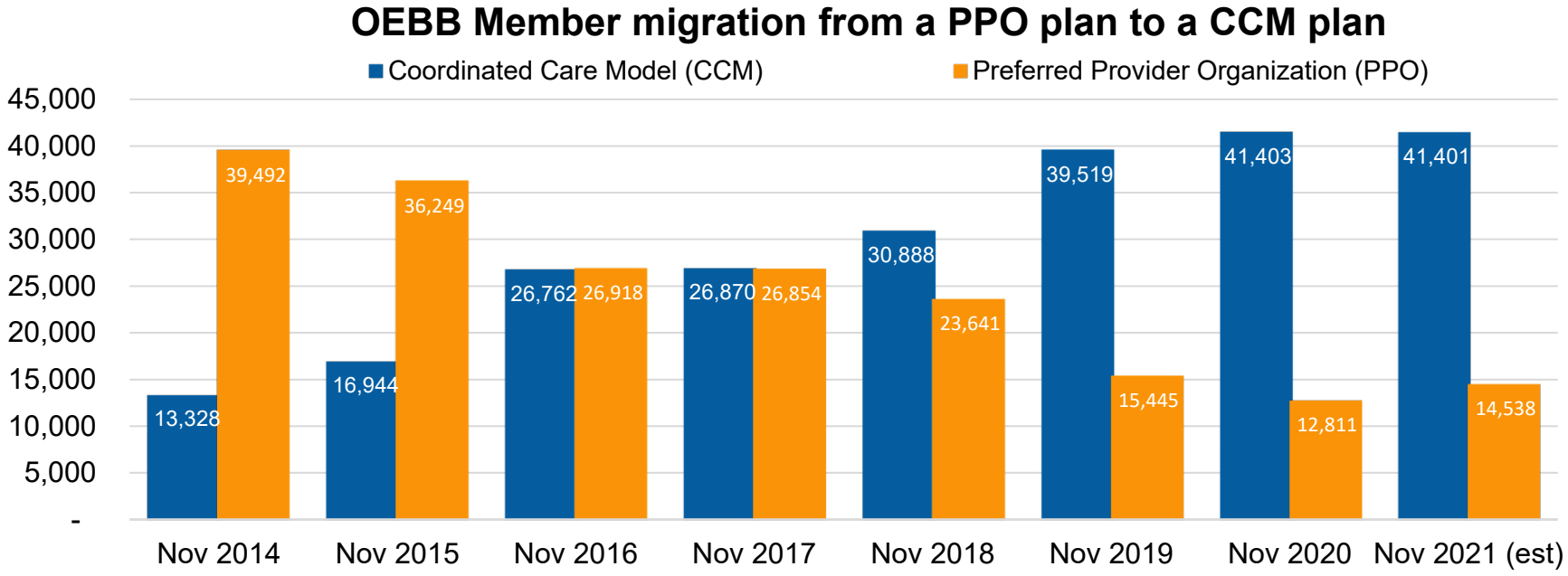
- Engage employers regularly to ensure the affordability definition remains relevant to all participating entities.
- Monitor and audit utilization and plan performance to ensure high quality benefits.
- Incorporate criteria specific to legislative cost requirements (3.4 percent renewal increase cap) into carrier contracts.
- Require proposers to outline their plans and specific steps they will take to promote these criteria in medical offices and care locations around the state.
- Incentivize coordinate care plans and improve access to culturally specific services across the state.
- Integrate coordinated, patient-centered care – physical, mental and dental.
- Demonstrate improved health outcomes.
- Embrace alternative payment models.

OEBB also actively engages in OHA committees, including:

- Primary Care Payment Reform Collaborative.
- Health Plan Quality Metrics Committee to support adoption of aligned quality incentives.
- Pharmacy Cost Collaborative.

The board is dedicated to moving away from a “fee-for-service” model and incentivizes members to enroll in a Coordinated care model plan. The following graphic illustrates OEBB members moving from a preferred provider organization (PPO) plan to a coordinated care model (CCM) plan with a lower cost shares.

Oregon Educators Benefit Board



<u>OEBB cost containment programs</u>

OEBB has recognized and taken steps to provide incentives for appropriate care and management of chronic conditions through benefit plan design with the goal of containing costs:

- Members have no copayment, coinsurance, or deductible for office visits associated with management of certain chronic conditions (asthma, diabetes, cardiovascular disease and congestive heart failure).
- Value pharmacy benefit provides medications used to manage common chronic conditions with no copayment.

- Condition management and prevention programs offered at no out-of-pocket cost to members under OEBB and PEBB medical plans, including evidence-based programs for members living with a chronic condition and prevention programs that specifically target members at risk of developing diabetes.
- Additional copays were included to discourage the use of certain procedures and treatments that had less-invasive options that were equally effective.

OEBB has also used alternative payment models to control cost including:

- Reference pricing for joint replacement and gastric bypass services.
- Shared risk payment models for its Moda PCP 360 medical plans.

OEBB quality measures and fees at risk

In the 2023-25 biennium OEBB will continue to include quality measures and performance targets in health plan contracts to support better health, better care, and lower cost. The specific quality measures selected will be based on the Statewide Aligned Quality Measures menu developed by the Health Plan Quality Metrics Committee for coordinated care organizations (CCOs), PEBB and OEBB plans, and the Oregon Health Insurance Marketplace.

Wellness initiatives and promoting member health

OEBB supports prevention and member wellness by offering members access to no-cost wellness programs. Wellness programs help members in a variety of ways, including helping people with chronic conditions live healthier lives, helping prevent the onset of diabetes; providing emotional, social and financial health services; helping overcome tobacco use; and helping achieve and maintain weight loss goals.

OEBB has met the 3.4 percent overall expenditure increase and annual premium increase “test” nearly every year since 2012. Fulfilling the growth cap has been done by executing on cost containment strategies and promoting program efficiencies. OEBB faces challenges in meeting the 3.4 percent tests as a payer in the commercial market

in battling trend, provider market leveraging and the timing of the annual growth cap. From 2020-2022, the global pandemic heavily impacted utilization levels. The “bounce-back” of deferred care and quantifying the impact on the health of OEBB members will be better understood in upcoming claims cycles.

Policy Package 426 OEBB-PEBB Benefit Management Replacement System

The Legislatively Adopted Budget for OEBB and PEBB includes additional funding to continue with the Benefit Management System (BMS) replacement project, which will allow OEBB and PEBB to combine enrollment systems, enhance and modernize members and administrator experience. Top modernization goals include:

- The ability to implement and maintain latest security best practices.
- Mobile app compatibility.
- Compatibility with commonly used browsers, operating systems and devices.
- Flexibility to accommodate business partners’ and customers’ needs.
- Expanded automated error checking and data validation.
- Availability of on-demand enrollment and training tools for members and administrators.
- Self-service tools and features for members and administrators.
- Automated dependent eligibility verification among and between OEBB and PEBB member groups.

OEBB and PEBB are in the initial stages of the replacement BMS implementation with their contracted vendor utilizing policy package funding from the current biennium. This policy package will fund the remaining implementation activities including additional project staffing, vendor implementation costs, hosting and licensing fees, oversight fees for quality assurance, and contingency allowances. The implementation plan outlined by the selected vendor, LifeWorks, has a go live date in the first quarter of 2025.

Revenue sources and changes

Oregon Revised Statute (ORS) 243.880 established the Oregon Educators Benefit Account to cover administration expenses. The account’s revenue is generated through an administrative fee included in premiums for OEBB

medical, dental and vision benefits, which is considered Other Funds revenue. By statute, the administrative fee cannot exceed 2 percent of total monthly premiums. ORS 243.882 prohibits the balance in the account from exceeding 5 percent of the monthly total of employer and employee contributions for more than 120 days.

ORS 243.884 established the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and subsidize premiums.

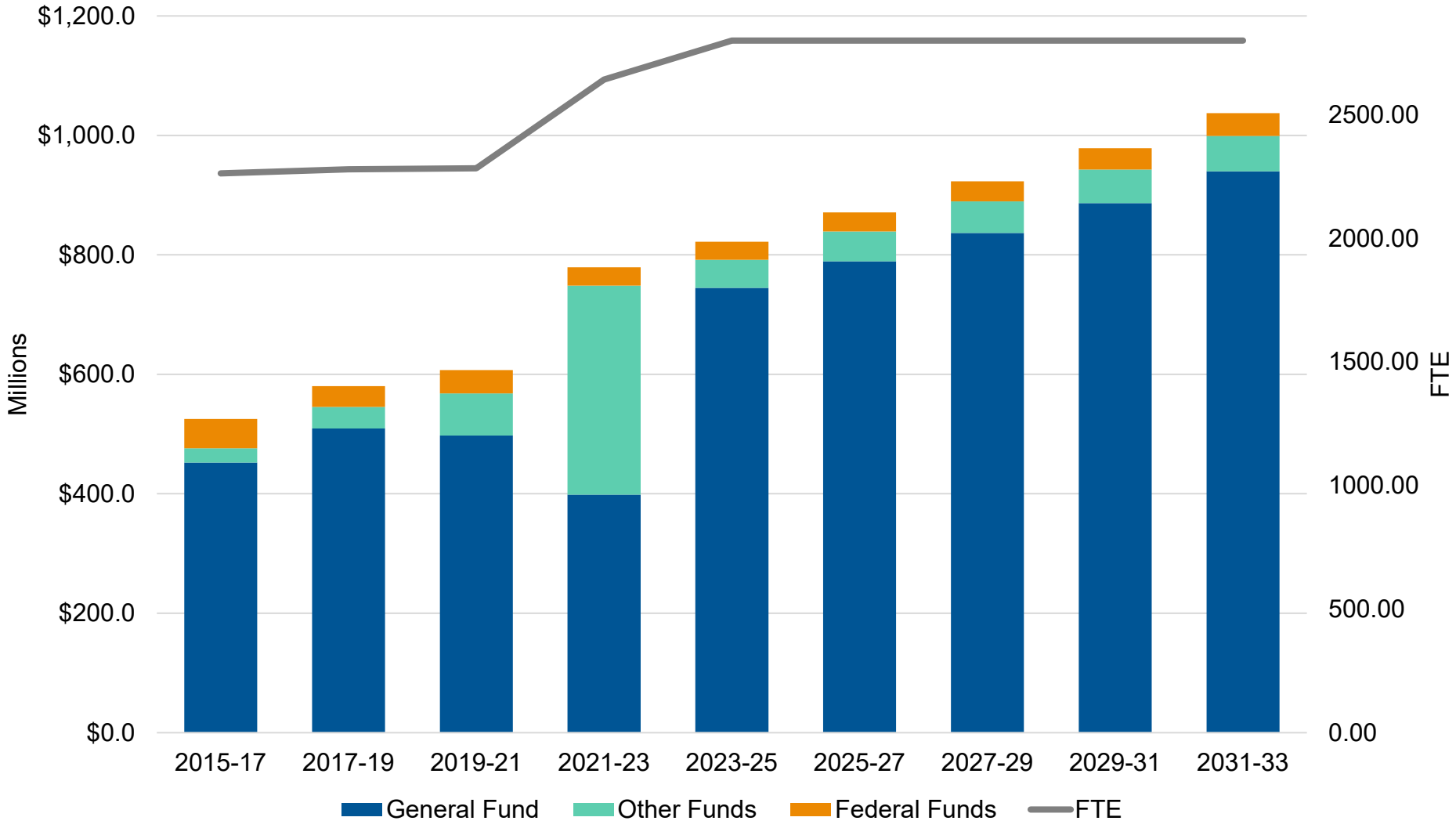
Proposed new laws that apply to the program unit

None.

Oregon Health Authority: Oregon State Hospital

Executive Summary

Program Contact: Dolly Matteucci, Superintendent
503-945-2850



Executive Summary

Division overview

Oregon State Hospital (OSH) is an essential part of the statewide behavioral health system, providing the highest level of psychiatric care for adults from all 36 counties. The hospital's primary goal is to help people recover from their mental illness and return to life in the community, contributing to healthy and safe communities for all people in Oregon. Oregon State Hospital promotes public safety by treating people who are dangerous to themselves or others in a secure, therapeutic setting. The hospital works in partnership with the other divisions of the Oregon Health Authority including the Health Systems Division (HSD), the Psychiatric Security Review Board (PSRB), regional hospitals, community mental health programs, advocacy groups and other community partners to ensure people with mental illness get the right care, at the right time, in the right place.

OSH operates two campuses with a total of 743 licensed beds, with 592 beds in Salem and 151 beds in Junction City. OSH services are provided 24 hours per day, seven days a week. Oregon's only state-operated secure residential treatment facility also reports to the superintendent of OSH. Pendleton Cottage, a 16-bed facility, is located on the grounds of the former Eastern Oregon Training Center in Pendleton. The secure mental health treatment program provides a community treatment setting for people who need a secure level of care as their first step out of the state hospital.

Funding request

The 2023-25 Governor's Budget for the Oregon State Hospital includes $743.7 million General Fund, $38.6 million Other Funds, and $30.0 million Federal Funds as well as position authority for 3,024 positions (2,800.23 FTE). The budget includes policy package #402 for specialized treatment services and supports and policy package #411 with funding and position authority for the remaining phases of the OSH sustainable staffing plan.

Program descriptions

Oregon State Hospital's role is to provide services and treatment to individuals that will prepare them for discharge when they no longer require hospital level of care. Services include 24-hour on-site nursing, psychiatric and other

Executive Summary

credentialed professional services, treatment planning, pharmacy, laboratory, food and nutritional services, and vocational and educational services. The hospital is accredited by the Joint Commission on the Accreditation of Health Organizations and all 24 hospital-licensed units (21 on the Salem Campus and 3 in Junction City) are certified by the Centers for Medicare & Medicaid Services (CMS). Services are provided by psychiatrists, nurses, and mental health professionals. Upon discharge, people transition to the community with improved skills to better understand and manage their symptoms, fully participate and live in their local community in a variety of community-based settings, and when able, hold a job.

Services are delivered through Interdisciplinary Treatment Teams of which patients and designated family members are team members. Treatment teams collaborate with patients to develop individualized treatment care plans to identify and achieve short- and long-term goals. These goals address potential safety risks, mitigate illness and promote recovery. Treatment care plans indicate which treatments a patient needs such as individual therapy, treatment therapy groups, medications, activities of daily living (cooking, personal finance), community integration and vocational rehabilitation or paid work. Treatment teams also work with each patient to ensure their individual needs are met, including but not limited to, culture, language, religion, LGBTQ+ status, or disability. If the need cannot immediately be met within the hospital's existing resources, the team will find a contractor, such as an interpreter or faith practitioner, to deliver these services for the patient.

Personal Services costs are the main budget driver for the Oregon State Hospital. Salaries, taxes and benefits for staff comprise 88 percent of OSH's 2021-23 Legislatively Approved Budget. Of the 2,658 positions currently budgeted for the Oregon State Hospital, 86 percent are direct-care staff such as nurses, psychiatrists, psychologists, etc. Per ORS 441.154 and ORS 441.155, the staffing plan for OSH is set by the nurse staffing committee, composed of both nurse management and AFSCME-RN union members. The number of staff the hospital needs is based on the level of acuity (the severity of symptoms, direct care needs) and commitment type (civil, guilty except for insanity, aid and assist). Sufficient staffing is key to OSH's ability to provide adequate mental health care treatment and services to its patient population in the most efficacious and efficient manner possible. Timely delivery of effective treatment including patient progression through OSH levels of care and timely discharge are critical to the ability of OSH to comply with legal

Executive Summary

requirements. The Mink Order of 2002 requires OSH to admit individuals under Aid and Assist orders within seven days of the signed judge's order. The December 2021 Interim Settlement Agreement with Oregon Health Authority, Oregon State Hospital, Metropolitan Public Defenders and Disability Rights Oregon consolidated two related cases, and appointed a neutral expert in both matters, to make recommendations to address capacity issues at the Oregon State Hospital. Dr. Pinals, the neutral expert, has submitted four reports to Federal Court Judge Michael Mosman that include recommendations to address OSH capacity issues in support of the seven day admission requirement for individuals under aid and assist orders, and also address the behavioral health continuum needs that support the right care, in the right time, and the right place, to improve behavioral health service access to the people of Oregon while relieving the pressure of over-reliance on OSH.

Program justification and link to long-term outcomes

As the only Psychiatric Hospital in Oregon, OSH is devoted to the diagnosis and treatment of people experiencing mental illness. Like any hospital, patients are admitted to OSH for an episode of care. Unlike other hospitals, OSH has most services a patient might need in one location with 24-hour on-site psychiatric and nursing care in a secure and safe environment. This establishes OSH as a key contributor to the 10-year OHA goal of creating health equity and allowing all patients to achieve full health potential and well-being. The contribution and progress of OSH along this path are measured and monitored through OSH's key goals.

OSH's key goals identify our core business, what we strive to do each day as we live our mission, vision and values. Our key goals are identified on our Fundamentals Map, including outcome measures for accountability. The OSH Fundamentals map supports the OHA performance system.

OSH's key goals are:

- Excelling in recovery-oriented care and treatment.
- Ensuring safety in all environments.
- Improving processes and performance.
- Recruiting and engaging outstanding staff.

Executive Summary

- Employing information technology effectively.

Program performance

OSH uses Lean methodology as the primary foundation for continuous improvement and organizational performance. Through Lean, OSH has a robust system to align and link all the services it provides with organizational goals and desired outcomes. OSH also tracks performance metrics throughout the hospital using the Lean Daily Management System (LDMS) and the OSH Performance System. This framework provides a clear line of sight to ensure the work is achieving the desired outcomes. Performance improvement work was disrupted between 2020-2022, due to OSH's need to respond to the COVID-19 pandemic. The focus of 2023 is to rebuild and reinvigorate these expectations.

Performance System

The OSH Performance System focuses on the hospital's fundamental work processes and desired outcomes, while enforcing discipline around measurement and metrics. The Performance System helps the hospital generate targeted breakthrough initiatives and use problem-solving techniques to address areas where performance is poor. The OSH Fundamentals Map supports the overarching OHA Tier One Fundamentals Map.

The performance system scorecard monitors the hospital's outcome and process measures from the Fundamentals Map, which show progress toward key goals. The scorecard is a way for hospital leadership to manage data, monitor progress and identify achievements. Having this data available enables the hospital to proactively assign resources to continuous improvement teams early enough to make vital improvements that affect patient outcomes, improve safety and reduce costs.

Some examples of metrics tracked on the scorecard are:

- Patient treatment hours
- Incidents of aggression

Executive Summary

- Patient and staff injuries
- Incidents and duration of seclusion and restraint
- Length of stay
- Admissions wait times
- Time between placement on the Ready-to-Transition List and discharge
- Staff turnover

OSH holds quarterly performance reviews (QPRs) every three months to check the status of our organizational health using the scorecard. QPRs create the discipline to review the status of the routine work (fundamentals) and initiatives (breakthroughs), and to drive problem solving as needed to achieve the goals of the organization.

Enabling legislation/program authorization

The hospital operates under ORS 161.295-400, 179.321, ORS 426, and ORS 443. These statutes provide the authority to operate, control, manage and supervise the Oregon State Hospital campuses and state-delivered residential treatment facilities.

Funding streams

The 2023-25 Governor's Budget for OSH, excluding capital improvement, totals $812.3 million and is made up of 92 percent General Fund revenues. On an ongoing basis, OSH generates Other Funds revenue through billing of services to Medicare for eligible patients. Medicaid funds make up the Federal Funds portion of the budget.

Significant proposed program changes from 2021-23

OSH is a critical component of the behavioral health system in Oregon. OSH strives to meet the needs of each patient while remaining nimble and responsive to the demands for beds and services across the patient populations. OSH internally reconfigures services to meet the demand for hospital level of care services across the continuum realizing the interplay of service needs across our continuum partners.

Executive Summary

The pandemic has challenged OSH, as it has many service providers, to provide the services necessary to the people of Oregon who require hospital levels of care. Low staffing numbers and high vacancy rates have led to staff fatigue and low morale. At times, staffing has forced OSH to modify its operations to ensure staffing levels are sustained at the necessary levels to care and provide treatment for patients. In policy package #411, the 2023-25 Governor's Budget builds in the remaining phases of the OSH sustainable staffing plan and provides OSH with positions for a "posting factor." These posting factor positions are used to backfill staffing posts on units when they are vacant due to planned or unplanned employee time off. With this additional support, when all positions are filled, OSH will have a budgeted programmatically sound staffing plan for direct nursing care.

Following the report of an independent expert, OSH has adopted admissions processes to provide available beds to the greatest number of individuals requiring a hospital level of care, equalizing the admission timeframes for individuals under Aid and Assist orders and those deemed Guilty Except for Insanity, with these population types prioritized for bed use. With the operationalization last biennium of all OSH beds across both campuses (the opening of the last two SRTF units at Junction City), the ongoing challenge will be to admit and discharge at sufficient rates to maximize the utilization of the campus space to serve those who need services at the hospital. Meeting this challenge requires the right number of trained staff at OSH and effective and efficient treatment and processes and is equally dependent upon a robust and functioning behavioral health continuum of service.

Oregon Health Authority: Oregon State Hospital

Salem Campus

The Governor's Budget continues funding for the Oregon State Hospital (OSH) - Salem Campus services substantially at the current service level for the 2023-25 biennium. This includes the transition back to General Fund from one-time funding made available from the American Rescue Plan Act. This budget also includes funding for promoting equity at OSH (policy package #402) and a sustainable staffing plan for direct nursing care (policy package #411).

Activities, programs and issues in the program unit base budget

Salem Campus detail

- Capacity: 24 units (592 beds)
- Operating: 24 units (559 beds)
- Population served: aid and assist, guilty except for insanity (GEI), neuropsychiatric (high medical need), and civil commitment (includes voluntary commitments by guardian).
- Census: 530.5 (Daily average population for 2022)
- Square feet: 1.3 million

Background information

Populations served

Oregon State Hospital serves adults who need intensive psychiatric treatment for severe and persistent mental illness. With 24-hour on-site nursing and psychiatric care, the hospital helps patients gain the skills they need to successfully transition back to the community.

The Salem campus serves individuals under three different commitment types:

- **Aid & Assist** – People who come to Oregon State Hospital through a court order under Oregon law (ORS 161.370) for treatment that will help them understand the criminal charges against them and to assist in their own defense.

Salem Campus

- **Guilty Except for Insanity (GEI)** – People who come to Oregon State Hospital who have successfully pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.
- **Civil** – People who come to Oregon State Hospital through a civil commitment require 24-hour care that is not available through community programs. These patients have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs – such as health and safety – because of a mental disorder.

Treatment programs – Oregon State Hospital serves patients in the program that best meets their treatment and psychiatric acuity needs.

- **Springs** – The Springs program serves patients from all three commitment types. These patients experience co-occurring mental and physical illnesses that often require hospital-level care for dementia or organic brain injuries. Patients each have individual treatment care plans and attend treatment mall groups every weekday. Treatment groups feature sensory and behavioral therapy, focusing on daily living skills, coping and problem-solving skills, and medication management.

- **Archways** – The Archways program primarily serves people under Aid and Assist court orders. This program helps patients stabilize, gain the ability to cooperate with attorneys, understand the charges against them, and participate in their own defense. Patients each have individual treatment care plans and attend treatment mall groups every weekday. Treatment groups primarily focus on understanding the court system and learning basic legal terminology. Other treatment groups and resources include a law library, legal assistance, symptom management, anger management, physical fitness, medication management and drug and alcohol education. Treatment teams conduct hospital level of care assessments to identify individuals that no longer need hospital level of care for ongoing competency restoration, providing notification to the committing court and CMPHD.

During their stay, patients are periodically evaluated by forensic evaluators to determine if they are able, never able or not yet able to stand trial.

- **Harbors** – The Harbors program provides acute care psychiatric treatment across all commitment types. Patients each have individual treatment care plans and attend treatment mall groups every weekday. Treatment groups are designed to achieve psychiatric stabilization to transition to lower levels of psychiatric care within the hospital. Treatment groups also focus on symptoms management, medication management, legal skills acquisition, and practicing coping skills.

- **Pathways/Bridges** – Pathways/Bridges is a combined program. Pathways serves the GEI and Aid and Assist population. Bridges serves people in GEI population patients who are preparing to transition back to the community. Bridges units are licensed at the secure residential treatment level of care. The goal is to help patients achieve their highest level of health, safety, and independence as they prepare for discharge or conditional release to a less-restrictive community setting. Individuals work on living skills through daily treatment mall activities, classes, and approved outings. They also participate in discharge planning with their treatment team members.

- **Crossroads** – The Crossroads program provides progressive care services for patients from all three commitment types. Patients each have an individual treatment care plan and attend treatment mall groups every weekday. These groups are designed to help patients learn how to manage their symptoms and medications, develop coping and recreational skills, budget and manage their money, and plan and prepare meals.

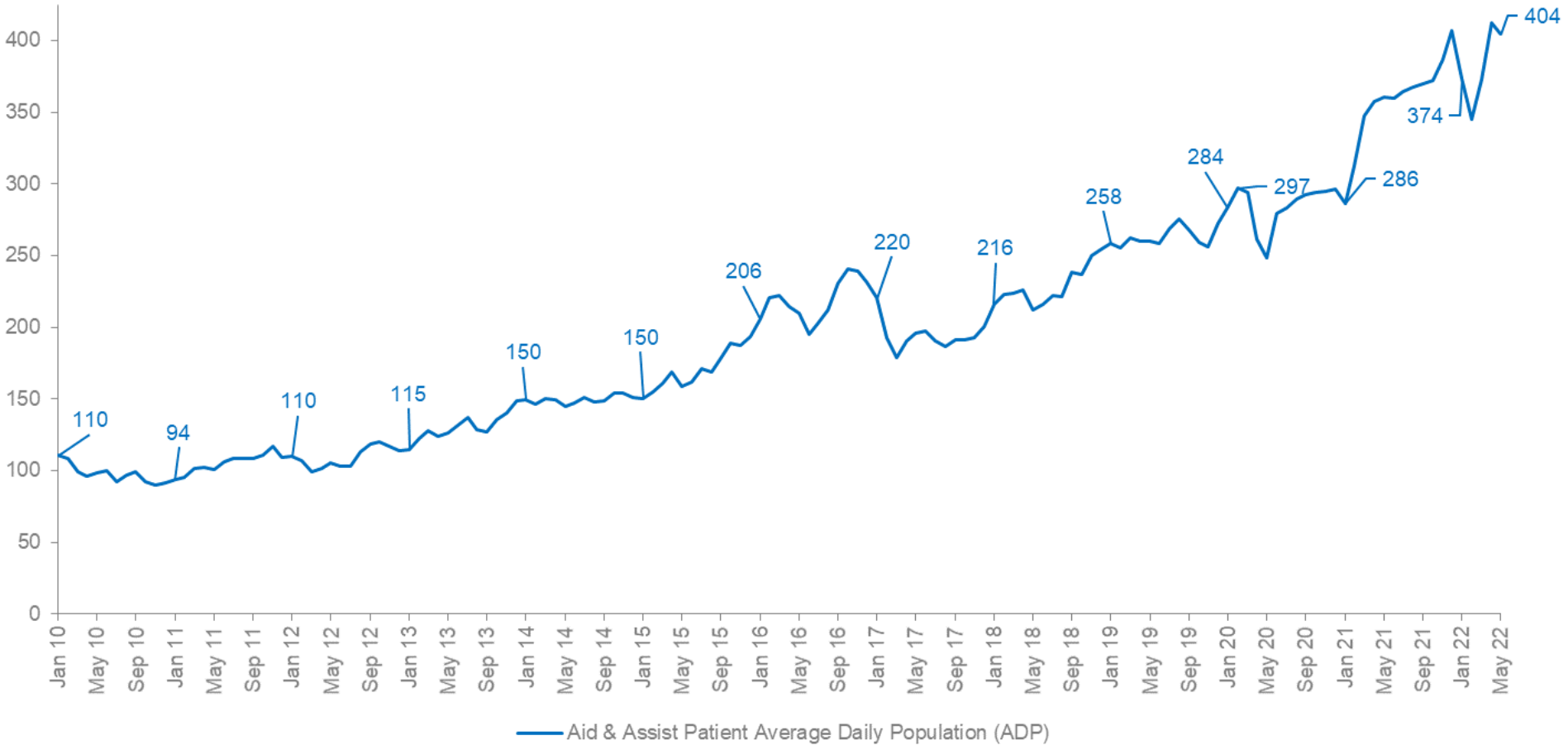
Increasing Aid and Assist population

The number of people sent to OSH to be restored to competency so they can assist in their own defense has grown significantly over the past several years. To serve this growing population OSH has consolidated units, converted units and opened units. The Aid and Assist population at OSH spiked dramatically in October 2018 and has

continued to increase through 2022. The Average Daily Population (ADP) increased from 221 in 2018 to 404 in May 2022. Because of this unprecedented increase, multiple conversions were required to provide hospital bed capacity to serve people under Aid and Assist orders that are waiting in jail to receive psychiatric care and competency restoration services.

Key to addressing this issue is developing a robust array of community services, including crisis interventions – such as mobile crisis teams and assertive community teams – that enable law enforcement and other community partners to connect people with mental health services, rather than arrest them. Additionally, community capacity for competency restoration must expand via diversion pre-hospitalization and post-hospitalization for those who do not require hospital level of care. The Oregon Health Authority (OHA), including the Health Systems Division (HSD) and OSH, is working with community partners to strengthen and expand these services.

Salem Campus



Salem Campus

Nurse Staffing

Adequate nurse staffing is fundamental for effective treatment and patient and staff safety at OSH. Per Oregon Revised Statute 441.154 and 441.155, the staffing plan for OSH is set by the Nurse Staffing Committee, composed of both nurse management and AFSCME-RN union members. On average, about 20.1 percent of the OSH direct-care staff (registered nurses, licensed practical nurses, and mental health technicians) are absent each day. OSH has experienced an increase in its rate of non-delivered staff since the pandemic. This number does not include planned absences such as vacation or personal business. To meet the staffing plan's minimum staffing requirements, the hospital is requesting a true posting factor for non-delivered staff and utilizes a system of voluntary overtime opportunities for employees to cover for other staff absences. If not enough people volunteer, the hospital must mandate staff to work overtime. However, even with overtime shifts and nursing agency contracted staffing, the hospital's staffing needs are not always met.

In addition to back-filling unplanned absences, OSH nursing staffing requirements are affected by:

- Acuity – The hospital needs a greater staff-to-patient ratio to maintain a patient-centric and effective treatment in a safe environment to accommodate for the severity of illness in the patient population.
- Precautions – The hospital needs additional staff to carry out physician-ordered patient "precautions," which is when one staff is assigned to monitor and engage an individual patient who the physician has assessed as having a medical risk or risk of harming themselves or others.

Per statute, the OSH Nurse Staffing Committee established a Nurse Staffing Plan in April 2017 (revised most recently in late 2019). In addition to meeting the requirements of the law regarding the length of shifts, lunch-break coverage, mandatory overtime, etc., the staffing plan also ensures the hospital meets the standards needed to maintain Centers for Medicare & Medicaid Services (CMS) certification.

Salem Campus

The prevalence of staff call-outs (unplanned absences) and physician-ordered patient precautions has driven staffing needs well beyond the Nurse Staffing Committee's staffing plan. Historically and currently, OSH has relied on overtime as the primary means to meet staffing needs when direct-care staff are absent and to staff patient acuity/precaution needs. Over the past three years, OSH has averaged 18,795 hours and $884,023 in monthly overtime to fill planned and unplanned direct-care staff vacancies, in addition to an increased reliance on contract agency staffing.

However, the 2015 Secretary of State audit of OSH overtime practices pointed out that *"Excessive overtime creates safety risks because it can lead to fatigue, affecting nursing staffs' ability to deliver good patient care, making good clinical decisions, and communicating effectively. Fatigued nursing staff could make errors, take unnecessary risks, be forgetful, and be in a poor mood."*

Further, in 2016, The Joint Commission visited OSH to follow up on concerns of inadequate staffing levels. The surveyor investigated the following standard: *EP 3 §482.62(d)(2) - (B150) - (2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.* Because the surveyor observed the high level of unplanned direct-staff absences at OSH, she found that: "*This Standard is NOT MET as evidenced by: Observed in Record Review at Oregon State Hospital (2600 Center Street, NE, Salem, OR) site for the Psychiatric Hospital deemed service. In 35 of 112 shifts reviewed, staffing was noted not to meet the organization's expected staffing matrix."*

In 2019-21 the Legislature set aside a Special Purpose Appropriation of $20 million and directed the OSH to develop *a programmatically and fiscally sustainable staffing plan*. OSH submitted that plan in November 2021 and in May 2022 received 228 new positions. These positions represent the first of three phases to implement OSH's sustainable staffing plan. The majority of the positions —134 — replace the limited duration (LD) float pool OSH established in 2017 to ensure adequate nurse staffing to provide active treatment, a therapeutic milieu, and a safe environment. Previously, the cost for these LD positions and increased nurse agency staffing was not budgeted and

has been a driver of shortfalls since 2017-19 into 2021-23 as the division has only partially afforded to make up costs from its existing budget allocation.

Revenue sources and changes

The Oregon State Hospital receives most of its funding from the state General Fund. Other Funds revenues consisting of service revenues generated through the billing of Medicare and third-party insurance and local revenue from the hospital café, coffee shop, and patient made wood products sales account for a small portion of the budget. Finally, Federal Funds from Medicaid and Disproportionate Share Hospital (DSH) payments make up the remaining budget.

One of the financial impacts of a shifting population at Oregon State Hospital is lower numbers of patients on Medicare being admitted. This has reduced the collection of Medicare revenue necessitating fund shift adjustments for 2021-23. DSH payments have also declined due to adjustments in the FMAP rate.

Proposed new laws that apply to the program unit

Senate Bill (SB) 219 will substantially increase the number of evaluations FES will have to conduct and send to the courts and parties. After the initial report, subsequent evaluations are “progress reports” and may be brief updates rather than lengthy reports as currently required. This will allow the increased cadence in FES to be somewhat easier to manage, but additional evaluator and staffing positions will still be needed, even if the reports are simpler. The shortened timeframes will also require sufficient staffing to provide active treatment for aid and assist patients. This bill was proposed by HSD and OSH.

House Bill 2273 updates outdated and pejorative language by replacing “mental hospital” and “state hospital” to “the Oregon State Hospital.” These language changes will have no substantive impact on Oregon laws. But they will assist

with reducing the stigma against people who have been patients at the Oregon State Hospital. House Bill 2273 was proposed by OSH.

State-Delivered Secure Residential Treatment Facility

The Governor's Budget continues funding for the Oregon State Hospital - Pendleton Cottage, a 16-bed state-delivered secure residential treatment facility, at the current service level for the 2023-25 biennium.

Activities, programs and issues in the program unit base budget

Pendleton Cottage is a state-operated secure residential treatment facility in Pendleton, Oregon. With the capacity to serve up to 16 people, Pendleton Cottage provides 24-hour mental health treatment services for adults in a residential setting. In the 2021-23 biennium, the facility averaged a 97.5 percent occupancy rate, with an average daily population of 15.6. The mission of Pendleton Cottage is to help people recover from their mental illness by focusing on positive life experiences, self-confidence and community integration. Pendleton Cottage is often the first step for people transitioning from the state hospital to a life in the community.

Background information

People served

Pendleton Cottage serves people who have been civilly committed or who are under the jurisdiction of the Psychiatric Security Review Board. Residents no longer require hospital level of care and still need 24-hour care and a higher level of supervision due to the status of their mental illness, safety and security concerns, and/or the severity of their offense.

Treatment philosophy

Pendleton Cottage uses the recovery model for person-centered treatment planning in which residents direct their own treatment. Together, residents and their treatment teams create an integrated service and support plan that incorporates the resident's residential service plan, treatment care plan, and the resident's self-stated dreams, desires and goals.

State-Delivered Secure Residential Treatment Facility

Residents who are under the jurisdiction of the Psychiatric Security Review Board also must meet the expectations outlined in their conditional release plan. To align with the self-directed treatment approach used at Pendleton Cottage, residents are encouraged to determine how they will meet their conditional release requirements and are offered opportunities for choice.

Pendleton Cottage services

- On-site and telemedicine psychiatric services
- Individual therapy
- Vocational services including on-site paid employment opportunities
- Recreational services, both on- and off-site
- In-house case management
- Medication administration, monitoring and teaching
- Nursing services for individuals who have significant medical needs, such as diabetes, chronic obstructive pulmonary disease, or physical disabilities.

Facility

Opened in 2009, Pendleton Cottage consists of two separate houses, allowing for the opportunity to serve both men and women. One house has the capacity to serve up to four women and four men, and the other house serves up to eight men. The property also includes a greenhouse and park for the residents to use.

In October 2016, Pendleton Cottage opened the Lane Activity Center, a new treatment space where residents participate in leisure and therapeutic group activities. The center enhances the facility's ability to offer active treatment and help individuals develop the skills they need to successfully move to a lower level of care.

State-Delivered Secure Residential Treatment Facility

Staffing

Pendleton Cottage has 45 staff, including the administrator, to meet the residents' complex behavioral and medical needs. The average staffing ratio is three staff to eight patients, with at least three direct-care staff and one nurse on every shift. Staff provide:

- Resident supervision
- Therapeutic interventions
- Medical assistance
- Clinical work
- Case management
- Liaison to Psychiatric Security Review Board, including monthly progress reports

Revenue sources and changes

Revenue sources for Pendleton Cottage in the 2023-25 Governor's Budget include General Fund. Other Funds revenues consist primarily of private payment Room and Board, with additional revenues for service reimbursement and meal tickets. Federal Funds revenue consist of the federal match of Medicaid claim billing. The increase in services billed for has resulted in a minor increase in Federal Funds revenue and is represented in the 2023-25 fund shift adjustment.

Proposed new laws that apply to the program unit

None.

Junction City Campus

The Governor's Budget continues funding for the Oregon State Hospital - Junction City Campus services at the current service level for the 2023-25 biennium. This includes the transition back to General Fund from one-time funding made available from the American Rescue Plan Act. This budget also includes funding for promoting equity at OSH (policy package #402), and a sustainable staffing plan for direct nursing care (policy package #411). Bond-financed Capital Improvement funds are also set aside for the development of specialized space to accommodate patients with unique care needs.

Activities, programs and issues in the program unit base budget

Junction City Campus Detail

- Capacity – 7 units, (151 beds)
- Operating – 7 units, (145 beds)
- Populations served – civil commitment (includes voluntary commitments by guardian), guilty except for insanity (GEI)
- Census – 139.9 (daily average population for 2022)
- Square feet – 220,000

Background information

Populations Served

Oregon State Hospital serves adults who need intensive, psychiatric treatment for severe and persistent mental illness. With 24-hour, on-site nursing and psychiatric care, the hospital helps patients gain the skills they need to successfully transition back to the community.

Junction City Campus

There are two commitment types served at the Junction City campus:

- **Civil** – People who come to Oregon State Hospital through a civil commitment require 24-hour care that is not available through community programs. They have been found by the court to be a danger to themselves or others, or unable to provide for their own basic needs – such as health and safety – because of a mental disorder. A subset of this population is called *Voluntary by Guardian*. Working through the court system, legal guardians may commit their wards who meet civil commitment criteria.

- **Guilty Except for Insanity (GEI)** – Oregon State Hospital serves patients who have successfully pleaded Guilty Except for Insanity (GEI) for crimes related to their mental illness. These patients are under the jurisdiction of the Psychiatric Security Review Board.

Treatment program
Because of its small size, the Junction City campus has only one treatment program. The Junction City campus provides varied treatment mall and group therapy offerings. The program's intent is to help patients achieve their highest level of health, safety and independence as they prepare for discharge or conditional release to a less-restrictive community setting. Individuals work on living skills through daily treatment mall activities, classes and approved outings. Patients also participate in discharge planning with their treatment team.

Although the campus admits people from all 36 counties, an emphasis is put on serving seven southern counties – Lane, Curry, Klamath, Douglas, Jackson, Coos and Lake.

Revenue sources and changes

The Governor's Budget for Junction City campus of the Oregon State Hospital includes General Fund and Other Funds revenues, which consist of service revenues generated through the billing of Medicare and third-party

insurance as well as local revenues derived from the hospital café and coffee shop. The Junction City campus receives no Federal Funds revenue.

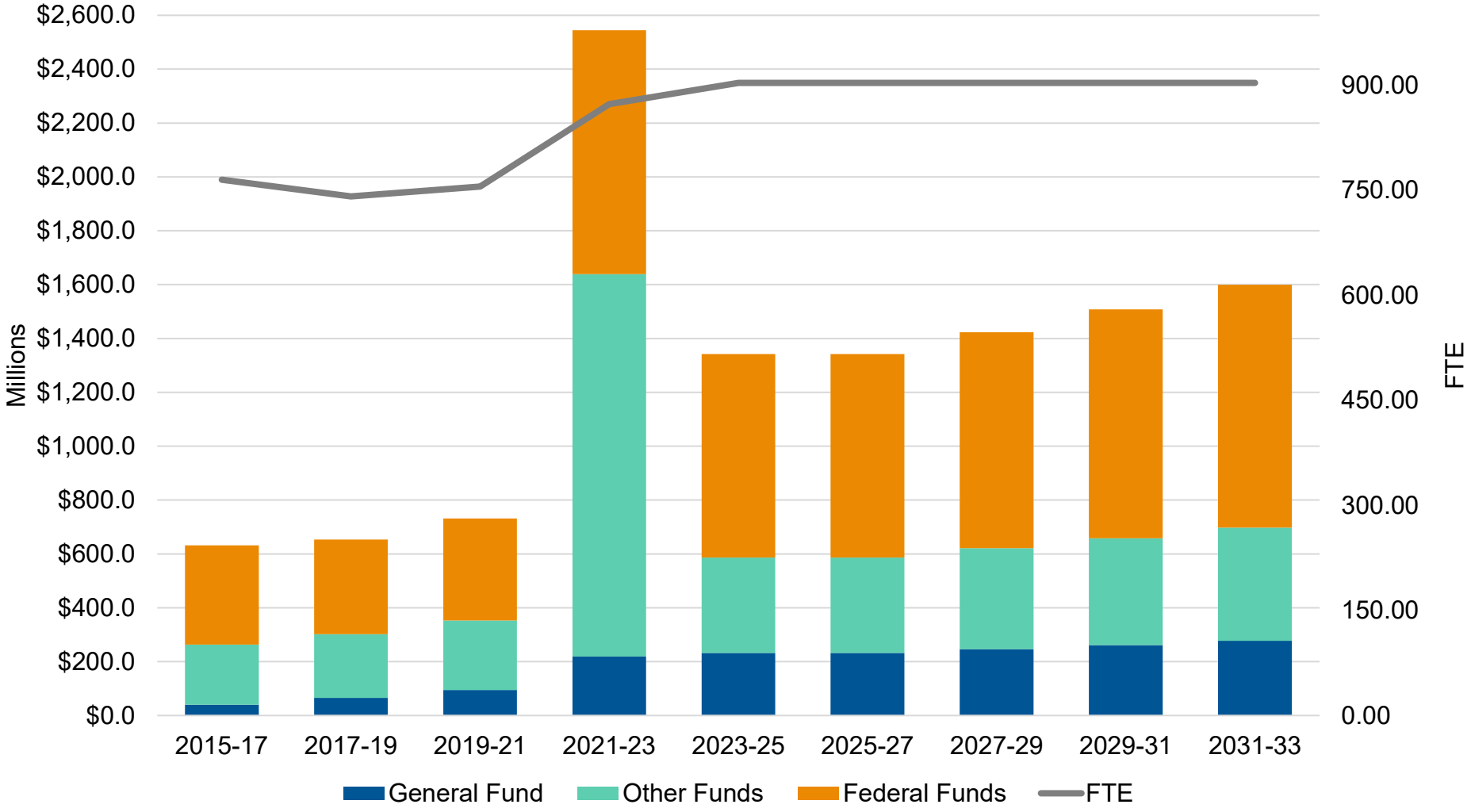
Proposed new laws that apply to the program unit

House Bill 2273 updates outdated and pejorative language by replacing “mental hospital” and “state hospital” to “the Oregon State Hospital.” These language changes will have no substantive impact on Oregon laws. But they will assist with reducing the stigma against people who have been patients at the Oregon State Hospital. HB 2273 was proposed by OSH.

Oregon Health Authority: Public Health Division

Executive Summary

Program Contact: Rachael Banks, Public Health Director
971-673-1222



Executive Summary

Division overview

Public health uses equity practice, data and science to achieve better health outcomes, improve care and lower or contain health care costs by preventing the leading causes of death, disease, and injury in Oregon. The OHA Public Health Division (OHA-PHD) works in partnership with local public health authorities (LPHAs), Tribes, community-based organizations (CBOs), health systems and a number of sectors to elevate community priorities for health into programs designed to eliminate health inequities by 2030.

Funding request

OHA-PHD's 2023-25 Governor's Budget includes phasing out of COVID-19 response funding. The 2023-25 OHA-PHD budget also includes critical investments in state, local, Tribal and community-based public health infrastructure that is necessary to continue progress toward eliminating health inequities through response to ongoing communicable disease threats; environmental health hazards including wildfire, extreme heat and water quality; and continued implementation of voter-approved and legislatively mandated public health programs that are implemented across Oregon communities.

Program descriptions

The mission of OHA-PHD is to promote health and prevent the leading causes of death, disease, and injury in Oregon. The OHA-PHD vision is lifelong health for all people in Oregon. OHA-PHD implements the 2020-24 State Health Improvement Plan (SHIP), Healthier Together Oregon through 62 strategies are organized in five priority areas: Institutional bias; Adversity, Trauma, and toxic stress; Economic drivers of health (including issues related to housing, living wage, food security and transportation); Access to equitable preventive health care; Behavioral health (including mental health and substance use).

The community-led, equity-centered strategies included in Healthier Together Oregon are a result of the work the public health system has done to modernize its practice. Oregon's public health system includes LPHAs, Tribes, CBOs and OHA-PHD. The public health infrastructure developed as a result of public health modernization has

been essential to Oregon's response to COVID-19 and emerging public health threats, including opioids and hMPXV. The ongoing focus on health equity and cultural responsiveness by the public health system has allowed engagement with community members and CBOs to utilize public health data to quickly identify community-level impacts of a public health threat and engage quickly with communities and partners to provide culturally and linguistically responsive communications to keep Oregonians safe.

Program justification and link to long-term outcomes

Public health programs and interventions contribute to reductions in health care costs and improved health outcomes through the community-led initiatives designed to prevent disease and injury. OHA-PHD uses data and culturally and linguistically responsive practices to work toward the OHA goal of eliminating health inequities by 2030. OHA-PHD works with communities that are most impacted by health inequities to collect and share health data to determine priorities for funding and policy. In 2023-25, OHA-PHD will implement public health modernization investments that provide the necessary public health infrastructure to support ongoing and complex public health needs, including the secondary impacts of COVID-19. OHA-PHD will need to phase out short-term COVID-19 Federal Fund investments and phase in other long-term General Fund and Federal Fund investments to sustain investments in communicable disease control and health equity, including cohesive, community-led approaches to equity across OHA-PHD's 100 program areas.

Program performance

OHA-PHD has a system of performance management and quality improvement to inform program implementation. Specifically, OHA-PHD collects and reports annually on SHIP health outcome measures, which are also reflected in the Oregon Health Authority Key Performance Measures and public health accountability measures. In 2023, OHA-PHD will submit its application for reaccreditation with the National Public Health Accreditation Board, further cementing OHA-PHD's public health practice as meeting or exceeding national accreditation standards.

Executive Summary

Enabling legislation/program authorization

OHA-PHD plays a central role in ensuring the health of all people in Oregon. Chapters 431 and 433 of Oregon Revised Statutes set forth hundreds of code sections enabling a wide range of public health activities carried out by state public health and its partners. Federally funded public health programs are implemented according to federal laws.

Funding streams

For the 2023-25 biennium, the OHA-PHD Governor's Budget comprises General Fund, Federal Funds and Other Funds. Federal revenue includes entitlement grants such as Medicaid and more than 72 categorical grants. As a part of COVID-19 response, OHA-PHD has received over $700 million in funding from federal grants and CARES Act funds to address both the immediate pandemic and long-term strategic planning to address pandemic and any other future outbreaks. Congress has passed the Consolidated Appropriations Act of 2021 and the American Rescue Plan Act.

OHA-PHD's Other Funds revenue sources include fees for activities in such areas as newborn screening tests; licensing of facilities including hospitals; and statutorily dedicated funds from the Tobacco Use Reduction Account.

Significant proposed program changes from 2021-23

In the 2023-25 biennium, OHA-PHD will continue advancements in public health modernization by continuing a focus on health equity, communicable diseases, environmental health, emergency preparedness and the indirect impacts of COVID-19 on health, such as access to preventive care, behavioral health and community cohesion. COVID-19 has highlighted the critical foundational capabilities and programs necessary to respond to new public health threats and achieve OHA's 10-year goal of eliminating health inequities.

Executive Summary

In order to sustain the costs of service delivery in fee-based programs, the 2023-25 OHA-PHD Governor's Budget includes fee increases for the Newborn Screening Program and the Oregon Environmental Laboratory Accreditation Program (ORELAP).

Additionally, OHA-PHD will implement Senate Bill 1549 – Temporary Staffing Agencies; Senate Bill 1554 (2022) – COVID-19 After Action Report; HB 4098 – Opioid Settlement Fund; House Bill 4077 – Environmental Justice; House Bill 2842 (2021) – Healthy Homes Grant Program; Senate Bill 587 – Tobacco Retail Licensure (2021); Ballot Measure 109 (2020) – Psilocybin Services, among other legislation impacting public health in Oregon.

Office of the State Public Health Director

The Governor's Budget includes funding for the 2023-25 biennium to continue current service levels. It also contains several policy packages to support building health equity and community-focused public health, which includes continuing public health modernization, strengthening access to reproductive health care, and increasing capacity to respond to emerging issues.

Activities, programs and issues in the program unit base budget

The Office of the State Public Health Director (OSPHD) guides the strategy, operations, scientific activities, communication, and policies of all public health programs and ensures that Oregon's public health system is effective, efficient and aligned with the OHA goal to eliminate health inequities by 2030. This work includes cross-division coordination of health equity initiatives for the public health system, including health equity training and capacity building, community-led data collection, policy development, strategic planning and workforce diversity recruitment and retention. The office sets state and division-wide public health priorities in collaboration with state and local government agencies, Tribes, and community-based organizations. With support from OSPHD, the Public Health Division is organized into three centers: Center for Public Health Practice, Center for Prevention and Health Promotion, and Center for Health Protection.OSPHD provides equity, scientific, fiscal, policy and operations leadership to all public health programs and is organized into five units: Finance, Operations, Equity, Policy and Partnerships, and Science and Epidemiology.

The OSPHD Equity Unit provides overall coordination and leadership for public health division-wide strategic initiatives, public health systems change, including public health workforce development and capacity building related to antiracism and decolonization within public health practice. The Unit leads community-determined statewide public health efforts and collaborates with OHA and Oregon Department of Human Services (ODHS) towards OHA's strategic goal of eliminating health inequities by the year 2030. The Equity Unit mobilizes partners and collaborators to advance health equity, decrease inequities in population health outcomes, and address social

determinants of health among underserved populations through statewide community- and culturally-specific strategies including outreach, engagement and equitable service delivery.

OSPHD works to identify and rectify gaps in health equity practice through equity assessments and data; collaborating with the OHA Equity and Inclusion Division, Community Partner Outreach Program, regional health equity coalitions, and affected communities and populations regarding comprehensive health equity planning and development; partnering with communities to determine culturally-specific priorities and invest public health resources in them; improving the collection REALD data to understand health by race, ethnicity and language, gender identity, place, and poverty; and building PHD organizational structures, policies and supports to promote workforce diversity.

The Finance Unit manages the Oregon Health Authority Public Health Division (OHA-PHD) budget process, fiscal management, position management, legislation and contracts with local public health authorities, federally recognized Tribes and community-based organizations.

The Operations Unit manages OHA-PHD human resources, building operations, risk, employee safety and wellness, business continuity, quality improvement activities and workforce development. The Operations Unit leads division wide initiatives that improve the effectiveness of a modern and equity-centered public health system, including maintaining Oregon's Accredited Public Health status. The Operations Unit facilitates optimal public health employee engagement to inform the OHA strategic plan and performance system, PHD strategic planning, workforce recruitment, retention and professional development, and quality improvement initiatives. The Operations Unit also provides oversite and coordination across PHD's Health Information Technology projects; and directs and implements PHD's Continuity of Operations Plan, safety procedures and practices.

The Science and Epidemiology Unit includes population health data collection and reporting, program evaluation, clinical aspects of state public health service delivery, and ethical review of public health studies involving human

subjects through the OHA-PHD Institutional Review Board. The Science and Epidemiology Unit aligns public health data and collection reporting around race, ethnicity, language, and disability (REALD) as well as sexual orientation and gender identity (SOGI) data. The unit also supports community-based approaches to public health data collection by working directly with communities of color and Tribal communities to collect, analyze, interpret and report disaggregated public health data that is important to community.

The Policy and Partnerships Unit leads the development and implementation of strategic initiatives to improve equity and the social determinants of health through a modern public health practice. The unit is responsible for supporting legislative policy strategy and administrative rulemaking and developing and implementing statewide plans, which support OHA-PHD's nationally-accredited status, including Oregon's State Health Improvement Plan (SHIP) and the OHA-PHD Strategic Plan. The unit manages cross-division funding programs for 147 community-based organizations, 33 local public health authorities, nine federally-recognized Tribes and one Urban Indian Health Program. The unit cultivates strategic partnerships for a cohesive public health system. The unit staffs the Public Health Advisory Board, which has directed the public health system to lead with racial equity and supported the public health system's commitment to health equity through implementation of public health modernization.

OSPHD works with partners to implement Oregon's SHIP, Healthier Together Oregon, which is focused on changing the harmful policies and practices that have created conditions by which communities of color, Tribal communities and communities experiencing other historical and contemporary injustices have not had the same access to health. Healthier Together Oregon implementation is led by the PartnerSHIP, its external advisory committee.

The COVID-19 pandemic continues to have a major impact on the public health system and the core work of the division. Throughout the COVID-19 response, every unit within OSPHD has directly supported the COVID-19 response:

- Equity began within the COVID-19 response to facilitate community listening sessions, invest in communities and develop community-led quality improvement strategies to mitigate unjust health outcomes stemming from the pandemic.
- Finance leads all COVID-19 financial administration to date, including contract management, time coding, tracking all expenditures, FEMA reimbursement and management of federal investments in COVID-19 response.
- Operations organizes COVID-19 response and resilience staffing, staff wellness, safety and security, in-office, remote and hybrid facility needs across Oregon, and information technology infrastructure needed for the response.
- Science and Epidemiology provides scientific leadership for the COVID-19 response through the State Health Officer and State Epidemiologist and through analysis of key COVID-19-related health data.
- The Policy and Partnerships Unit provides cohesive COVID-19 response support, including administration of COVID-19 investments to local public health authorities, Tribes, and community-based organizations to provide culturally and linguistically responsive services for people affected by COVID-19. The unit facilitates COVID-19 related administrative rulemaking and administers policy change.

Background information

OSPHD works to ensure that decisions and priorities set in Oregon are community led, supported by public health data and grounded in public health practice and science to work toward OHA's 10-year goal of eliminating health inequities. OSPHD efforts focus on population-wide policy, systems and environmental changes. This work includes extensive coordination with Oregon's local public health authorities, federally recognized Tribes and community-based organizations. State public health programs also partner with a range of state and local agencies and organizations, health care providers, insurers, coordinated care organizations, state and federal agencies and the private sector.

Office of the State Public Health Director

Strategic planning and accountability

As part of national accreditation, OSPHD is responsible to develop an annual report and ongoing support for three prerequisites: a state health assessment, a state health improvement plan, and an organizational strategic plan, developed every five years. In 2018, OSPHD published Oregon's second State Health Assessment, which includes a set of quantitative state population health indicators. State population health indicators are updated annually and serve as the backbone for OSPHD's reporting of OHA-PHD's key metrics, including key performance measures, Oregon's State Health Improvement Plan (SHIP) measures, and public health accountability measures. OSPHD continues to implement REALD and support the use of data to identify and meaningfully address health inequities. From 2018-2020, OSPHD convened the PartnerSHIP, a multisector charged with guiding the development of the 2020-2024 SHIP. The PartnerSHIP used the State Health Assessment and feedback from communities across Oregon to identify the following five priorities for the 2020-2024 SHIP:

- Institutional bias
- Adversity, trauma and toxic stress
- Economic drivers of health (including issues related to housing, living wage, food security and transportation)
- Access to equitable preventive health care
- Behavioral health (including mental health and substance use)

Healthier Together Oregon officially launched in September 2020 through its new website, healthiertogetheroregon.org. The PartnerSHIP provides community-based leadership for the plan through 2024. OSPHD has established a cross-OHA Core Group to support implementation of Healthier Together Oregon with the OHA Equity and Inclusion Division, External Relations, Health Policy and Analytics and Health Systems Division. OSPHD partners with Health Policy and Analytics to align implementation of community health improvement plans by local public health authorities, coordinated care organizations and nonprofit hospitals with Healthier Together Oregon so that these plans can also be used to achieve statewide health outcomes.

Public health modernization

Office of the State Public Health Director

Since 2013, OSPHD has provided leadership for Oregon's public health modernization initiative. This effort began with House Bill 2348 (2013), which established the Task Force on the Future of Public Health Services, recommendations from which were used to create House Bill 3100 (2015). Since then, OSPHD has worked to implement the statutes governing public health modernization, including:

- Adopted a series of foundational capabilities and programs for governmental public health, including cultural responsiveness and health equity.
- Changed the composition and role of the Oregon Public Health Advisory Board on January 1, 2016.
- Required an assessment of how foundational capabilities and programs are provided and what resources are needed to achieve full implementation.
- Requires local public health authorities to submit plans for implementing the foundational capabilities and programs no later than December 2025.

Further refinements to the implementation of public health modernization were made with the passage of House Bill 2310 (2017). For the 2017-19 biennium, the Legislature made an initial $5 million General Fund investment in public health modernization. In the 2019-21 biennium, the Legislature added an additional $10 million General Fund investment for public health modernization. The $45 million investment in public health modernization for the 2021-23 biennium supports significant investments in Local Public Health Authorities, Tribes, community-based organizations, and OHA-PHD in order to:

- Continue to enhance regional infrastructure created during the 2019-21 biennium, including regional epidemiologist positions, data analysis and surge capacity agreements.
- Build public health system strategies for health equity and cultural responsiveness, community partnership development, assessment and epidemiology, leadership and organizational competencies, and communicable disease and environmental health interventions.
- Implement local and Tribal public health modernization plans.

- Build community-specific climate resilience strategies for communities most impacted by wildfires, smoke and extreme heat.
- Center community in communicable disease and emergency preparedness communications and responses.
- Update public health surveillance systems to be co-designed with communities and researchers from Tribal and communities of color, incorporate new data collection methods, and provide more granular levels of data.
- Evaluate the effectiveness of the public health modernization investment, including annual collection and reporting of public health accountability measures.

Per ORS 431.123, the Public Health Advisory Board, a 17-member committee of the Oregon Health Policy Board, supports implementation of public health modernization through three subcommittees:

- The Incentives and Funding Subcommittee is charged with developing a formula for distributing state funds for local public health authorities using the criteria set forward in ORS 431.380.
- The Accountability Metrics Subcommittee manages a series of quality measures for which state and local public health authorities will be financially accountable through the implementation of public health modernization.
- The Strategic Data Plan Subcommittee develops community-based plans for improving the quality of public health surveys and implementation of REALD.

The Public Health Advisory Board also provides oversight for Oregon's State Health Assessment, SHIP and the Preventive Health and Health Services Block Grant.

The public health infrastructure developed as a result of public health modernization has been essential to Oregon's response to COVID-19 and low case numbers relative to other states of a similar size and geography. Specifically, Oregon benefited from additional state and local epidemiologist positions to track data to quickly manage and respond to outbreaks; the Surge Epidemiologist brought on by public health modernization led outbreak investigation and COVID-19 support with the Department of Corrections and Oregon Youth Authority, a critical role

for addressing COVID-19 inequities. The ongoing focus on health equity and cultural responsiveness by the public health system has allowed better engagement with community members and community-based organizations. Health equity staff that have been hired by state, local and Tribal public health modernization funds have supported the COVID-19 response by applying principles of health equity and community partnership development to the work. Finally, work to prevent communicable disease transmission in high-consequence settings including long-term care facilities and homeless shelters was already underway across the state before the COVID-19 pandemic hit Oregon, so those relationships have been leveraged to respond to COVID-19.

The Public Health Advisory Board has adopted a health equity policy and procedure to ensure all board decisions promote equity and do not further health inequities; this policy and procedure commits the public health system to leading with race in its pursuit of health equity. The local public health authority funding formula includes several variables related to health equity so that future General Fund resources can be focused on communities experiencing the greatest burden of poor health outcomes.

Revenue sources and changes

The 2023-25 budget for OSPHD is composed of General Fund, Federal Funds (primarily through the agency's federally approved cost allocation plan), and Other Funds.

A portion of the General Fund is pass-through funding to local public health authorities to support local communicable disease outbreak surveillance. The remaining General Fund is used to fund new positions to support the implementation work of modernization, data and collection, and enhancements to critical data systems at the state.

The Legislature appropriated a total of $60.6 million General Fund to support the ongoing implementation of public health modernization. Of this investment, $47 million was allocated to Local public health authorities, community based organizations, federally recognized Tribes and the Urban Indian Health Program, NARA, to carry out local

and Tribal public health modernization strategies. The remainder has funded positions and contracts at the state level that are essential for the effective and efficient delivery of public health protections and coordination across the public health system.

OSPHD administers the State Support for Public Health investment in communicable disease prevention. In the 2021-23 biennium, $10.1 million was allocated to continue support for local communicable disease outbreak response at the current service level.

The office also receives federal funding from the Centers for Disease Control for the National Initiative to Address COVID-19 Health Disparities and the Preventive Health and Health Services Block Grant to address state-determined public health priorities.

Proposed new laws that apply to the program unit

Legislative concept #428 – Public Health Housekeeping makes minor statutory changes to facilitate implementation of public health laws.

House Bill 2279 (2023) – Death with Dignity Act repeals the residency requirement in Oregon's Death with Dignity Act.

Center for Health Protection

The 2023-25 Governor's Budget continues funding the Center for Health Protection programs at the current service level. The budget includes policy packages related to the Domestic Well Safety Program supporting state-wide domestic well drinking water safety and implementing a workplan to mitigate and protect public health from nitrate contamination in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA), investigate exposures to toxic substances and ensure food safety where OHA has local environmental health responsibilities. The budget also includes Other Funds limitation for Oregon Psilocybin Services to continue to implement Ballot Measure 109 and the framework for licensing and regulating Psilocybin Services.

Activities, programs and issues in the program unit base budget

The Center for Health Protection (CHP) protects the health of individuals and communities by establishing, implementing, and ensuring compliance with regulatory and health-based standards. CHP protects people in Oregon from environmental health hazards including those that may occur in drinking water, through exposure to radiation, and through food. The center also ensures compliance with critical areas of health care. The center's seven sections partner with local public health authorities, communities affected by environmental health hazards, Tribes, private practitioners, and medical experts. CHP works through its various programs towards achieving OHA's 10-year strategic goal to end health inequities by ensuring that communities of color, Tribal and communities experiencing lower-income are protected from environmental health risks. CHP also ensures that communities experiencing health inequities have safe and equitable access to health care facilities, emergency services, and to health-related services and professions.

Non-regulatory programs in CHP track, assess, and collaborate with community partners to provide outreach and education to vulnerable populations disproportionately exposed to built and natural environmental health risks, such as radon and lead exposure and the effects of climate change.

Center for Health Protection

Drinking Water Services (DWS) ensures the safety of drinking water provided by all public water systems in Oregon. The program administers and enforces state and federal safe drinking water quality standards, , inspects public water systems, advises operators on response to contaminant detections, assesses treatment efficacy, and provides regulatory and technical assistance to public water suppliers. DWS assists public water systems and communities with protecting their sources of drinking water from contamination. DWS also provides low-cost financing to communities to construct safe drinking water infrastructure, including funding assistance to underserved and economically disadvantaged communities..

Environmental Public Health (EPH) identifies, assesses, and reports on threats to human health from exposure to environmental hazards. EPH is called upon by local, state, federal and Tribal natural resource management, occupational safety, environmental and other agencies to assess risks to human health posed by changing conditions, policies and practices, and recommend interventions to address those risks. EPH recognizes that communities of color, communities living with lower-incomes, and Tribal communities experience disproportionate risk for environmental exposures due to long-standing policies and practices that intentionally disinvest and place environmental health risks within these communities. To address environmental health equity, EPH prioritizes its work accordingly to address inequities in exposure to environmental health hazards.

Health Care Regulatory and Quality Improvement (HCRQI) ensures safe and high-quality health care through assessment, education and regulation of health facilities and providers. During the ongoing COVID-19 response and recovery, the section provided regulatory guidance and flexibility options to support hospital capacity. The Health Facility Licensing and Certification program licenses and certifies health care facilities, providers and suppliers in acute care and community-based programs. The Emergency Medical Services and Trauma Systems program ensures the effectiveness and coordination of the state’s emergency medical response system for illness and injury. The program encourages improvements in the emergency care of pediatric patients and regulates systems that provide emergency care to people who experience a sudden illness or traumatic injury.

Center for Health Protection

Health Licensing Office (HLO) is a central licensing and regulatory office that oversees multiple health and related professions. HLO protects the health, safety, and rights of Oregon consumers by ensuring that only qualified applicants are authorized to practice. HLO reviews and approves applicant qualification, conducts examinations, inspects thousands of licensed facilities and independent contractors, responds to, and investigates consumer complaints, and disciplines licensees who violate state requirements.

Oregon Medical Marijuana Program (OMMP) administers the Oregon Medical Marijuana Act (OMMA). The OMMP oversees the medical marijuana cardholder registry for patients, caregivers, and growers, ensures compliance with tracking and reporting requirements, and regulates medical marijuana dispensaries, processing sites, growers and grow sites.

Oregon Psilocybin Services (OPS) implements the Oregon Psilocybin Services Act (Ballot Measure 109 (2020)). OPS licenses and regulates the production of psilocybin products and the provision of psilocybin services. During a two-year development process, from January 1, 2021, to December 31, 2022, OPS worked with the Oregon Psilocybin Advisory Board (OPAB), Rulemaking Advisory Committees (RACs), community partners, and the public to establish rules and regulations for the implementation of the measure. OPS adopted rules on December 27, 2022 and began accepting applications for licensure on January 2, 2023.

Radiation Protection Services (RPS) protects workers, patients, and the public from unnecessary and unhealthy radiation exposure. This is accomplished through on-site facility inspections, licensing of radioactive materials, and registration of X-Ray and tanning devices, environmental monitoring, radiological preparedness training and emergency response, and radio analytical laboratory services. This section provides Oregon’s sole public resource for radiation-related incidents.

Center for Health Protection programs are engaged in or working toward health equity and inclusion strategies increasing cultural competency among staff and advisory board members; providing funding assistance for safe

drinking water system construction projects in disadvantaged communities; integrating health equity as a core priority in environmental public health analyses and interventions; reviewing regulatory and compliance procedures to address discrimination issues; collecting and reporting data that are disaggregated by race, ethnicity, language and disability status (REALD).

Background information

The Center for Health Protection programs are grounded in the principles of population-based public health, providing services and regulatory oversight for all people in Oregon.

Drinking Water Services (DWS) regulates nearly 3,400 public water systems statewide. The section certifies 1,700 public water system operators and 1,500 backflow device testers and specialists. Contracts with county health departments and the Oregon Department of Agriculture provide for oversight of smaller public water systems served by groundwater sources. DWS regulates larger public water systems and those with treatment systems and provides technical assistance to water systems and partners. DWS provides technical expertise and best management practices related to emerging contaminants that may affect drinking water quality, including cyanotoxins and Per and polyfluoroalkyl substances (PFAS).

Environmental Public Health (EPH) protects Oregon communities from health risks in the environment and provides scientific and technical expertise on health concerns pertaining to built and natural environments. Environmental health components of Public Health Modernization, House Bill 5024 (2021), along with federal funding, helps to build state capacity for environmental epidemiology and toxicology, climate adaptation, land use and health and policy and management oversight, with investments for local public health authorities, Tribal public health departments and community-based organizations.

EPH established a new Healthy Homes and Schools Unit to implement House Bill 2842 (2021) and SB1536 (2022), that established a new Healthy Homes Grant Program in OHA. The new unit will consolidate this work with existing

programs including regulation of clandestine drug lab clean-up, lead-based paint safety, detecting and preventing childhood lead poisoning, supporting radon awareness and outreach, and regulating hazardous chemicals in children's products under the Toxic Free Kids Act Program.

EPH's Assessment Unit evaluates hazardous exposures in the environment that can impact human health, and houses the agency's public health toxicologists and climate and health team. Public Health Modernization adds capacity to provide technical assistance to local public health authorities, tribal health departments and community-based organizations to conduct climate and health work, and other intersections between health and the built environment. Assessments and partner engagement take into consideration that some communities face greater risks and environmental health inequities.

EPH Surveillance Unit monitors data on lead poisoning, pesticide exposures, occupational health, domestic well safety, beach safety, harmful algae blooms, and other environmental health hazards, and works to make information accessible to public health professionals, partner agencies, policy makers and the public. The unit focuses its efforts on data related to populations at disproportionate risk from environmental health hazards. This unit houses OHA's project in the Lower Umatilla Basin Groundwater Management Area, working with local partners, to provide water testing and treatment to residents exposed to elevated levels of nitrates in their domestic well water. The unit also develops health advisories for fish consumption, harmful algae blooms and beach water quality.

EPH's Food, Pool and Lodging Health and Safety Unit assists local health departments to ensure safety for more than 20,000 full-service and temporary restaurants, public pools, and tourist accommodations. In two counties that returned public health authority to OHA in recent years, the agency has local responsibility to license, inspect and carry out enforcement responsibilities to ensure these facilities comply with health and safety rules to protect the public.

Center for Health Protection

Health Care Regulatory and Quality Improvement (HCRQI*)* oversees several health care facility types and providers. The Health Facility Licensing and Certification program oversees approximately 91 ambulatory surgical centers, 16 birthing centers, 81 dialysis facilities, 783 hemodialysis technicians, 68 home health agencies, 71 hospice agencies, 66 hospitals and hospital nurse staffing programs, 185 in-home care agencies, 116 rural health clinics, and 10 other provider types.

The Health Facilities Planning and Safety unit works to ensure that facilities are safe and effective and meet nationally accepted building standards. This program reviews design and construction plans and issues project approvals for approximately 200 health facility projects annually. Within the unit the Certificate of Need program evaluates whether a proposed service or facility is needed.

Emergency Medical Services and Trauma Systems (EMS/TS) Program works with partners and nine advisory boards to monitor and improve the emergency systems of care. The program licenses 134 ambulance service agencies, 731 ambulances, and 11,883 Emergency Medical Services Providers (EMSPs). It certifies EMT training courses, provides continuing education and on-demand educational outreach. The program also operates the Oregon Trauma Registry and the Oregon EMS Information System that are used for health care improvement and research in Oregon. The Trauma program also inspects 45 designated trauma centers.

Health Licensing Office (HLO) administers 17 boards, councils, and programs: Art Therapy; Athletic Trainers; Behavior Analysis; Certified Advanced Estheticians; Cosmetology; Denture Technology; Dietitians; Direct Entry Midwifery; Electrologists and Body Art Practitioners; Environmental Health Specialists; Hearing Aid Specialists; Lactation Consultants; Long Term Care Administrators; Music Therapy; Respiratory Therapy and Polysomnography; and Sexual Offense Treatment. In 2021, HLO oversaw 5,598 facilities and 70,036 different licensees, administered 10,078 examinations, issued 5,425 licenses and registrations, renewed 19,624 licenses and registrations, conducted 10,983 inspections, and investigated 887 complaints.

Center for Health Protection

Oregon Medical Marijuana Program (OMMP) registers 17,459 medical marijuana patients, over 6,000 caregivers, and regulates over 5,000 medical growers at 4,522 grow sites. OMMP registers and annually inspects medical marijuana dispensaries. . The program also oversees all compliance testing rules for marijuana items and hemp in the state. OMMP works with the Oregon Cannabis Commission, an advisory body tasked with advising OHA and Oregon Liquor and Cannabis Commission on the administration of medical and recreational cannabis regulations.

Oregon Psilocybin Services (OPS) implements the Oregon Psilocybin Services Act (Ballot Measure 109 (2020). Measure 109 directs Oregon Health Authority (OHA) to license and regulate the production of psilocybin products and the provision of psilocybin services. Oregon is the first state in the nation to create a regulatory framework for psilocybin services. During a two-year development period OPS worked with the Oregon Psilocybin Advisory Board (OPAB), community partners, and the public to establish rules for psilocybin products and services. OPS is organized into three program areas: Policy and Engagement, Licensing, and Compliance. OPS programs will center health equity, including outreach to partners and communities and ensuring access to psilocybin services.

Radiation Protection Services (RPS) licenses or registers more than 14,000 sources of radiation statewide. It routinely inspects those radiation sources in more than 4,200 facilities including hospitals, dental and medical clinics, radiation oncology clinics, tanning salons, and academic and research facilities. Registrant, licensee, and public domain incidents involving potential/actual radiation over-exposure are investigated and mitigated. RPS staff also conduct radiation environmental surveillance activities and test food products for radiation contamination prior to import/export. Finally, radiological emerging technologies are evaluated, and regulations are enacted for their safe use.

Revenue sources and changes

The 2023-25 Center for Health Protection budget comprises Other Funds, primarily in the form of fees for services, General Fund, and Federal Funds. Funding for each program is described below.

Center for Health Protection

Drinking Water Services (DWS) receives funding from federal grants, fees, and the General Fund. DWS collects fee revenue from four programs: Backflow Tester/Specialist Certification, Water System Operator Certification, Water System Plan Review fees and Water System Annual Fees. Revenue from fees and the General Fund contribute to the required state match for federal grants. DWS receives two federal grants from the Environmental Protection Agency (EPA) which constitute the largest source of program revenue: The Drinking Water Primacy grant ($3.2 million per biennium) and the Drinking Water State Revolving Fund (DWSRF) capitalization grant. The DWSRF base funding includes support for infrastructure project financing (69 percent) and set asides for specific program functions (31 percent). From late 2022 to 2026, DWS's annual allocation from the Bipartisan Infrastructure Law is about $51 million for infrastructure projects (Base funding and Supplemental funding), over $30 million for service line inventory development and lead service line replacement, and $10 million for treatment of emerging contaminants such as PFAS, cyanotoxins, and manganese. Disadvantaged communities are priority recipients for all grants. DWS will use a small percentage of this grant to fund four positions to cover the additional workload associated with this new funding.

Environmental Public Health (EPH) historically received most of its funding from federal grants and fees, with small amounts of additional funding coming from intergovernmental agreements with state agency partners and the General Fund. EPH receives Federal Funds revenue from Centers for Disease Control and Prevention (CDC) grants for Climate and Health, Environmental Health Data and Capacity improvement, Childhood Lead Poisoning Prevention, Environmental Health Assessment (toxicology) and Environmental Public Health Tracking, with a recent 25 percent cut to the Tracking grant. EPH also receives federal funding from the Environmental Protection Agency (EPA) for radon monitoring and public outreach and to enforce lead-based paint best practices.

EPH receives Other Funds revenues through intergovernmental agreements with local public health authorities that assess license fees through OHA's delegated authority to support foodborne illness, public pool, and tourist facility health and safety activities. Other Funds revenue also supports the Clandestine Drug Lab Program and some lead-based paint activities. Additionally, OHA's health risk assessment and communication work supporting the Oregon

Center for Health Protection

Department of Environmental Quality's (DEQ) Cleaner Air Oregon regulatory program is funded through an interagency agreement. The Pesticide Exposure Safety and Tracking Program (PEST) is funded through an interagency agreement with Oregon Department of Agriculture. EPH also has interagency agreements with DEQ that supports the clandestine drug lab cleanup and issue beach water quality health advisories and with Oregon Health and Sciences University for occupational health surveillance work

EPH received General Fund for a new Healthy Homes Grant Program, House Bill 2842 (2021), augmented by Senate Bill 1536 (2022) and through OHA's Public Health Modernization to support toxicology, epidemiology, and other staff. House Bill 4077 (2022) appropriated General Fund for EPH to staff development of an Environmental Justice Mapping Tool together with DEQ under oversight of the state Environmental Justice Council. The September 2022 Legislative Emergency Board provided EPH General Fund to test and treat domestic well water of people exposed to nitrate-contaminated groundwater in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA) straddling Morrow and Umatilla Counties. Finally, EPH also receives a small amount of General Fund to help support the Toxic Free Kids Act (TFKA) program authorized in Senate Bill 478 (2015). The Governor's Budget proposes additional General Fund to sustain the agency's contaminated domestic well response in the LUBGWMA; to investigate risks of exposure to PCBs and other toxic substances to develop fish advisories for subsistence and recreational fishers in Oregon's rivers; and to license, inspect and enforce food, pool and lodging health and safety rules in Curry County, which returned public health authority to OHA.

Health Care Regulation and Quality Improvement (HCRQI) section receives federal funding from the Centers for Medicare and Medicaid Services to perform health facility surveys and certification. Some regulatory work such as hospital nurse staffing and in-home care agencies and is supported with General Fund. The Health Facility Licensing and Certification program funding sources include fees for licensing and inspection of health care facilities. Emergency Medical Services and Trauma Systems (EMS/TS) program within HCRQI receives federal funding from the Health Resources & Services Administration to administer the Oregon EMS for Children program. Additionally, fees support the licensing and oversight of emergency medical services providers and ambulance

services. EMS/TS also receives about $3.2 million General Fund per biennium and roughly $331,000 per biennium from the Criminal Fines and Assessment Account. HCRQI also receives $1.95 million General Fund as a pass-through to support the Oregon Patient Safety Commission's Early Discussion and Resolution program and receives funds to support a contract with Oregon Health and Sciences University for administration of the Oregon Portable Orders for Life Sustaining-Treatment (POLST) Registry.

The Health Licensing Office (HLO) collects fees for applications, examinations, issuance and renewals of licenses and registration, disciplinary actions, and other administrative fees. Each board, council and program has its own fees, which are used to cover its administrative costs and HLO. HLO collects more than $7 million in fees. Senate Bill 1549 (2022) directed HLO to authorize and regulate temporary staffing agencies. HLO received some General Fund in the 2021-23 biennium to cover costs to implement regulation of these entities.

Oregon Medical Marijuana Program (OMMP) section collects fees for issuing medical marijuana cards to qualifying patients and maintains a registry of those patients. The program also collects fees for the registration of grow sites, dispensaries and processing sites and collects a pass-through fee for entities required to use the OLCC cannabis tracking system. Program revenue continues to decline since the legalization of recreational marijuana. The section also receives some General Fund, to support the Oregon Cannabis Commission.

Oregon Psilocybin Services (OPS) received General Fund for start-up costs and staff positions for the 2021-23 biennium to begin implementation of Measure 109, the Oregon Psilocybin Services Act. OPS will receive Other Fund revenue from licensing fees after January 2, 2023, when OHA begins accepting applications for licensure of psilocybin manufacturers, psilocybin testing labs, psilocybin service centers, and psilocybin facilitators. It may take several months to a year following January 2, 2023, for revenue from license fees to cover the costs of OPS's work, as businesses work to ensure it is in compliance with statute, rules, and any local government land use, zoning, or other requirements or prohibitions. OPS does not expect to have enough licensure fee revenue to cover the costs of

the section's work until the end of the first year of the 2023-25 biennium. OPS will need any carryover funds from the 2021-23 biennium to help support the section's work.

Radiation Protection Services (RPS) receives primary funding from three fee-based regulatory programs. They are the X-Ray Machine Program, Radioactive Material Licensing Program, and the Tanning Device Program. All three collect fees by licensing or registering devices that produce or contain radiation sources. In addition, RPS has renewed a 2022-2027 fee for service contract with the Food and Drug Administration to inspect all Oregon facilities performing mammography examinations. The 2021-23 Legislatively Adopted Budget included biennial fee increases totaling $1.4 million for the three RPS fee-based regulatory programs. Gross RPS program fees total approximately $6.2 million per biennium.

Proposed new laws that apply to the program unit

None.

Oregon Health Authority: Public Health Division

Center for Prevention and Public Health Promotion

The 2023-25 Governor's Budget continues funding for most of the Center for Prevention and Health Promotion programs at the current service level.

Activities, programs and issues in the program unit base budget

The Center for Prevention and Health Promotion's mission is to help Oregon's communities and residents achieve and sustain lifelong health, wellness and safety through partnership, science and policy. The center's work is essential to achieving the OHA ten-year goal of eliminating health inequities. The center promotes population and community-based strategies to increase capacity for K-12 schools to provide school health services, health education, and be a safe and supportive environment; increase stability and safety in families; increase equitable access to healthy options and preventive health services; decrease the burden of health inequities borne by communities of color and Tribal communities; increase access to healthy food and increase healthy eating and physical activity for all people in Oregon; reduce overdose and risky prescribing of opioids; reduce suicide and other intentional and unintentional injuries; reduce tobacco, alcohol and other drug use; prevent and reduce secondary impacts of COVID-19 and support recovery.

Background information

The Center for Prevention and Health Promotion has the following five sections that work to achieve its mission:

Adolescent, Genetics and Reproductive Health (AGRH) is now the Adolescent, Sceenwise and Reproductive Health (ASRH) section. ASRH promotes the health, well-being, and quality of life for all people in Oregon through the development and use of evidence-based policies, tools, educational resources, programs, and clinical preventive services to support adolescent, sexual and reproductive health across the lifespan. ASRH commits to working towards racial equity by addressing racism, acknowledging implicit bias, and shifting practice eliminate health inequities. ASRH:

Center for Prevention and Public Health Promotion

- Encourages the adoption of evidence-based programs and practices that support positive youth development and promote authentic youth engagement.
- Collaborates with the education system to provide quality health services, increase implementation of K-12 health education and inform local and state policy development.
- Provides access to essential preventive health services through a statewide network of school-based health centers (SBHCs), reproductive health clinics, school nurses, mental health providers and ScreenWise providers regardless of gender identity, sexual orientation, race, sex, disability or immigration status.
- Reduces breast, cervical and hereditary cancer inequities by supporting equitable access to early detection.
- Supports and ensures the provision of culturally and linguistically appropriate practices and services at the state and local levels through funding and establishment of standards of care.
- Supports public health systems that provide high-quality preventive health services for adolescents, people of reproductive capacity, and individuals at high risk from genetic conditions.
- Engages collaboratively with partner organizations and community members to inform policies, clinical services and activities that address systemic, structural, and institutional injustices and advance health equity.
- Recognizes the role of trauma and resilience in health behavior and outcomes and creates prevention policy and programming that acknowledges trauma and adverse experiences while enhancing developmental strengths and protective factors.
- Develops comprehensive programmatic and policy responses to emergent needs related to the changing national landscape of reproductive health access and services.
- Funds community-specific organizations that serve communities of color and tribal communities to address structural barriers to care borne from institutional bias, oppression, trauma and toxic stress.

Health Promotion and Chronic Disease Prevention (HPCDP*)* works with communities, local public health authorities and Tribes to increase the opportunities for all Oregonians to eat better, move more, live tobacco-free, drink less alcohol and take charge of their own health. HPCDP does this by analyzing and monitoring the

occurrence of chronic diseases and their risk factors by demographic characteristics, including but not limited to such as gender, race, ethnicity, geography, income, disability, education, age. HPCDP develops and administers programs and promotes policies to prevent chronic diseases and associated risk factors among populations disproportionately impacted by health inequities.

Many of the risk factors for chronic disease have been created by systemic racism, discrimination, oppression, and adverse childhood experiences and trauma that result in unequal access to chronic disease prevention resources and opportunities for maintaining lifelong health and wellbeing. Chronic diseases include asthma, arthritis, cancer, diabetes, heart disease and stroke. Risk factors for chronic conditions include tobacco use, alcohol and drug misuse, physical inactivity, experiencing discrimination, and poor nutrition. HPCDP's strategies to prevent and manage chronic disease include:

- Equipping Tribes, local public health authorities, and other diverse communities with the strategies, data, guidance and support they need to recognize historic and current injustices, reconcile disproportionate rates of disease and addiction, make sustainable policy solutions for their communities to rectify injustices and reduce tobacco use, alcohol and drug misuse, and increase access to healthy eating and physical activity.
- Funding for local public health authorities, Tribes, regional health equity coalitions and coordinated care organizations (CCOs) to redistribute resources and power to work on community-based strategies that support health equity.
- Providing $20 million of funding to community-based organizations to develop and implement new, culturally specific strategies to address the root causes of tobacco use.
- Maintaining three mass-reach communications brands to communicate about chronic disease risk factors and provide opportunities for Oregonians to take action in their communities including Smokefree Oregon, Place Matters Oregon, and Rethink the Drink, as well as two culturally specific sub-brands, Vive sin fumar and the Native Quit Line.

- Working with Oregon's behavioral health treatment system to understand barriers to treating nicotine addiction and increase access to tailored cessation supports.
- Collecting data and evaluating all programs, including their impact on health inequities.
- Working with other state agencies like the Oregon Department of Corrections and the Oregon Department of Transportation to change policies and procurement to improve nutrition, physical activity, and access to self-management supports across state enterprise.
- Developing and implementing the Oregon Tobacco Retail License program to reduce youth smoking initiation and nicotine addiction across the lifespan.

Injury and Violence Prevention (IVP) prevents injuries and deaths due to violence, suicide, prescription and illicit drug overdoses, transportation related injury, child maltreatment, youth sports concussions, and unintentional injuries. Some strategies include:

- Supporting local public health authorities, Tribes and community-based organizations in preventing overdoses from prescription and illicit opioids and other drugs.
- Working with pharmacies, employers and community human services organizations to make naloxone rescue universally available to prevent deaths due to opioid overdose, and managing the Reverse Overdose Oregon initiative.
- Administering the Opioid Settlement Prevention, Treatment and Recovery Board, which directs allocations of funding from the state's portion of national opioid settlement funds.
- Improving pain care and promoting non-pharmacological pain care options, and supporting this work with culturally responsive messaging and resources for Tribes and other communities of color and rural Oregonians.
- Providing timely, high quality, public data on injury and violence via interactive web-based data dashboards.
- Supporting expansion of the Healing Hurt People hospital-based violence intervention program and establish a professional pathway for community violence prevention and intervention peers.

- Working with diverse communities and health care and behavioral health care agencies to track and prevent suicide attempts and reduce suicide deaths across the lifespan by implementing the Zero Suicide quality improvement model.
- Coordinating the State Child Fatality Review Team to identify systems level changes to reduce child fatalities and serving as Oregon's data steward for the National Fatality Review Case Reporting System, to support local reviews.
- Providing the web-based Prescription Drug Monitoring Program, which serves more than 26,500 prescribers, pharmacists and their delegates to support safe prescribing decisions.
- Promoting opioid prescribing and tapering guidelines and working within CCOs and other health systems to use them to improve patient safety, reduce incidence of opioid use disorder, improve pain care, and reduce overdoses.
- Managing the Oregon Violent Death Reporting System and the State Unintentional Drug Overdose Surveillance System tracking trends in overdoses, suicide attempts and deaths, and firearm injuries.
- Supporting the Save Lives Oregon state naloxone clearinghouse to ensure access to naloxone rescue and provision of overdose and suicide prevention grants to community based organizations.

Maternal and Child Health (MCH) promotes health across the lifespan of individuals and families by investing in preconception, pregnancy, and early childhood health. Programs address perinatal health (before, during and after pregnancy), infant and child health, newborn hearing screening, home visiting, oral health, and family violence prevention. MCH leads with social justice and anti-racism to identify and focus on historical and current inequities that lead to poor health outcomes.

The program monitors the health of Oregon's pregnant individuals and families with three-year-old children through the Pregnancy Risk Assessment and Monitoring System (PRAMS) and Early Childhood Health in Oregon (ECHO) surveys; monitors the prevalence of birth anomalies through our Birth Anomalies Surveillance System (BASS) and monitors the state of oral health through the Oregon Oral Health Surveillance System. The program manages data

systems for infant hearing screenings, the home visiting system and its programs, and statewide oral health, disaggregating data by race and ethnicity.

MCH houses Oregon's Title V Maternal and Child Health Services block grant programs that support promoting and improving the health and well-being of mothers, children, and their families and focus on well-women care, breastfeeding, child injury prevention, positive youth development/anti-bullying, establishing a medical home, transition into adulthood, reducing toxic stress and trauma, addressing social determinants of health and equity, and provision of culturally and linguistically responsive services. Title V supports activities such as:

- Assessment and monitoring of maternal, family and child health needs and inequities
- Policy and program development
- Workforce development
- Program assurance through technical assistance and support
- Coordination with state agencies and community partners
- Systems development to better address the needs of Oregonians, including children and youth with special health needs
- Statewide and community specific health promotion activities that address historic and current inequities

MCH has established and launched Oregon's Maternal Mortality and Morbidity Review Committee. This committee examines the root causes of death of individuals who died during pregnancy up to 365 days post-partum and makes recommendations for system and systemic changes to prevent maternal mortality and morbidity.

MCH received supplemental COVID-19 funding for the Rape Prevention and Education/Intimate Partner Violence prevention work to support virtual training and education opportunities and outreach at the community level.

Maternal and Child Health is also the home for Oregon's universally offered home visiting system. This system works toward ensuring every family of a newborn receives the opportunity to have 1 to 3 nurse home visits during the first few months of the newborn's life. MCH is prioritizing integration of Community Health Workers into the home visiting care team to better support families with culturally specific services and supports around COVID-19.

Nutrition and Health Screening (NHS) The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) safeguards the health of about 111,000 low to moderate-income women, infants, and children up to age five each year who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating and referrals to health care and other community services. Oregon WIC participants use an electronic benefit transfer (EBT) system to purchase healthy foods at local authorized retailers. In addition, the Oregon Farm Direct Nutrition Program (FDNP), which encompasses both the WIC FDNP and the Senior FDNP, provides around 60,000 WIC participants and 60,000 seniors living with low-income
with FDNP checks once a year to purchase fresh, locally grown fruits, vegetables and cut herbs directly from local farmers. FDNP and SFDNP serves a racially and ethnically diverse low-income population. FDNP and SFDNP connects with participants speaking 82 languages and offers print and translation services through program partner 211 info.

WIC services are delivered through public health, Tribal health clinics, and non-profit programs. The WIC Program focuses on maternal and child growth and health, breastfeeding education and support, including peer-to-peer breastfeeding support through the WIC Breastfeeding Peer Counseling Program, nutrition-focused counseling, promotion of a healthy lifestyle and prevention of chronic diseases including obesity, and providing culturally and linguistically appropriate services and materials.

NHS program staff provide a variety of training to local staff who deliver WIC services, including annual civil rights training. The WIC program also influences the availability of nutritious foods in Oregon's communities by requiring large and small WIC authorized grocery stores in all areas of the state to carry a minimum stock of healthy foods

including low-fat milk, whole grains, low-sugar cereals, and produce. The foods available through WIC offer a variety for the wide range of families served. The Oregon FDNP program collaborates with farmers and farmers markets statewide to provide vouchers for fresh produce for WIC families and low-income seniors. WIC also provides critical data on the maternal and child population by race, and ethnicity and other demographics; and evaluates programs and carries out competitively funded research studies.

Revenue sources and changes

The Center for Prevention and Health Promotion revenues include General Fund, Federal Funds Limited, Federal Funds Non-Limited, Other Funds Limited, and Other Funds Non-Limited. General Fund revenue supports adolescent health promotion and school health service programs such as School-Based Health Centers, school-linked mobile and telehealth programs and school nursing, Oregon Contraceptive Care program (1115 family planning Medicaid demonstration waiver), and the Oregon Reproductive Health Equity Act (RHEA) to provide coverage for a full range of reproductive health services. General Fund also supports the Youth Suicide Prevention Program, the Family Connects Oregon universally offered home-visiting program and the WIC Farm Direct Nutrition Program food vouchers. In the 2021-23 biennium, CP&HP received a one-time appropriation for Seeding Justice for advancing reproductive health equity under House Bill 5052 ($15 million General Fund). CP&HP also received appropriations for House Bill 4045 Community Violence Prevention Grants ($1.1 million General Fund).

Two new program changes were approved, policy package #453 for a fee increase for the Prescription Drug Monitoring Program (PDMP). The fee ensures that PDMP continues as a crucial health care tool that allows prescribers to ensure they are fully informed of the prescription history of their patients when prescribing controlled substances. The budget also includes policy package #408, which includes expenditure limitation for a strong statewide licensing system for retailers who sell tobacco products and inhalant delivery systems, as well as funds allocated by House Bill 4045 to support expansion of hospital-based violence prevention programs and by House Bill 4098 for administration of the new Opioid Settlement Prevention, Treatment and Recovery Board and Fund.

Center for Prevention and Public Health Promotion

The center receives Federal Funds through the following federal grants and programs:

- The Centers for Disease Control and Prevention grants for arthritis, cancer, diabetes, heart disease and stroke, obesity, tobacco, alcohol, sodium, cancer registry.
- Core Injury and Violence Prevention, National Violent Death Reporting System, Emergency Department Surveillance of Nonfatal Suicide Related Outcomes.
- Promoting Adolescent Health through School-Based HIV/STD Prevention and School-Based Surveillance.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) grants for Youth Suicide Prevention and Early Intervention and Substance Abuse, Prevention and Treatment.
- Supplemental COVID-19 funding for Rape Prevention and Education and Intimate Partner Violence prevention.
- ARPA funding for Maternal Child and Health support home visiting services and Women and Children vouchers for the fruit and vegetable program.
- U.S. Department of Agriculture WIC Nutritional and Health Screening Program.
- Health Resources & Services Administration (HRSA) for Maternal & Child Health Title V and Home Visiting programs.
- Medicaid 1115 family planning waiver, Oregon Contraceptive Care which receives 90 percent federal match through the Centers for Medicare and Medicaid Services.
- Office of Population Affairs' Title X Program, which supports the provision of culturally and linguistically responsive reproductive health services.
- Administration for Children and Families for Personal Responsibility Education Program.
- Centers for Medicare & Medicaid Services (CMS) Meaningful Use HIT/E for Emergency Medical Services (EMS) & Trauma Data Systems and integration of the Prescription Drug Monitoring Program into clinical electronic health record.
- Funding to support opioid overdose prevention by means of grants awarded to other programs within the Oregon Health Authority via the SAMHSA State Targeted Response grant (OHA Health Systems Division).

Center for Prevention and Public Health Promotion

Non-pandemic federal grant award amounts declined through the 2021-23 biennium as grants expired, requiring program service levels to be adjusted accordingly.

The Center's Other Funds revenues include statutorily dedicated funds under the Tobacco Use Reduction Account (TURA), BM 108 tobacco taxes, Tobacco Retail Licensing, the Electronic Prescription Monitoring Fund, the Opioid Settlement Prevention, Treatment and Recovery (OSPTR) Fund as well as marijuana tax revenues for alcohol and other drug prevention.

Proposed new laws that apply to the program unit

None.

Center for Public Health Practice

The 2023-25 Governor's Budget continues funding for most of the Center for Public Health Practice programs at the current service level.

Activities, programs and issues in the program unit base budget

The Center for Public Health Practice protects the health of individuals and communities through the prevention and control of infectious diseases, provision of integrated care and treatment for persons living with HIV, issuing Oregon vital records, monitoring population health, and ensuring emergency public health services in natural and human-caused disasters. The center's programs provide many of the essential services in the state public health's Continuity of Operations Plan and have played a key role in Oregon's response to the COVID-19 pandemic. The center is committed to bringing community into the design and implementation of interventions to reduce health inequities and burden of disease, as well as the impacts of all hazard response and recovery on communities facing systemic, contemporary and historic racism, bias and oppressions. The center's work is central to Oregon's achievement of the triple aim, health system transformation and the Oregon Health Authority's strategic goal to end health inequities by 2030.

The center has six sections:

- Center for Health Statistics, also known as vital records – birth, death, marriage and divorce certificates (CHS)
- Acute and Communicable Disease Prevention (ACDP)
- Oregon State Public Health Laboratory (OSPHL)
- HIV, Sexually Transmitted Diseases and Tuberculosis Prevention (HST)
- Immunizations
- Health Security, Preparedness and Response (HSPR)

In collaboration with partners, the center invests resources to reduce the burden of disease and health inequities across the state. The center's programs work with local and Tribal governments, a wide range of community

partners, health care providers, and affected communities to prevent, investigate and control infectious diseases. The center coordinates interventions to control disease outbreaks; screens all newborn infants for biochemical disorders to prevent disability or death; and collects and analyzes vital record data needed to understand and plan for health trends. As part of public health emergency preparedness, the center conducts testing for biological agents of mass destruction (for example, anthrax, plague) and emerging public health events and diseases such as the COVID-19 pandemic.

The Center for Public Health Practice delivers core public health services necessary to maintain a healthy population and respond to and recover from disasters. Preventable disease vaccine programs ensure that children are healthy enough to attend school regularly and learn successfully. The center's communicable disease interventions preventing influenza and foodborne disease outbreaks (such as hepatitis, E. coli) allow parents to remain at work and sustain a healthy economy. The center's HIV/STD and tuberculosis programs work with local partners and the community to prevent and eliminate disease transmission. The center's HSPR programs track the surge capacity of hospitals and public health agencies to respond in health emergencies (such as COVID-19, wildfires and earthquakes). The center's services are delivered every day throughout the year. Duty officers are on call 24/7 to provide technical support at the public health lab, for epidemiology guidance, and for assessing the initial stage of a public health incident and coordinating responders.

Programs in the Center for Public Health Practice are engaged or working toward the following health equity and inclusion strategies by:

- Increasing cultural competency of staff.
- Increasing workforce diversity, equity and inclusion.
- Conducting Health Equity Impact Analyses on new and existing efforts.

Center for Public Health Practice

Background information

Center for Public Health Practice program activities are described below.

Center for Health Statistics is responsible for registering, certifying, amending, and issuing Oregon vital records, including:

- Maintaining approximately 6.5 million vital records for birth, death, marriage, divorce, fetal death.
- Registering 130,000 vital events that occur in Oregon annually.
- Issuing 138,000 certified copies of records and 30,000 amendments annually.

Information from vital records is used to assess the health of people in Oregon and identify health inequities so that public health can develop programs to improve health and equity. For example, race, ethnicity, language and disability information is now being gathered on birth records. This new information will provide a better understanding of health and birth outcomes for different populations, and to identify health inequities. The vital statistics system continues to modernize by implementing interoperability standards so timely death data can be shared with federal and state partners.

Acute and Communicable Disease Prevention (ACDP) identifies and prevents the spread of communicable diseases that cause illness and death, including *E. coli* O157 infection, meningococcal disease, influenza, hepatitis, antibiotic-resistant bacteria, healthcare-associated infections, and vector-borne diseases. ACDP collaborates with partners to reduce disease transmission associated with food, water, animals, insects, human contact, and health care. The section works with Oregon's local public health, Tribal health jurisdictions, health care providers, and communities to identify diseases, collect case information, identify risk factors, determine transmission routes, protect exposed individuals, and control disease transmission. ACDP has expanded its workload to assist with the COVID-19 pandemic, including administration of grants totaling approximately $485 million dollars that support the COVID-19 Response and Recovery Unit; implementation of genomic surveillance; implementation of wastewater

surveillance; leadership for SARS-COV-2 testing strategy; contributing senior health advisor (SHA) clinical expertise to response planning and spokesperson needs forwarding COVID-19 related rulemaking needs; enhanced informatics capacity to accommodate pandemic related needs; and implementation of regional public health infection control capacity for congregate and healthcare settings.

The Oregon State Public Health Laboratory performs 6.4 million tests on 329,750 human specimens biennially, including newborn screening of all infants born in Oregon. The lab's specimens come from 33 local health departments and 68 hospital and clinical labs in Oregon, as well as 3,000 individual medical practitioners in the region. In addition to clinical diagnostic testing, the laboratory provides surveillance testing and whole genome sequencing for enteric pathogens to assist ACDP in outbreak investigations. The Laboratory Compliance section oversees certification of clinical laboratories and accredits environmental laboratories. This includes laboratories that monitor the safety of drinking water, cannabis, psilocybin, and the environment in Oregon. The OSPHL is also responsible for emergency laboratory response to COVID-19 and other emerging pathogens and biological and chemical threats throughout Oregon. OSPHL has been at the forefront of the state's COVID-19 testing response and has tested over 130,000 specimens to date and has sequenced nearly 6,000 COVID-19 specimens. OSPHL maintains PCR capacity for 300-400 specimens per day and is building capacity to perform up to 300 genetic sequences per week. The lab supports the OHA mission through the following statewide and multi-state activities:

- Medical laboratory tests for state and local health department communicable disease control programs for purposes of disease diagnosis, prevention, surveillance, and treatment.
- Tests for food, water and other environmental samples for evidence of microbial contamination.
- Provides 6.1 million tests biennially on 150,000 newborn babies for genetic disorders of body chemistry that can cause severe intellectual disability or death if undetected.
- Provides specialized reference tests that are unavailable elsewhere, especially for diseases of public health significance (for example, anthrax, tuberculosis, *E. coli* serotyping, SARS-CoV-2 and new pathogens).
- Responds to public health emergencies including outbreaks of infectious diseases and bioterrorism.

Center for Public Health Practice

- Provides regulation to ensure the quality of testing in medical, marijuana, environmental, and drug screening laboratories throughout Oregon.

The HIV, Sexually Transmitted Diseases and Tuberculosis section (HST) works collaboratively with local public health authorities, health care providers, community-based organizations to prevent the transmission of HIV, STD and TB disease, improve health outcomes and eliminate health inequities. The primary program functions include prevention and communicable disease control, and monitoring. The HST section monitors the incidence and prevalence of disease, using data to develop public health policy and interventions. The section develops rules, policy, procedure, and standards of care, and provides training, consultation and technical assistance for outreach, testing, disease investigation, outbreak response, linkage to care, and treatment. The section's client population includes individuals at risk for or diagnosed with HIV, STDs or TB. The section targets resources to populations that are disproportionately affected, such as people who inject drugs, men who have sex with men, people of color, immigrants and refugees. Services promote the elimination of HIV/STD/TB transmission and improved health outcomes and include local outreach and education, testing, condoms, lab costs, medications, case management and adherence support.

The **Immunization** section works with local public health authorities, public and private immunization providers, Tribes, schools, childcare facilities, higher education, community-based organizations, and local coalitions to meet Oregon's vaccination needs and to reduce the incidence of vaccine-preventable disease in Oregon by:

- Supporting the state's immunization infrastructure and measuring the gaps in access to care.
- Revising programs to increase racial equity across all service areas.
- Maintaining the ALERT Immunization Information System (IIS).
- Distributing approximately $75,000,000 of vaccine annually.
- Identifying and promoting evidence-based public health practices, driven by equity.

- Collecting immunization data (available by age, gender, race and ethnicity) from health care providers and making these data available to local entities to achieve complete and timely immunization of all people in Oregon.
- Maintaining the federal Vaccines For Children (VFC) program and special vaccine supply programs for people of all ages served at hundreds of private and public access locations.
- Overseeing school immunization law.
- Maintaining readiness to distribute vaccine in outbreaks and pandemics.

During the COVID-19 pandemic, Immunizations coordinated the distribution of federally owned COVID-19 vaccines and supplies to 1,837 unique public and private vaccinating partners, delivering 8,014,863 COVID-19 vaccinations to date. These vaccinations are recorded and stored in the ALERT IIS for clinical and public health purposes.

The Oregon Immunizations Program promotes the health of all people in Oregon by investing in activities that ensure access to vaccines for all. These efforts include the Vaccines For Children (VFC) program, which provides vaccine at no cost to 62 percent of Oregon's children, who might not otherwise be vaccinated due to inability to pay. The Immunization Program operates the Vaccine Access Project, ensuring vaccine opportunities for underrepresented communities including those housed in carceral setting; the use of the ALERT IIS (Immunization Information System); data to support clinical decision support for immunizers; analyses of immunization status and need across gender, race or ethnicity; supporting Tribal centers, community-based organizations and local coalitions.
The Immunization Program also houses the COVID-19 therapeutics team, established to support the equitable distribution of anti-virals and other therapies developed to protect against COVID-19. The team allocates federal doses distributed to Oregon, provides communication support to providers and to the public, delivers technical assistance to Oregon providers, and expands access to therapeutics through the federal Test 2 Treat program and

through a contract arrangement with the Oregon Primary Care Association. This team will operate through June 2023.

The Health Security, Preparedness and Response (HSPR) section supports systems to prepare for and respond to all hazards that affect the health of people in Oregon. Public health emergency preparedness is a foundational capability of a modern public health framework. HSPR emphasizes cultural responsiveness through partnerships with Tribal governments, hospitals and health care systems, emergency medical services, law enforcement, fire, and local public health authorities to build community resiliency through emergency preparedness planning, training, exercises, and coalition development. These partnerships include funding for health care and public health programs in local and Tribal agencies, as well as support for essential public health functions related to communications, laboratory services and communicable disease control. The program manages a stockpile of personal protective equipment and medical supplies. The program works to ensure equitable inclusion of persons with limited English proficiency and other language and access needs in planning activities. Current activities focus on hospital and health system surge supports, respiratory disease response, health equity planning, mass casualty planning, and all hazards response.

HSPR also manages:

- The State Emergency Registry of Volunteers in Oregon, with 6,484 registered licensed health professionals providing 56,496 hours of emergency services in the past year and a half in response to all hazard emergency response, including COVID-19, extreme weather, and wildfires.
- The AmeriCorps VISTA program, which places new public health professionals in public health and nonprofit agencies for one year of national service to build public health capacity and eliminate poverty. HSPR oversees 60 national service volunteers annually.
- Critical public health information platforms such as the Health Alert Network and Hospital Capacity System, which allow for 24/7/365 mass communication and situational awareness between public health and health care organizations and provide communication options for those who are deaf or hard of hearing.

Center for Public Health Practice

Revenue sources and changes

The 2023-25 Governor's Budget for the Center for Public Health Practice is comprised of Federal Funds, Other Funds, and General Fund.

In response to the COVID-19 pandemic, the center received over $600 million of federal funding for a broad range of response activities, including case investigation and contact tracing, laboratory testing, healthcare system infection control capacity, and vaccine distribution. These federal funds have supported the staff and contracts based within the COVID-19 Response and Recovery Unit as well as the Public Health Division. Much of the center's funding is categorical, finite and directed toward federal priorities, which do not always align with state or local priorities. The center's programs have responded creatively to state priorities while continuing to meet grant objectives. This is particularly true in the areas of communicable disease prevention and immunization, which require a base level of infrastructure to operate effectively.

The center's General Fund is used to pay for staff, supplies and equipment necessary to coordinate and deliver services to people in Oregon. The center pays counties to deliver the Vaccines for Children program, using Medicaid matching funds and leveraged by General Fund.

In the HIV/STD/TB (HST) section, CDC funding has not kept pace with the increased need for services necessary to control and ensure treatment for sexually transmitted infections and tuberculosis. Fifty one percent of General Fund is allocated for distribution to local public health for HIV prevention, STD and TB testing, contact tracing and treatment. In addition to HRSA, Ryan White federal funding of approximately $6 million annually, CAREAssist (Oregon's AIDS Drug Assistance Program) generates program income through the 340B Drug Pricing program model. This Other Fund net balance of $58 million promotes a continuing annual carryover of restricted funds for maintenance of program operatives. The program obligates the full amount of these restricted Other Funds carryover balance to pay for medical services and medications for persons living with HIV and for projects that

support Oregon's initiative to eliminate new HIV infections, *End HIV Oregon*. The End HIV Oregon initiative supports enhanced statewide services to include HIV early intervention housing, behavioral health, case management and other supportive services that prevent the transmission of HIV and improve the health outcomes of persons diagnosed with HIV.

The STD program received $2.3 million from the American Rescue Plan Act. These funds have been awarded to local public health authorities to support the expansion of a response-ready workforce of contact tracers (known as Disease Intervention Specialists) at the local level to mitigate the spread of STD, HIV, and COVID-19.

The Acute and Communicable Disease Prevention (ACDP) section historically receives about $20 million Federal Funds per biennium from the CDC, primarily through the Emerging Infections Program (EIP) and the Epidemiology and Laboratory Capacity (ELC) grants. Along with roughly $1 million General Fund, these grants support communicable disease monitoring, outbreak investigation, interventions and evaluation activities. The program maintains Orpheus, a statewide case reporting and outbreak information system, as well as ESSENCE, a statewide syndromic surveillance system that monitors all emergency department visits (data available by race and ethnicity via a medical record or using CDC-specified designations).

As of July 2021, ACDP has received approximately $485 million from the Centers for Disease Control (CDC) dedicated to COVID-19 case investigation, contact tracing, testing, and disease control across Oregon. The ELC program received $3.3 million from the American Rescue Plan Act to be used to strengthen SARS-CoV-2 variant surveillance and increase sequencing capacity statewide through the implementation of geographically representative variant surveillance as well as strategic partnerships with academic and commercial partners statewide. Of that total, approximately $377 million remains available for planned work in the 2021-23 biennium.

In the Immunization section, state funding supports pass-through dollars to the local public health authorities; a maintenance and support contract with Gainwell for ALERT IIS; and staff and infrastructure support. To support the

response to the COVID-19 pandemic, Immunizations received $83 million additional federal funds over the course of 2020-2024 – with the majority of those funds passed to local public health authorities, Tribes and community-based organizations.

The Oregon State Public Health Laboratory (OSPHL) revenues for the 2021-23 biennium are approximately $30 million Total Funds. In recent biennia, increasing operating costs have outpaced revenues and OSPHL has evaluated current fee rates and structures.

Communicable disease testing increases access to health care by providing testing regardless of ability to pay or insurance coverage. Primary submitters are local health departments and community clinics. OSPHL bills for as many tests as possible using the Medicaid fee-for-service fee schedule but does not recover enough revenue to fund the testing. New laboratory technology is changing the number and types of specimens sent to OSPHL, shifting the workload to OSPHL without corresponding funding to support the testing. OSPHL is also experiencing increased costs associated with maintaining laboratory information systems to support electronic data collection and transmission among local, state and federal partners.

Evaluations of additional fee structures will continue in the 2023-25 biennium.

The Center for Health Statistics (CHS) revenues include mostly Other Funds, primarily in the form of fees for services, and some Federal Funds, in the form of deliverable-based contracts for timely and accurate birth and death data. Other Funds include payments from state agencies that use vital records information. Fees from the sale of birth certificates comprise most of the fee revenue. The remaining revenue comes from sales of other types of certificates and extra fees for expedited processing and amendments. The Center for Health Statistics received CARES Act funding to develop and implement standard interoperability with the state's electronic death system and the National Center for Health Statistics to provide more timely death data.

Center for Public Health Practice

The Health Security, Preparedness and Response (HSPR) section is funded through three federal grants, the Crisis Cooperative Agreement, Public Health Emergency Preparedness, and Healthcare Preparedness. These funds support state and local health department preparedness staff and activities, regional health care coalitions, and grants to partners for innovative community planning and response. As of December 2022, HSPR is receiving approximately $60.9 million from CDC Cares Act and ARPA funds. $35.3 million from Cares act to build capacity for the COVID-19 response across the public health system and with healthcare and community partners and $25.6 million from APRA funds to establish, expand, train, and sustain the public health workforce to support jurisdictional COVID-19 prevention, preparedness, response, and recovery initiatives, including school-based health programs.

Beginning with the 2021-23 biennium, the Health Security, Preparedness and Response section receives General Fund to support one position related to Senate Bill 762.

In the 2023-25 biennium, the Governor's Budget invests $1.0 million General Fund in the Health Security, Preparedness and Response section to support management of personal protective equipment and medical supplies from the pandemic.

Proposed new laws that apply to the program unit

None.

Indirect Cost Rate

The 2023-25 Governor's Budget continues to provide the limitation needed to implement and operate an indirect cost rate for the Public Health Division at the current service level.

Activities, programs and issues in the program unit base budget

As part of pursuing the implementation of a division-wide indirect cost rate, Public Health has a Detail Cross-Reference Number (DCR) specific to the indirect cost rate and separate from the program Centers and Office of the State Public Health Director. This functions as budgetary structure to house needed limitation and does not contain any program areas.

The technical accounting entries required to operationalize an indirect cost rate will produce duplicative expenditure data in an internal services fund specific to tracking and reconciling indirect costs assessed to Public Health. Limitation is in Federal Funds and Other Funds to cover the duplicative costs and accommodate the necessary accounting processes. There are no additional "real" expenditures, and the duplicated costs will be excluded from statewide reporting by excluding the internal services fund.

Background information

The Public Health Division currently operates under the Oregon Health Authority's federally approved cost allocation plan for the purpose of allocating indirect costs. As Public Health has many revenue streams (more than 72 categorically dedicated federal grants for the 2021-23 biennium in addition to billable contracts and fee revenues), operationalizing an indirect cost rate streamlines the funding request process and provides certainty across funding streams as to how each will be impacted by indirect costs. This allows Public Health to maximize use of available funding to direct resources in the best manner to achieve positive outcomes for Oregonians and eliminate health inequities across the state.

Indirect Cost Rate

Public Health continues to implement a division-wide indirect cost rate and works with the Cost Allocation Unit to keep the plan updated as revisions are completed and as negotiations occur with Cost Allocation Services, however, some of that work has slowed due to staff turnover and Public Health resources being prioritized to address the COVID-19 response.

Revenue sources and changes

The indirect cost rate DCR limitation is both Other Funds and Federal Funds.

Proposed new laws that apply to the program unit

None.

Oregon Health Authority
2023-25 Policy Package

Division:	Oregon State Hospital
Program:	Salem and Junction City campuses
Policy package title:	OSH Specialized Treatment Services and Supports Program
Policy package number:	402
Related legislation:	None

Summary statement:

As an important step towards achieving agency goals, the Oregon State Hospital (OSH) recognizes, supports, and promotes initiatives that contribute to the advancement of equity and inclusion by active collaboration with the Equity and Inclusion Division in creating policies, processes, procedures, and developing or implementing strategies that advance the agency mission, vision, values, and transformation goals. Transformational change and progress cannot be achieved with one FTE to support the largest workforce within the Oregon Health Authority (OHA), and the people cared for at OSH. This policy package provides investment and redistribution of resources to build a successful and sustainable infrastructure necessary in fulfilling the shared goal of health equity for all Oregonians.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$3,498,590**	**$0**	**$0**	**$3,498,590**	**27**	**12.78**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

The Oregon State Hospital (OSH) is the largest workforce division of the Oregon Health Authority (OHA) and provides services to some of the most vulnerable Oregonians, who have both historically and currently, been harmed by inequities in systems of care. OSH experiences chronic systemic capacity limitations that have prevented it from carrying out strategies to address inequities in the system for both the people served and the service providers. Health equity work has been historically undervalued and deprioritized, and resources required for transformational change at OSH are lacking. Resources are required to facilitate diversity and equity programs and initiatives, foster the implementation of culturally appropriate policies and practices consistent with state and federal requirements, coordinate implementation of laws and regulations such as Section 1557 of the Affordable Care Act and the Americans with Disabilities Act, and promote an increased understanding of the relevance of cultural responsiveness, culturally appropriate care, and diversity to building an organization that effectively meets the needs of its diverse patient population and workforce. There is currently one position to support this work for nearly 3,000 OSH employees and up to 675 clients between the two hospital campuses, and Pendleton Cottages.

In the current state of resource deficiency, OSH will not be able to meet OHA's mission of eliminating health inequities in Oregon, meet the Governor's State of Oregon DEI Action Plan, or provide care that aligns with the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards) as outlined by the U.S. Department of Health and Human Services (HHS). Current investments are focused on responding to emergency situations and restabilizing the division to a pre-pandemic operational state. Simply operating at the historic institutional level is not sufficient for the provision of patient and staff services that address the diversity of the community,

are equitable and inclusive to all community members, and meet a qualitative standard of excellence for addressing health inequity.

2. What would this policy package buy and how and when would it be implemented?

This policy package invests in resources dedicated to building an infrastructure that supports culture change necessary for meeting the goals of eliminating health inequities and the provision of national CLAS standards of care. Recognizing, reconciling, and rectifying historical and contemporary injustices for patients and staff require funding for resources including but not limited to:

- Dedicated professionals trained at the intersection of equity and mental health
- Patient-specific cultural, linguistic, and identify-affirming needs and supports
- Extensive workforce training related to equity, inclusion, diversity, anti-racism, and social determinants of health
- Clinical training related to the identification and facilitation of culturally and linguistically responsive treatment services
- Treatment resources required for the implementation of culturally and linguistically responsive treatment services
- Professionals who can work with frontline staff, patients, and managers to create inclusive and welcoming units

Additional dedicated OSH staffing resources are needed for the full implementation, tracking, and integration of Race, Ethnicity, Language, Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) standards of data collection to drive decision-making processes at all levels of operations. This would include policy and practice implementation, provision of culturally and linguistically responsive and trauma-informed services, service quality improvement initiatives, and staff training for working with diverse populations. These resources are requested in the OSH policy

package as OSH is moving towards utilizing REALD data to align treatment services with treatment needs specific to patients at OSH.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   Lack of sufficient resources dedicated to equity and inclusion work is a long-standing detriment to progress and impedes the ability to: provide patient care that is culturally-and linguistically appropriate, patient-centered, and trauma-informed; implement systems of equitable hiring, retention, professional development, and supports for the workforce; provide training about culturally and linguistically appropriate care to service providers; and implement initiatives that are responsive to the needs of diverse communities. OSH does not have funding allocated to provide patients with cultural supports such as globally recognized gender-affirming care and treatment for LGBTQIA2S+ patients, treatment and leisure materials for Limited English Proficiency patients, treatment programming and supports for patients of color, and resources necessary to help patients from diverse backgrounds connect with community for successful recovery and reintegration. Patient-specific supports create better therapeutic alliances with providers, decreases time spent in higher levels of care, increases adherence to treatment after reintegration into the community, and increases staff and patient satisfaction with services. These fundamental principles of equity and inclusion are essential for creating a therapeutic community where all people can reach their full

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

potential and well-being and are not disadvantaged by socially determined circumstances, do not experience discrimination or harassment, and can be assured that they will be welcomed with respect and dignity in a professional and inclusive atmosphere.

Quantifying results

4. What are the long-term desired outcomes?

The integration of diversity, equity, inclusion, and anti-racism work has been researched and demonstrates that organizations that have a foundation of equity and inclusion see financial gains through staff retention and decreased litigation and investigations related to discrimination, harassment, and civil rights violations, as well as higher rates of patient and staff satisfaction. This policy package would provide resources to create a framework and internal infrastructure for equity and inclusion work in alignment with the Equity and Inclusion Division, OHA's transformation strategies, and needs identified by community partners who are invested in a shared goal of excellence and equity in patient and staff well-being.

5. How will OHA measure the impacts on health inequities of this policy package?

There are qualitative and quantitative metrics that would be collected and analyzed, primarily with regards to patient treatment services. The REALD & SOGI system of demographic collection can be utilized to analyze statistics surrounding target population groups and specific about patient stays:

- Patient treatment satisfaction survey
- Treatment outcomes for target populations:
  - Decrease in length of stay (measured in days spent at OSH)
  - Decrease in recidivism rates (measured in number of hospital readmissions),

  - Increase in treatment adherence (measured in completion of treatment care plan goals, attendance in treatment activities, etc), and
  - Increase in engagement with treatment services (measured in participation in treatment activities, groups, individual therapy, etc),
  - Decrease in time spent in higher levels of care (measured by days spent at OSH, days in acute care facilities, number of ER admissions specific to mental health, etc)
  - Increase adherence to treatment services after community reintegration (measured by recidivism rates to OSH as well as community tracking of engagement with community resources such as appointments)
- Number of allegations, reports, and/or complaints regarding harassment, discrimination, civil rights violations, abuse, or other workplace issues to monitoring agencies: Equity and Inclusion Division, Human Resources, Basic Rights Oregon, Disability Rights Oregon, Department of Justice, Office of Training and Investigation Services, Equal Employment Opportunity Commission

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In 2018, Oregon State Hospital created the OSH Diversity Liaison position in collaboration with the OHA Equity and Inclusion Division. This single position is the only dedicated resource to facilitate diversity and equity programs and initiatives, foster the implementation of culturally appropriate policies and practices consistent with state and federal requirements, coordinate implementation of laws and regulations such as Section 1557 of the Affordable Care Act and the Americans with Disabilities Act, and promote an increased understanding of the relevance of cultural responsiveness, culturally appropriate care, and diversity to building an organization that effectively

meets the needs of the diverse patient population and workforce. This single resource is insufficient to create cultural change that is integrated and sustainable.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   The OSH Diversity Liaison has exhausted existing internal resources, which are dedicated to the provision of patient care on a day-to-day basis. All current resources are allocated to keeping the hospital operational at a level necessary to provide treatment services and care. Those staffing and funding resources are not able to be shared across programs.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   The OHA Equity and Inclusion Division is the primary collaborator with Oregon State Hospital. There are partners in the work, such as the Oregon State Hospital Advisory Board, Joint Commission, Basic Rights Oregon, Disability Rights Oregon, Department of Justice and others that will be made aware of the work and have interest in its success.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    Agencies that provide services to patients before and after they discharge from OSH would be provided more complete information about the appropriate services necessary to assist each individual patient in a successful reentry to the community.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): October 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

Assumes that position descriptions can be reviewed and established through the OHA Human Resources process timely.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

All patients who are admitted to OSH will have access to these culturally and linguistically appropriate and specific treatment services. This includes globally recognized gender-affirming care and treatment for LGBTQIA2S+ patients, treatment and leisure materials for Limited English

Proficiency patients, treatment programming and supports for patients of color, and resources necessary to help patients from diverse backgrounds connect with community for successful recovery and reintegration. Patient-specific supports create better therapeutic alliances with providers, decreases time spent in higher levels of care, and increases adherence to treatment after reintegration into the community.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package is specific to new positions, as existing positions do not exist in the current staffing model for the hospital. These positions all impact treatment services for any person admitted to OSH under any type of commitment.

Total of 27 new permanent, full-time positions (12.78 FTE) priced between eight and 18 months to accommodate a phased hiring approach so new managers may hire their teams.

Nineteen positions in Salem:

- One Diversity Equity & Inclusion Administrator 1
- One Executive Support Specialist 2
- One Human Resource Analyst 3
- One Research Analyst 4
- One Administrative Specialist 2
- One Diversity Equity and Inclusion Manager 2
- One Operations & Policy Analyst 4
- Twelve Training & Development Specialist 2

Eight positions in Junction City:

- Two Operations & Policy Analyst 3
- Five Training & Development Specialist 2
- One Diversity Equity & Inclusion Manager 2

16. What are the start-up and one-time costs?

$49,500 for initial program planning.

17. What are the ongoing costs?

Standard position costs in 2023-25: $3.27 million
Language differential for 22 specific client-facing positions that will be recruited for bi- or multi-lingual preference in 2023-25: $44,854
Other Services & Supplies (S&S) is $135,900, which includes:

- Second devices for 7 specific positions
- System furniture
- Culturally specific patient supports

18. What are the potential savings?

OSH does not anticipate any direct savings to its operating budget.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Oregon Health Authority: 2023-25 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$2,942,282			$2,942,282	27	12.78
Services & Supplies	$556,308			$556,308		
Capital Outlay						
Special Payments						
Other						
Total	**$3,498,590**	**$0**	**$0**	**$3,498,590**	**27**	**12.78**

Oregon Health Authority
2023-25 Policy Package

Division:	Equity and Inclusion Division
Program:	REALD & SOGI
Policy package title:	REALD & SOGI Implementation: Getting to Data Equity
Policy package number:	403
Related legislation:	House Bill 2134 (Standards for Collection of Demographic Data, 2013), House Bill 4212 (Strategies to Protect Oregonians from the Effects of the COVID-19 Pandemic, 2020), and House Bill 3159 (Data Justice Act, 2021)

Summary statement:

This policy package requests resources and funds to address requirements of House Bill 4212 and House Bill 3159 to better collect Race, Ethnicity, Language, Disability (REALD) and Sexual Orientation, Gender Identity (SOGI) data from providers and insurers. REALD & SOGI data is OHA's best tool to assess how racism, disablism, lack of language access, sexism and heteronormative dominance impact individual and community health. It is also OHA's best tool to close the significant gaps in health inequities experienced by populations that remain invisible. The data also helps OHA evaluate effectiveness of patient and person-centered care. The current lack of quality REALD & SOGI data contributes to more expensive and less effective services, particularly for members of Tribal communities, people of color, those with disabilities, and members of the LGBTQIA2S+ community. Solutions must be culturally appropriate and protect citizens' data privacy and security while providing flexibility. OHA can achieve the call to action by communities most impacted by health inequities and by legislation with sufficient resources, staffing, professional supports, and tools.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$12,699,241**	**$1,080,734**	**$1,909,447**	**$15,689,422**	**7**	**7.50**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. **Why does ODHS/OHA propose this policy package and what issue is OHA trying to fix or solve?**

   The READLD & SOGI data standards[1] are intended to help OHA achieve its 2030 goal of eliminating inequities with better data to identify and address inequities. Without good quality and complete READLD & SOGI data, OHA remains limited in its ability to assess how racism, disablism, transphobia, homophobia, heterosexism, and lack of language access impact individual and community health. This in turn makes services more expensive and less effective and keeps populations most impacted by inequities invisible. READLD & SOGI is a manifestation of data justice as READLD data standards came from Asian Pacific American Network of Oregon, Oregon Health Equity Alliance and other communities most impacted by health inequities and were codified by House Bill 2134 in 2013. Data justice supports communities by using data to elevate their voice and reveal the systemic inequities they experience.

   The barrier addressed by the development of a centralized READLD & SOGI Registry receiving data from providers and insurers, mandated by House Bill 3159 (Data Justice Act passed in 2021 by the Oregon legislature), is poor data infrastructure and lack of investment for collecting READLD & SOGI resulting in poor data quality, which in turn perpetuates bias in what gets collected and how it is used or not used (for example, national standards for race/ethnicity, no disability data). Such lack of

[1] See here for an at-a-glance view of the READLD data standards. Note that the draft SOGI data recommendations have not been codified into the OARs. The SOGI draft recommendations were, however, put into practice in data systems relating to COVID-19 early 2020. The ONE system (for the Oregon Health Plan) also included gender identity in 2021. OEI will convene a rulemaking advisory committee early 2013, following a series of meetings with providers and community members in fall 2022.

investment and poor resourcing often stems from not recognizing that REALD & SOGI are proxies for exposure to racism, disablism, and other forms of structural oppression.

This policy package represents an investment to gather more meaningful data collection, which is "critical for the livelihood of our diverse communities, particularly those who have been oppressed in nearly all facets of society" (1). These communities (Tribal communities, communities of color, immigrant and non-English speaking communities, disability communities, and LGBTQIA2S+[2] communities) are also most impacted by health inequities.

A barrier that would be addressed by this policy package is the lack of understanding by provider staff about how best to collect demographic information (2). Further, the lack of buy-in from provider staff can undermine data collection, which are more likely to come from communities where there is minimal diversity. However, the lack of buy-in also can come from health care settings that are diverse who may feel that disparities in health outcomes are due to structural determinants, not to differences in health care (3).

Currently OHA receives varying levels of demographic data from health providers and insurers for 31 data systems, such as the Trauma Registry and the Cancer Registry. Of these, only five comply with REALD standards and only one consistently receives REALD data from providers—the Oregon Pandemic Emergency Response Application (OPERA), which contains COVID-19 case management data. Additionally, the REALD & SOGI data is not updated regularly. This problem is the impetus for House Bill 3159, expanding the scope of House Bill 4212 (for COVID-19) to all providers and insurers, so that we can receive REALD & SOGI data from providers and insurers for

[2] LGBTQIA2S+ is an inclusive term that includes people of all genders and sexualities, such as lesbian, gay, bisexual, transgender, questioning, queer, intersex, asexual, and pansexual.

all 31 data systems. Currently, demographic data from providers received for the 31 systems is largely limited to race and ethnicity, in the form of the federal Office of Management and Budget (OMB) race/ethnicity categories. These OMB categories represent a “failure to reflect substantial diversity within various groupings, can mask critical between- and within group differences that policies and programs should address. Lack of adequately disaggregated data can contribute to the unmet needs of underrepresented populations by rendering them invisible when policies are made, resources are allocated, and programs are designed and implemented; it reflects systemic inequities and, when oppressed or excluded racial or ethnic groups are involved, systemic racism” (4).

Data are coming to OHA in ways that are inconsistent and fraught with data quality issues. The lack of dedicated resources for onboarding, data quality evaluation, auditing, and remediation of REALD & SOGI data has made it difficult to ensure high quality, standardized, clean data are available for evaluation and appropriate response. Consequently, obtaining REALD & SOGI data requires laborious effort and existing data cannot be effectively analyzed due to lack of timely and complete information. Preparing REALD & SOGI data for analytics and reporting has also been challenged by lack of automated processes. These challenges have also made it difficult to monitor data quality and REALD compliance and inhibit OHA’s ability to publish COVID-19 REALD data on our COVID-19 reporting dashboards or use this information to inform culturally specific interventions to eliminate inequities.

As Oregon’s REALD standards expand beyond the nationally recognized standards for electronic case reporting, and because of the high demand for rapid ingestion of large volumes of data from providers, laboratories, and health systems, OPERA, a case management system for positive cases of COVID-19 only, was unable to sufficiently import the REALD data available for positive cases. House Bill 4212 only requires providers to submit REALD data annually, so a previous case who

tested negative with complete REALD data is not populated in OPERA later when they test positive unless the provider resubmits that data. This created a serious barrier that undermines OHA's credibility with communities and could have dire consequences. For example, when examining the impact of COVID-19 among Black/African American communities in March 2022 using REALD data, OHA could not find evidence of inequities (50 percent missingness in REALD race/ethnicity data skews the data in such a way that makes it hard to discern impact of COVID-19). Yet, we know that the pandemic disproportionately affected American Indian/Alaska Native, Asian, Black, Hispanic or Latina/o/x and Pacific Islanders from our analyses of OMB race/ethnicity from electronic lab reports (about 30 percent missingness). These communities were 3–5 times more likely to have been hospitalized with or died from COVID-19 before vaccinations were readily available. Understanding who is disproportionately affected is important for OHA's 2030 goal of eliminating health inequities by identifying targeted interventions, policies and meaningful community engagement. However, OMB race and ethnicity categories do not capture the diversity of demographic identities. We need to do better.

Consequently, due to these failures and challenges, we are also not in compliance with the following legislative mandates:

- House Bill 2134 (Standards for Collection of Demographic Data, 2013): requires REALD information to be captured in all systems and surveys maintained by OHA and the Oregon Department of Human Services (ODHS) that request or store person-based demographic information.
- House Bill 4212 (Strategies to Protect Oregonians from the Effects of the COVID-19 Pandemic, 2020): requires providers ordering COVID-19 tests to collect and submit REALD data to OHA.
- House Bill 3159 (Data Justice Act, 2021): builds upon both House Bill 2134 and House Bill 4212 by adding SOGI data collection standards to the OARs associated with House Bill 2134,

and mandating the creation of a registry for providers, insurers, coordinated care organizations (CCOs), and individuals to electronically submit, review, and update data.

These bills focus on communities that experience health inequities, and together support OHA's goal of creating the conditions for data equity so that communities can do data justice.

For the first time, with the passage of House Bill 3159, OHA has an opportunity to collect REALD & SOGI data from providers and insurers in a consistent manner, following the data collection standards established by rulemaking advisory committee processes. With the requested resources, OHA would have sufficient capacity to support providers and insurers in their data collection efforts with technical assistance, training, and development of resources. Further, the providers and insurers would not have to submit demographic data to multiple OHA programs (for example, Trauma Registry, Cancer Registry); this would be automated with the Repository (back end). The Registry and Repository would allow us to use REALD & SOGI data to improve care/services and identify and address inequities.

The collection of demographic data that aligns with REALD & SOGI standards, along with investment in how that data is processed and prepared for analytics and reporting, would help OHA understand better who are most impacted by health inequities across 30+ surveillance data systems in OHA, such as the Cancer Registry and OPERA (COVID-19). Accurate, complete, and timely demographic data collection, with automated processes for cleaning and processing the data for analytics, are needed to identify populations most impacted by health inequities and understand what specific health services and supports they need. Through this we can better serve these communities.

2. What would this policy package buy and how and when would it be implemented?

This policy package requests funds to continue multi-biennia efforts to meet legislation outlined in House Bill 2134 (Standards for Collection of Demographic Data, 2013), House Bill 4212 (Strategies to Protect Oregonians from the Effects of the COVID-19 Pandemic, 2020), and House Bill 3159 (Data Justice Act, 2021). Supporting data collection by external providers, insurers, and individuals, the Initial Registry, Initial Repository, and creating the Enterprise Scale Statewide REALD & SOGI Registry and Repository represents an investment in data equity and facilitates data justice within communities most impacted by health inequities.

Staffing to support data collection efforts and the Repository

This policy package would abolish three limited duration positions and establish them as permanent full-time positions. It would also establish nine new permanent full-time positions. The net impact of this policy package is seven new positions (7.50 FTE) for an estimated total of $2.0 million for positions-related costs. These positions are needed to:

- Maximize data quality of REALD & SOGI data by increasing buy-in and support from providers and helping providers collecting REALD & SOGI data from patients and members understand how to ask the questions in a culturally centered and appropriate manner.
- Respond to and fill data requests for data files from the Repository (both initial and enterprise scale states).
- Liaise with other OHA divisions to manage division-level requests and coordinate appropriate uses of the Repository data.

Initial Registry (building on the work done in 2022/23 in the 2023-25 biennium):

The piloting of the patient-facing survey tool for REALD & SOGI demographic data collection demonstrated it performed well, but it will need ongoing supports and enhancements. OHA would

enhance and maintain the patient-facing survey tool for REALD & SOGI demographic data collection at an estimated cost of $1.4 million. Enhancements would expand existing functionality to enable individuals to receive e-mail confirmation and additional information after submitting the survey and provide options for those who are houseless or do not have a phone. Other enhancements include allowing providers to request to onboard, migrate the platform to state-supported Microsoft, verify address entered, incorporate skip logic to streamline user experience and data quality, offer multilingual integration, and add parameters to filter questions based on age. This tool is one of the mechanisms by which REALD & SOGI data can be submitted to OHA via the initial Registry on a mobile app with QR code functionality.

Initial Repository (building on the work done in 2022/23 in the 2023-25 biennium):
Due to the challenges in data quality, and lack of automated processing so that OHA can use REALD & SOGI data to identify and address inequities, the COVID-19 Response & Recovery Unit (CRRU) data team is working with a vendor to develop a datamart where high level data cleaning, transformation, and normalization of COVID-19 data occurs, including the REALD & SOGI data attached to a case. The CRRU data team is also working closely with the Equity and Inclusion Division to ensure REALD & SOGI programming is in alignment with enterprise-wide standards established by the division. This year OHA plans to replicate these processes with just REALD & SOGI data along with person level identifiers and dates, including data from Orpheus (Public Health Division's data environment for communicable diseases), ARIAS (Public Health Division's data environment for COVID-19 contact tracing), and the ONE system (Medicaid, SNAP, TANF and other ODHS programs). We will develop an additional layer of processing that will deduplicate the REALD & SOGI records (by person and time/event).

OHA aims to have the Initial Repository (COVID-19 + ONE REALD & SOGI) completed by June 2023. Also, OHA plans to implement the data transmission to CCOs and fee-for-service (FFS)

contractors, like the vaccination reporting, by June 2023. This will be transitioned to cloud interactive data environment during the 2023-25 biennium.

Additionally, OHA must continue to support the processes put in place for House Bill 4212 until the Enterprise Scale Statewide REALD & SOGI Registry and Repository goes live. And there is a need for staffing to handle the governance and data requests associated with the Repository. This policy package will cover:

- The ongoing maintenance and operation costs associated with automating the cleaning and preparing of REALD & SOGI data in the initial Repository
- Transitioning the flat file data transmission to CCOs and FFS contractors, such as Kepro and CareOregon, to a cloud interactive data environment

Enterprise Scale Statewide REALD & SOGI Registry and Repository
Following the passage of House Bill 3159 OHA determined the scope of work required to implement the bill and requests $18.9 million to purchase software and hardware, undertake third-party consultation, convert data systems to the cloud-based Azure service, and pay for IT professional services for initial planning and development of the Enterprise Scale Statewide REALD & SOGI Registry and Repository.

Planning for the Enterprise Scale Statewide REALD & SOGI Registry and Repository will include the capacity to share validated REALD & SOGI data files with CCOs, ONE, and over 30 other major data systems in OHA and ODHS. To achieve this solution, OHA will need to acquire appropriate consultative and development resources.

Whereas the Initial Registry will collect REALD & SOGI data from providers during the 2023-25 biennium for COVID-19 encounters, the Enterprise Scale Statewide REALD & SOGI Registry and

Repository will be implemented during the 2025-27 biennium. Per House Bill 3159, the Repository must allow a patient, member, or client to submit data directly to the Registry and allow CCOs, health care providers and health insurers to electronically submit data collected and query the Registry to determine whether it contains current data for a patient, member or client. With these functionalities, OHA would have the capacity to share clean data files to CCOs and FFS contractors such as Kepro, CareOregon, the ONE data system, and over 30 other major data systems in OHA and ODHS relying on data from providers and insurers.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further ODHS/OHA's mission and align with its strategic plan?**

This policy package represents an investment to create the conditions for data justice. "Data justice recognizes that the types of data the government collects and relies on are insufficient for understanding community needs, experiences, and equally important, desires. These data do not represent communities in ways that the communities would represent themselves – and government data often entirely erases some communities due to "the problem" of small sample size (for example, Pacific Islanders) or using too broad, and ultimately meaningless, categories (for example, Asian)" (5). This investment will help OHA gather more meaningful data by using REALD & SOGI data elements as proxies for exposure to the interlocking systems of racism, linguistic discrimination, disablism, transphobia, homophobia, heterosexism to identify, and address health inequities. These communities (Tribal communities, communities of color, immigrant and non-English speaking communities, disability communities, and LGBTQIA2S+ communities) are also most impacted by health inequities. Currently, OHA's ability to identify and eliminate health inequities is compromised by inadequate REALD & SOGI data, that is fraught with missing data and discordance.

This policy package is intended to address these challenges and directly supports OHA's goal of eliminating inequities currently faced by members of racial and ethnic minority groups, individuals with disabilities, and members of the LGBTQIA2S+ communities who face disproportionate economic and health inequities.

- The investment in **staffing** to support providers with data collection, build relationships, and increase readiness and buy-in to collect REALD & SOGI data is essential. Focusing on data solutions alone will not suffice. Staff with expertise specific to SOGI and race/ethnicity is also essential for ensuring data collection is done appropriately and that data analysis and reporting are done in accordance with best practices and guidance from researchers from the same communities (existing staff is able to cover expertise for disability and language). Staffing is also needed to support the Repository processes. The Repository will be the source of REALD & SOGI data for 30+ systems across OHA and ODHS, and it is imperative that we carefully manage the governance and processes to ensure data integrity and security. We will also need to work with other divisions to manage division-level requests and coordinate appropriate uses of the REALD & SOGI data.
- With the investment in the **Initial Registry**, a patient facing survey tool (mobile app) with QR code functionality, OHA will be able to make it easier for providers to send REALD & SOGI data to OHA and easier for people to provide REALD & SOGI information for themselves in a manner that respects their privacy and is easily accessible (ADA and in multiple languages). The tool has been proven to result in good data quality if workflows are in place to ensure processes, whereby patients/members are asked to answer the REALD & SOGI questions using the mobile app.
- With the investment in the **Initial Repository** we will be able to make it easier to bring together different streams of REALD & SOGI data for automated processing and cleaning. Due to the complexities of the REALD & SOGI data, detailed data cleaning must occur on the raw data prior to analysis being possible. The automation of these cleaning processes contributes to the

maximization of data completeness and data quality. For example, based on our work with the ONE Repository cleaning, we are able to reduce missingness of REALD race/ethnicity data for OHP members from 40 percent (DSSURS; no cleaning) to 19 percent (ONE; cleaned, average from 2017/18 thru Feb 2022). We anticipate similar or improved results when processing the COVID-19 REALD data. This will enable automation and consistency in the creation of analytic variables which will follow enterprise wide standards set by data governance best practices and community input with a focus on data decolonization. In turn, this will enable data analysts across OHA (OHP) and ODHS (APD, SNAP, TANF) to better understand the populations they serve, improve language access, and identify ways to address inequities by identifying targeted interventions, policies, and meaningful community engagement. The Initial Repository will allow OHA to achieve the following immediate goals:

  - Monitor providers' REALD & SOGI data quality and compliance by creating periodic demographic reports
  - Publish validated REALD & SOGI data on public facing OHA dashboards
  - Use REALD & SOGI data to identify and address inequities in COVID-19 impacts, and among OHP enrollees
  - Share clean REALD data with CCOs and FFS contractors who then can more easily use this data to identify and address inequities among their members, and ensure language access

- The investment in the **Enterprise Scale Statewide REALD & SOGI Registry** will expand the Initial Registry to include REALD & SOGI data from health providers and insurers for all members/patients. The ability to offer individuals a direct method to update their REALD & SOGI information and to allow providers to query and update their records as described in Section 2(1)(b) will dramatically improve transparency and equity by removing barriers which

currently prevent patients, clients, and members from being able to accurately describe their demographics.

- The **Enterprise Scale Statewide REALD & SOGI Repository** will build upon the cleaning processes set up for the Initial Repository, while further enhancing data quality and completeness for nearly everyone living in Oregon. The staffing for governance and Repository requests will carry over from the Initial Repository. This will enable the sharing of clean data files to CCOs and FFS contractors such as Kepro, CareOregon, the ONE data system, and over 30 other major data systems in OHA and ODHS relying on data from providers and insurers.
- This policy package would help OHA achieve the triple aim of better health, better care and lower costs by collecting REALD & SOGI data and bringing that data into the 30+ surveillance systems that currently rely on data from health care providers and insurers. Thereby, this will aid in our ability to monitor data on the health of individuals living in Oregon and using that data to implement meaningful and effective community health strategies.
- This policy package also facilitates the State Health Improvement Plan as most of the 30+ data systems reside in Public Health. The state's health priorities with strategies to advance improvement and measure progress will be greatly enhanced through complete and usable REALD & SOGI data.
- Finally, having usable and complete REALD & SOGI data enables impacted population groups to use more complete REALD & SOGI data for data informed community health improvement and data justice.

Additionally, the success of other policy packages relying on REALD & SOGI data that are in the Governor's Budget will not succeed without this investment. For example, policy packages that

would directly rely on the REALD & SOGI data from Enterprise Scale Statewide REALD & SOGI Registry and Registry will be hindered if this policy package is not supported. These include:

- Policy package #201: 1115 Medicaid Waiver
- Policy package #202: Redeterminations & Basic Health Program
- Policy package #406: Public Health Modernization
- Policy package #435: PEBB OEBB Benefits Management System Replacement

In addition to the above, efforts proposed in other policy packages would benefit from using quality REALD & SOGI data as proxies of exposure to discrimination and systems of oppression (risk factors) to ensure equity in services and care include the following:

- Policy package #402: Oregon State Hospital Specialized Treatment Services and Supports Program
- Policy package #415: Adult Intensive Services and Diversion

In summary, this package helps populations impacted by health inequities by ensuring REALD & SOGI data is appropriately captured, stored, and leveraged so that OHA may identify gaps in service continuity and improve patient or person-centered care and services.

Quantifying results

4. What are the long-term desired outcomes?

OHA believes REALD & SOGI data are its best measures or proxies of exposure to the interlocking systems of racism, linguistic discrimination, disablism, transphobia, homophobia, and heterosexism. Exposure to harmful systems of oppression have long been associated with poor health outcomes (6). Accurate and high quality REALD & SOGI information enables OHA to understand at a more granular level what communities are impacted and identify the right allocation of resources. Through

this we will work to identify focused interventions, enhance policies, and facilitate meaningful community engagement to achieve OHA's 2030 goal of eliminating health inequities.

OHA anticipates making continued progress through 2021-23, establishing an Initial Registry, with a patient facing survey tool, and an Initial Repository, which collects data from the Initial Registry. OHA will be able to monitor House Bill 4212 compliance by providers and publish REALD & SOGI data on a public facing COVID-19 dashboard. CCO's and FFS contractors will be able to access member transmissions.

With this investment, OHA anticipates making the following progress in upcoming biennia:

2023-25 biennium

- OHA and ODHS analysts, with ongoing supports and maintenance of the REALD & SOGI Initial Repository (with COVID-19 and ONE data) would be able to use high quality, more complete, and timely REALD & SOGI data to identify health inequities, reallocate resources, and develop culturally appropriate and accessible interventions to eliminate health inequities by:
  - Storing the raw data in a data environment for future retrieval as needed
  - Processing and cleaning REALD & SOGI data consistently
  - Creating calculated analytic variables for use by analysts across OHA and ODHS
- The Initial Repository and Initial Registry would yield more complete REALD & SOGI demographic data within the ONE population and for COVID-19 reporting.
- CCOs and FFS contractors would be able to access and retrieve clean REALD and gender identity data ready for analytics and reporting via a flat file initially, and later from a cloud-based interactive data environment.

- Data owners of existing REALD compliant data systems, such as OPERA, ARIAS, and Orpheus, would be able to retrieve REALD & SOGI data for the people in their systems and immediately be able to report on what they know about inequities with respect to COVID-19 and communicable diseases, respectively.
- These efforts would include the 30+ systems relying on data from providers and insurers.
- Providers, health insurers, and community members would be trained by four OHA Equity and Inclusion Division-led support specialists on REALD & SOGI data collection. This would enable increased REALD & SOGI reporting, high quality data, and the use of culturally appropriate practices to collect this demographic information.

2025-27 biennium:

- REALD & SOGI data would expand to statewide collection with a robust, scalable central REALD & SOGI data Registry and Repository. Providers, health insurers, CCOs, and individuals would be able to use the enterprise Registry and Repository to report, update, and query demographic information.
- REALD & SOGI data would support data justice. OHA, ODHS, CCOs, FFS contractors, and impacted communities could use the data to identify inequities, monitor trends, and inform interventions to address these inequities.

This investment would result in better clinical care with an improved knowledge based about inequities. For example, after New Jersey mandated disaggregated race/ethnicity in hospital discharge data, Chakkalakal and colleagues (7) found that acute myocardial infarction hospitalization rates increased for all Asian subgroups except Vietnamese, and suggested that “population health metrics for Asian-American subgroups may be prone to significant underestimation without widespread utilization of similar practices” in collecting disaggregated race/ethnicity data. Further,

the more we understand the nature of inequities, the more we can explore and understand causal mechanisms relating to exposure to racism, for example. This is true, not only between groups (for example, between white persons and Black or African Americans), but also within groups (e.g., between African immigrants and African Americans, 8). This policy package represents an investment to build data equity into our data systems so that communities can do data justice. The long-term outcome is better health and improved quality of life for all through the reduction of emergency and charity care expenditures, chronic illnesses, and functional limitations due to chronic conditions, and mortality.

If this policy package is not funded, OHA's ability to identify and enable opportunities for better health in all communities will continue to be severely limited due to lack of complete, reliable, and timely REALD & SOGI data. Communities most impacted by health inequities, including those who championed House Bill 2134 and House Bill 3159, will continue to be compromised by OHA's lack of progress. This is an ethical issue and is about equity: "Lack of adequately disaggregated data can contribute to the unmet needs of underrepresented populations by rendering them invisible when policies are made, resources are allocated, and programs are designed and implemented; it reflects systemic inequities and, when oppressed or excluded racial or ethnic groups are involved, systemic racism" (4). Indeed, we run the risk of saying that COVID-19 does not impact certain groups more than others, when in fact we know there are impacts based on aggregated OMB race/ethnicity data for example. Legally, OHA will remain out of compliance with House Bill 2134 (2013) which applies to all programs and activities across OHA; most of the remaining systems in OHA in non-compliance with House Bill 2134 are systems relying on data from providers and insurers. Understanding who is disproportionately affected is important for OHA's 2030 goal of eliminating health inequities by identifying targeted interventions, enhancing policies, and facilitating meaningful community engagement.

5. How will OHA measure the impacts on health inequities through this policy package?

Impacts on health inequities would be measured by success in the following areas:

- Whether REALD & SOGI data quality increases. This would indicate provider training and community acceptance successfully produced a Repository that is frequently updated and accurately represents community demographics in real time.
- Whether OHA, ODHS, CCOs and FFS contractors share and use the REALD & SOGI Repository to leverage real time data to identify health inequities, reallocate resources, and develop culturally appropriate and accessible interventions to eliminate health inequities. This would indicate that stakeholders trust the validity of REALD & SOGI data and understand the imperativeness of addressing vulnerabilities within specific populations.
- Whether communities most impacted by health inequities see meaningful progress toward eliminating health inequities. For example, the annual CCO metrics report now includes annual changes in performance by household language. Similarly, the Registry and Repository would allow monitoring across the range of providers and individuals contributing REALD & SOGI data.
- Communities most impacted by health inequities would receive and use more complete REALD & SOGI data to do data justice.

Investment in this package supports a myriad of OHA performance measures that have revealed persistent health disparities, including:

- KPM #1: Initiation of Alcohol and Other Drug Dependence Treatment
- KPM #2: Engagement of Alcohol and Other Drug Dependence Treatment
- KPM #3: Follow-up after Hospitalization for Mental Illness
- KPM #20: Access to Care
- KPM #21: Member Experience of Care

- KPM #22: Member Health Status
- CCO quality incentive measure: Meaningful Language Access to Culturally Responsive Health Care Services

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

House Bill 2134 was passed in 2013 with one funded position to put REALD into practice across the entire agency. This level of resourcing for an agency-wide systems change was insufficient to facilitate coordinated, systematic REALD implementation across the many OHA programs that collect, house, and analyze demographic data.

Between 2016 and 2019, progress was limited to focusing on the ONE system, understanding the data quality issues in the ONE system (OHP) and MMIS. In 2018, the REALD analyst in the OHA Equity and Inclusion Division published an Assessment of REALD Data Quality in the Oregon Health Plan ONE System Full Report. Based upon a deeper understanding of the inherent limitations in the MMIS system, the REALD analyst developed extensive programming to clean and process the ONE data. The result of this work is considerable. We are now able to reduce missingness of REALD race/ethnicity data by more than half for OHP members from 40 percent (DSSURS) to 19 percent (ONE), based on averages from approximately 2017 through February 2022. Due to these improvements, the OHA Equity and Inclusion Division has collaborated with the Health Policy and Analytics division (HPA) to develop a static flat file that can be used by HPA analysts for reporting metrics by REALD categories, including an updated CCO metrics dashboard that breaks out CCO performance by REALD categories. OHA published this dashboard with REALD disaggregated

metrics at a statewide level for the first time in fall 2022.[3] The agency continues to work collaboratively across divisions to achieve the full benefit of REALD data and help meet the strategic goal of eliminating health inequities by 2030. This work was also the impetus for the Initial Repository concept.

In 2017, the REALD analyst convened a group of internal and external stakeholders to develop an OHA policy requiring applicable programs to detail how they will comply with House Bill 2134. The internal policy, along with the inclusion of REALD in OHA's tier one performance measures, helped to improve compliance from about 10 percent in 2018 to 39 percent in June 2022 (28 of 72 major datasets applicable to House Bill 2134). Another 10 data systems are undergoing changes to become compliant over the next few years. In most cases, these data sets or surveys represent cases in which OHA or ODHS staff can control directly how REALD data is collected and can require that the REALD questions are asked according to the standards. However, systems that do rely on data from external sources, such as health providers and insurers, remain largely out of compliance with House Bill 2134.

Due to the pandemic and the lack of REALD data to discern impact of COVID-19, the Legislature passed House Bill 4212 (2020), which required providers to submit REALD for COVID-19 encounters. With additional resources provided by House Bill 3159 in 2021, the OHA Equity and Inclusion Division has been able to better to guide and support the implementation of REALD across the agency and with providers.

Based on lessons learned since 2016, and particularly during the pandemic, the REALD & SOGI unit clarified their role as the lead for REALD & SOGI in OHA and with ODHS OEMS. This includes

[3] See CCO Performance Metrics Dashboard: https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome

developing the business rules for the data dictionary, data cleaning, analyses, and reporting. The unit also monitors data quality and compliance for the ONE system and plans to do this for COVID-19 data once the Repository is built. (The Initial Repository went 'live' at the end of December 2022 and is being used to fulfil mission-critical projects, but there is a need for continuing refinements which will likely extend for the next 6 months.). These actions require a close partnership with data owners/stewards across the agency with the OHA Equity and Inclusion Division acting as the friendly "housing inspectors." The division is taking on this role to de-silo efforts relating to REALD & SOGI and to create and foster the conditions for communities most impacted by health equities to do data justice, so that OHA can eliminate health inequities by 2030.

Additional efforts are currently underway to leverage components of the existing OPERA COVID-19 system and establish a more robust Initial Registry, consisting of reporting from COVID-19 encounters, and an Initial Repository. See below for a description of these efforts.

Within the **Initial Registry**:

- PHD ACDP established components of the Initial Registry for COVID-19 REALD & SOGI data collection.
- OHA Equity and Inclusion Division and the CRRU collaborated on development of a patient facing survey tool which is an essential component of the Initial Registry.
- OHA Equity and Inclusion Division, ACDP, and HPA collaborated on provision of a series of webinars to providers to communicate requirements, why we have REALD, how to ask the questions, and to facilitate the development of systems by providers to achieve compliance.
- OHA Equity and Inclusion Divisionand the CRRU developed REALD & SOGI training for case investigators.

- OHA Equity and Inclusion Divisionand the CRRU are collaborating on a SOGI learning collaborative and a SOGI community of practice.

Within the **Initial Repository**:

- OHA Equity and Inclusion Division, ACDP, and the CRRU are collaborating on development of the Initial Repository. This involves reconfiguring how COVID-19 data is processed to include REALD & SOGI data for negative cases as well as positive. These can then be linked to later positive cases with missing REALD & SOGI information.
- The Initial Repository will consist of data directly from the Initial Registry as well as legacy REALD & SOGI data from a subset of existing agency systems. The Initial Repository went 'live' at the end of December 2022, and is being used to fulfil mission-critical projects, but there is a need for continuing refinements which will likely extend for the next 6 months.
- OHA Equity and Inclusion Division, ACDP, and the CRRU are collaborating on development of SQL coding with Deloitte that will automate cleaning of the REALD & SOGI data from OPERA and will be expanded to include data directly from the Registry, from Orpheus, ARIAS, and ONE.
- The Health Systems Division (HSD) will build a file transfer mechanism by June 2023 to provide clean REALD & SOGI data to CCOs and fee-for-service contractors that they can use to identify and address inequities.

With completion of the **Initial Registry and Initial Repository**:

- OHA will be able to use REALD & SOGI COVID-19 data to identify and address inequities
- OHA will increase compliance with House Bill 2134
- OHA Equity and Inclusion Division will be able to monitor providers' REALD data quality and compliance with House Bill 4212

- COVID-19 REALD & SOGI data will be published on OHA public facing COVID-19 dashboards.
- Valid REALD & SOGI data will be published on OHA dashboards relating to OHP members
- OHA will be able to use REALD & SOGI data to identify and address inequities in COVID-19 impacts and among OHP enrollees.

Activities with respect to House Bill 3159 and this policy package include the following:

- In early 2021, OHA Equity and Inclusion Division, HPA, HSD, and the Office of Information Services (OIS) initiated significant intra-agency planning to forecast a multi-biennium approach to REALD & SOGI implementation under House Bill 3159 and House Bill 2134.
- OHA Equity and Inclusion Division developed a REALD & SOGI website page to keep people informed about House Bill 3159 timelines along with options for folks to sign up for email notices as well.
- OHA Equity and Inclusion Division and HPA collaborated on webinars to keep people informed about House Bill 3159 and upcoming plans.
- In January 2022, leadership from the OHA Equity and Inclusion Division, HPA, HSD, and OIS attended a half-day retreat to achieve consensus on the importance and significance of REALD & SOGI data collection, identify ongoing agency efforts aligned with House Bill 3159, and understand divisional roles in House Bill 3159 implementation.

This policy package is the next step in funding, and the request has been anticipated and established as a future need from prior work based on House Bill 3159.

7. What alternatives were considered and what were the reasons for rejecting them?

- Expand the existing systems developed for the collection of REALD & SOGI data associated with COVID-19 encounters to apply to all providers and insurers for all patients. However, this is not feasible as these systems do not allow for reporting and updating REALD & SOGI data, as mandated under House Bill 3159. Further, these systems lack the functionalities needed to ensure fidelity in how the data is submitted to OHA. Therefore, this alternative was rejected.
- Continue using demographic information currently available within individual datasets. This option was rejected because it does not fulfill the House Bill 3159 mandate requiring providers and insurers to send REALD & SOGI data to OHA on at least an annual basis via the Registry. Nor does it allow for individuals to directly update their REALD & SOGI data.
- Obtain demographic data via linkages of existing state datasets. Within specific populations, such as individuals insured by the Oregon Health Plan, this method somewhat improves the availability of REALD-compliant data and gender identity, but not sexual orientation. This option is rejected because this information is generally only collected at the time of enrollment, and thus is not updated regularly. Further, it does not fulfill the House Bill 3159 mandate requiring providers and insurers to send REALD & SOGI data to OHA on an annual basis via the Registry and does not allow for data corrections or updates.
- Do nothing. If OHA does not collect REALD & SOGI data, it will continue to fail to fulfill the missions of House Bill 2134 and House Bill 3159. Indeed, Oregon has faltered for many years to address the health inequities encountered by Tribal communities, communities of color, immigrant and refugee communities, disability communities and LGBTQIA2S+ communities. We cannot postpone this work if we want to address OHA’s goal of eliminating inequities by 2030.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

REALD & SOGI is a manifestation of data justice as both bills (House Bill 2134 in 2013 and House Bill 3159 in 2021) came from Asian Pacific American Network of Oregon, Oregon Health Equity Alliance in 2013, Coalition of Communities of Color, Immigrant and Refugee Cascade Aids Project, Basic Rights Oregon, Oregon Health Equity Alliance, Racial Justice Council Health Equity Committee, Utopia PDX, Ecumenical Ministries of Oregon Virginia Garcia Memorial Health Center, and many other organizations serving or representing communities most impacted by health inequities.

This package is a collaborative effort between the OHA Equity and Inclusion Division, Health Systems Division, Health Policy & Analytics, and the Office of Information Services. OHA's Equity and Inclusion Division is charged with leading REALD & SOGI implementation for OHA and works closely with ODHS Office of Equity and Multicultural Services who is charged with leading REALD & SOGI implementation for ODHS. The Office of Information Services works in partnership with agency staff and vendors on the technical implementation relating to House Bill 3159 systems. Health Systems Division provides internal agency support regarding REALD & SOGI implementation as it relates to ONE, MMIS, and other health services data systems. Health Policy & Analytics supports the OHA Equity and Inclusion Division's work with REALD & SOGI implementation with external health care providers and insurers. Health Policy & Analytics will also be supporting the Initial Repository and enterprise scale Repository. The Office of Information Services works in partnership with agency staff and vendors on the technical implementation.

Other partners who will be invited to collaborate in this work as we move forward includes: CCOs, FFS providers, insurers, OEBB/PEBB, Oregon Association of Hospitals and Health Systems, Oregon Primary Care Association, and many others.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No. This policy package is not tied to the legislative concept OHA is proposing that's focused on protecting the privacy of individuals answering the REALD & SOGI questions in any setting, including those on committees, commissions and boards by excluding REALD & SOGI from Public Records Act.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Because the reporting requirements are placed on providers, CCOs, and payers it is reasonable to expect that provider groupings, which are not directly named within the bill itself, will be impacted through efforts to introduce efficiencies in reporting. This includes providers licensed by the boards described within the bill working in county health clinic, Tribal health clinics, or local public health authorities.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

- It is unknown whether enhanced funding might be available from the Centers for Medicare and Medicaid Services (CMS) for the components of this work related to Medicaid programs. This policy package has been priced with the assumption that this work is to the benefit of the entire agency and therefore utilizes the agency-wide cost allocation pool anticipated fund splits.
- The Public Health Emergency will end in December of 2023.
- Work for the patient facing survey tool is included in this policy package.
- Planned work in 2021-23 relating to the Initial Registry and Initial Repository will be completed on time.

13. Will there be new responsibilities for ODHS/OHA? Specify which programs and describe their new responsibilities.

Over the course of implementing House Bill 3159, ODHS and OHA will take on new responsibilities including planning for and establishing governance of the proposed REALD & SOGI Repository, Registry, and interfaces. These planning efforts would taper off as components of the project exit the planning phase and enter implementation, which would occur over multiple phases.

During the 2023-25 biennium:

- OHA Equity and Inclusion Division and HPA would have new responsibilities related to implementing the initial REALD & SOGI Registry and Repository within the ONE population and for COVID-19 reporting.
- OHA Equity and Inclusion Division would have new responsibilities regarding refining the REALD & SOGI patient-facing survey tool developed for COVID-19 reporting under House Bill 4212.

- OHA Equity and Inclusion Division would oversee the provider specialist team that trains providers, health insurers, CCOs, FFS contractors, and community members on REALD & SOGI data collection.
- OHA Equity and Inclusion Division, HPA, HSD, and OIS would collaborate to secure a vendor to implement the statewide Registry and Repository.

During the 2025-27 maintenance and operations phase, OHA and/or OIS in Shared Services would be responsible for supporting onboarding of payers and providers to use interfaces developed for submission of and access to REALD & SOGI data. The nature of this work is indeterminate and would be based on the final design of any User Interfaces or Application Programming Interfaces (API) implemented. This could include activities such as account provisioning and management, password support, API key support and management, or ongoing monitoring to ensure the security of the proposed solution.

In OHA, several positions have been granted to support onboarding efforts including direct collaboration with CCO and Medicaid partners. This policy package requests additional funding for positions within the OHA Equity and Inclusion Division and HPA to support these new responsibilities and to submit and process an RFP for the enterprise Registry and Repository.

There is no additional impact on OIS.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

A total of ten positions would be needed to implement this policy package. Seven of those positions would be new permanent, full-time positions and three positions would be modified from limited duration to permanent, full-time positions.

OHA Equity and Inclusion Division positions

- One limited duration Operations and Policy Analyst 4 (OPA4) position in HPA would be modified to a permanent, full-time position in the OHA Equity and Inclusion Division. This position would lead interim REALD Repository data governance efforts and data requests.
- One new permanent, full-time OPA4. This position would serve as a Race and Ethnicity Specialist. The position would work with provider specialists, stakeholders, and data teams to increase readiness and capability in asking and responding to race and ethnicity questions. Furthermore, the position would develop partnerships with stakeholders from communities most impacted by health inequities to inform how OHA validates, analyzes, and reports REALD race and ethnicity data from the initial REALD Registry, data environment, and Repository, and future enterprise House Bill 3159 Repository.
- One new permanent, full-time OPA4. This position would provide guidance and expertise regarding current federal and local standards, best practices, resources, and research on SOGI. The position would facilitate capacity building in community and provider settings. A significant proportion of this position's responsibilities would be dedicated to creating partnerships with stakeholders from LGBTQIA2S+ communities to refine SOGI content and data equity policies.
- One limited duration OPA4 position in HPA would be modified to a permanent full-time OPA3 in OHA Equity and Inclusion Division. This position would support the Repository team and partner with OHA and ODHS colleagues, community partners, and the REALD & SOGI

governance committee to inform and support changes to REALD & SOGI standards and analysis protocols.

- Three new permanent, full-time Program Analyst 3 positions. The three new provider specialist positions, working across three regions of the state, will maximize quality REALD & SOGI data collection from providers by assessing and increasing provider readiness, engaging and building relationships with provider leadership and related stakeholders, and communicating provider challenges and successes across interagency REALD & SOGI teams.
- One new permanent, full-time Information Systems Specialist 6 position. This position would oversee the intake, matching, and data storage of the initial and enterprise REALD Registry and Repository.

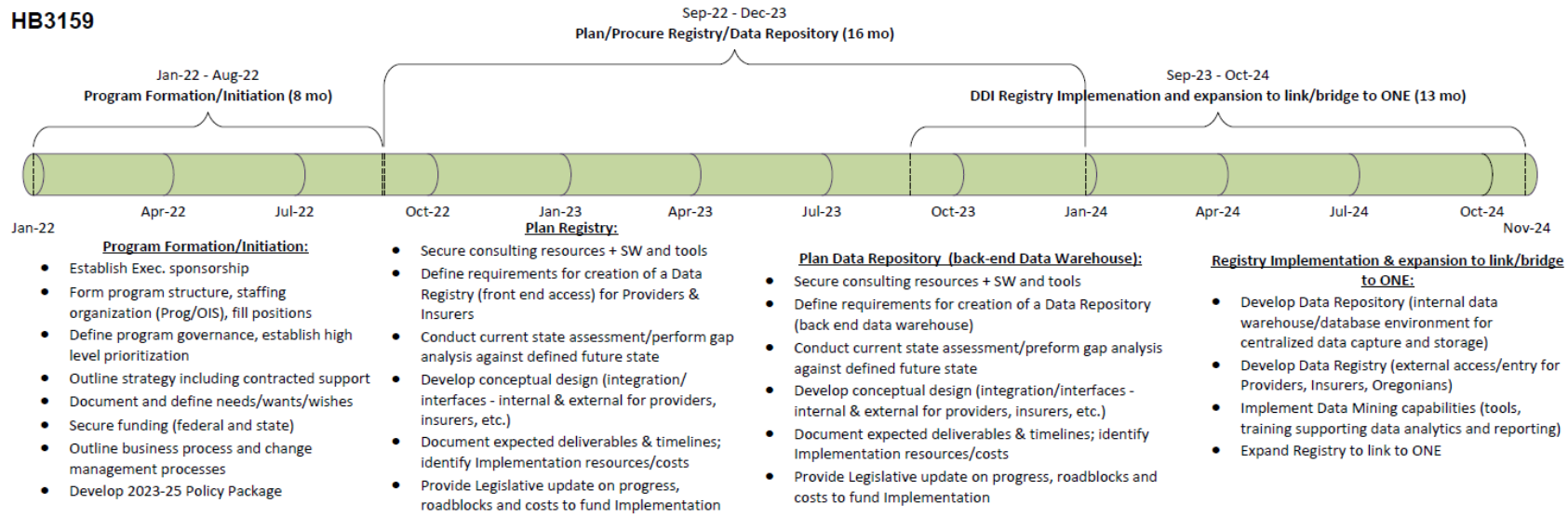
HPA positions

- One limited duration Research Analyst 4 position would be modified to a permanent, full-time position. This position would fulfill data requests and assist HPA reporting teams and interagency partners to develop reports and dashboards with REALD demographic components.
- One new permanent, full-time OPA3 position. This position would liaise with other divisions to manage division-level requests and coordinate appropriate uses of the initial REALD Registry and Repository. This position may be transferred to divisions for ongoing work.

OIS would leverage existing positions from House Bill 3159 and is not requesting additional staff for the 2023-25 biennium.

16. What are the start-up and one-time costs?

The following timeline provides a visual representation of expected one-time costs as well as where projected ongoing costs occur:



Start up and one-time costs include IT Professional Services for hosting ($3 million), DDI ($8.75 million), onboarding of external entities and training ($2.75 million), quality assurance ($0.25 million), and a vendor to complete the development of the Patient Facing Survey Tool ($1 million).

Total start up and one-time costs are $15.75 million.

The Maintenance & Operations (M&O) of the above solutions would be requested ongoing in the 2025-27 biennium.

17. What are the ongoing costs?

- Position-related costs: $2.0 million in 2023-25 (This will require a 2025-27 phase-in.)
- Second devices for positions, ongoing education, and software in the OHA Equity and Inclusion Division: $89,000
- Licensing: $800,000
- Software: $500,000
- Consulting: $150,000
- Maintenance and operations support for the patient-facing online survey tool: $400,000
- Third party Operations & Maintenance for the Initial Registry and Repository: $750,000 for 6 months (This would require a 2025-27 phase-in.)
- Microsoft Dynamics Licensing (patient-facing online survey tool): $430,000 for 1 year (This would require a 2025-27 phase-in.)

Total ongoing costs are $5.12 million in 2023-25.

On an ongoing basis, the maintenance of the Registry, Repository, and corresponding interfaces would comprise direct staffing costs within the agencies but may also include significant ancillary costs based on the plan for design, development, and implementation of a solution. This could include vendor costs and ongoing licensure costs.

18. What are the sources of funding and the funding split for each one?

As mentioned above, it is unknown whether CMS will provide enhanced funding for the components of this work that are Medicaid-specific. REALD & SOGI efforts benefit the entire agency and have historically used the agency-wide cost allocation pool to distribute costs to revenue sources. This

policy package assumes that will continue. Estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds.

19. What are the potential savings?

- With better REALD & SOGI data that can be used to guide clinical care and services resulting in better health for all, we would see reductions in emergency and charity care expenditures and costs related to chronic illnesses and functional limitations due to chronic conditions.
- Centralized storage of REALD & SOGI data and automation of cleansing data irregularities reduces manual processing inefficiencies and improves timely access to and linkages with demographic data. Consequently, health services can be provided swiftly and proactively to all individuals living in Oregon regardless of demographics. For example, future pandemic response may utilize the REALD & SOGI data to provide targeted population health supports to reduce risk in vulnerable communities.
- OHA would realize long-term improvements to data integrity and data equity allowing OHA staffing to transition from processing to analyzing data.
- Centralized storage would decrease redundancies in data storage across multiple environments and data privacy and security containment.
- The initial and enterprise Repositories would be designed to facilitate linkages with the 100+ state data systems that are required to be REALD & SOGI compliant. This would likely be resource efficient, as having a central source of REALD & SOGI data that is updated at least annually would entail less data storage and processing than retrofitting each individual data system.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$1,589,784	$111,654	$115,634	$1,817,072	7	7.50
Services & Supplies	$11,109,457	$969,080	$1,793,813	$13,872,350		
Capital Outlay						
Special Payments						
Other						
Total	**$12,699,241**	**$1,080,734**	**$1,909,447**	**$15,689,422**	**7**	**7.50**

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Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Office of the State Public Health Director
Policy package title:	Public Health Modernization
Policy package #:	406
Related legislation:	House Bill 2348 (2013); House Bill 3100 (2015); House Bill 2310 (2017); Senate Bill 253 (2019) House Bill 2965 (2021), Senate Bill 1554 (2022)

Summary statement:

Since 2013, Oregon has been on a path to fundamentally shift its practice to ensure essential public health protections are in place for all Oregonians through equitable, outcomes-driven and accountable services. The groundwork laid through initial investments in public health modernization have been critical to Oregon's management of the COVID-19 pandemic. However, the COVID-19 response has highlighted continued inequities in health outcomes and gaps in the public health system, specifically in health equity and cultural responsiveness and apply equity principles across all areas of public health practice. This policy package supports continued implementation of the key public health priorities selected by the Oregon Public Health Advisory Board (PHAB) for the 2023-25 biennium and builds on this work by making comprehensive investments across the public health system and elevating work that directly mitigates health inequities. Not funding this policy package puts at risk OHA's ability to ensure basic public health protections included in statute are available to every person in Oregon and challenges OHA in continuing to meet the deliverables and timelines prescribed in House Bill 3100 (2015).

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$50,000,000**	**$0**	**$0**	**$50,000,000**	**30**	**20.69**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Oregon families and communities continue to face new and increasingly complex public health threats. These public health threats do not impact all Oregonians equally. Systemic racism and historical and contemporary injustices have led to health inequities in the state and these inequities have been laid bare, and exacerbated by simultaneous public health emergencies along with long-standing and emerging public health threats. Most recently, people in Oregon have experienced COVID-19, a communicable disease that severely strained the health system and produced disparate impacts on people in Oregon. The demands on Oregon's public health system continue to increase as the impacts of COVID-19, continue to come to the fore (such as increased social isolation, alcohol use and youth behavioral health needs) and other communicable disease threats like hMPXV and highly pathogenic avian influenza emerge. People in Oregon also experienced extreme wildfires which displaced many people and produced wildfire smoke and dangerous air for weeks across entire regions of the state. These wildfires are consequences of a changing climate and, again, the burden of the fires is disparate. While Oregon has seen health improvements for some, some groups like communities of color and households living on low-incomes continue to experience an unjust burden of disease, are more exposed to hazards and have fewer resources (for example, access to care, culturally-responsive interventions and others) to support resilience and recovery. These compounding health needs require a public health system that is equity-centered, community-led and nimble.

In 2013, recognizing the need for a public health system that can support Oregon's health system transformation and achieve the Triple Aim, the legislature set a goal to have a public health system for the future. In 2016, all state and local public health authorities completed an assessment of capacity to implement foundational public health programs. Those assessments found significant gaps in the state's

ability to manage new communicable disease outbreaks, center equity and be culturally and linguistically responsive to community health needs, proactively measure and mitigate environmental impacts to human health, and collect and report public health data that is needed to solve emerging public health problems. Additionally, the COVID-19 pandemic highlighted inability of the public health system to ensure equitable health outcomes for all people in this country.[i] Now, public health system partners have a real understanding of the resources needed to respond to a pandemic and how pandemic response further complicates already-complex public health risks. Comprehensive efforts toward health equity require a shift in resources, moving from a chronically underfunded public health system to one that has the necessary resources to address these risks.[ii] [iii]

This policy package supports continued implementation of the key public health priorities selected by the Oregon PHAB for the 2023-25 biennium. These priorities aim to accelerate work toward health equity for communities of color, Tribal communities, immigrant and refugee communities, LGBTQIA2S+ communities, people living in rural Oregon, people with low income and other groups that experience intersecting oppressions.

2. What would this policy package buy and how and when would it be implemented?

Oregon is on a path toward achieving a public health system that is accountable for eliminating health inequities, prioritizes disproportionately impacted communities in prevention and response efforts, and achieves improved health outcomes. COVID-19 accelerated investments in health equity and forced Oregon to take a deeper look into the systems that create and exacerbate inequities so that the root causes of poor health can be addressed holistically.

The 2023-25 public health modernization efforts focus on expanding investment in and cementing partnership with community, prioritizing a public health workforce that is adequately trained, responsive and valued, and continuing to support the growth of healthy and resilient communities.

The 2023-25 policy package for public health modernization would:

- Invest in public health workforce development and retention;
- Build on lessons learned from the COVID-19 pandemic to respond to and mitigate emerging public health threats;
- Invest in governmental and community public health initiatives that engage Oregonians directly; and

Specifically, funding this policy package would result in the following system changes that are critical for protecting people from communicable disease and environmental health threats, as well as bolstering access to reproductive health services:

- Coordinated, statewide systems for responding to communicable disease and environmental health threats, including access to culturally and linguistically responsive services.
- Prevention initiatives that include local expertise to protect people from acute and communicable diseases.
-
- Continued development of plans to mitigate climate risks to public health.
- Emergency preparedness and response systems for environmental health-related events.
- Critical infrastructure supports for reproductive health clinical providers.

<u>Foundational Capabilities</u>

A public health system that is inclusive, nimble and representative is equipped with a set of skills and tools – foundational capabilities – that are the pillars for how the public health system protects people from health threats and achieves health for all.

Under ORS 431.131 and 431.141, the governmental public health system is required to provide foundational public health programs and capabilities. These **seven foundational capabilities** describe the framework in which this policy package would achieve the goals listed above and make progress toward an equitable Oregon.

- **Health equity and cultural responsiveness**: Ensure public health programs are co-created with communities and public health programs are culturally and linguistically competent.
- **Assessment and epidemiology**: Analyze data to understand emerging trends for communicable disease and environmental health threats; make data readily available to communities and partners who rely on the information and use data to implement culturally and linguistically responsive interventions.
- **Community partnership development**: Leverage coordinated care organizations, government agencies and other cross-sector partners and invest in community partners to increase the impact of public health modernization work in communities.
- **Emergency preparedness and response**: Work with communities and partners to prepare for, respond to and recover from public health threats and emergencies; ensure that populations most at risk are at the center of planning efforts.
- **Leadership and organizational competencies**: Develop the public health workforce to be better equipped to nimbly respond to new public health threats; use performance management and quality improvement to ensure that public health interventions are resulting in improved outcomes; spread capacity from public health modernization across public health program areas; build clinical program infrastructure.
- **Communications**: Ensure timely risk communications and proactive communications that are culturally and linguistically responsive.

- **Policy and planning**: Engage with partners, decision-makers and communities to develop and implement policy solutions that are responsive to community needs.

Foundational programs are the “nuts and bolts” work of public health modernization which cannot be successful without comprehensive foundational capabilities. In Oregon, foundational programs include topic-specific work and generally sit in one of the following categories:

- Environmental Health
- Prevention and Health Promotion
- Access to Clinical and Preventative Services
- Communicable Disease Control

This policy package would be managed by the Oregon Health Authority, Public Health Division (OHA-PHD). Throughout 2022, OHA-PHD will continue to convene local public health authorities (LPHA) and Tribal public health (TPH) authorities, community-based organizations, state agencies and representatives from other sectors to develop plans for the implementation of funded work to achieve equitable health outcomes and mitigate the highest risk impacts to health across the state. OHA-PHD will continue to evaluate efforts and outcomes from the current investment and adapt work to incorporate lessons learned into subsequent investments. This package is a continuation of investments over the past three biennia and, therefore, implementation is ongoing.

The specific work in this policy package includes:

Foundational Capabilities	
Oregon Health Authority-Public Health Division	Provide leadership and partnership for a community-based and equity-centered approach to public health in Oregon

	Build centralized support for public health programs to structurally include community voice and co-creation into practice
	Manage local and Tribal public health authority contracts and grants to community-based organizations
	Provide technical assistance to local, Tribal, community-based organization and clinical partner grantees to support program implementation
	Provide comprehensive translations, interpretation and accessible communications
	Maintain and annually report on public health accountability measures
	Engage in development of a statewide public health workforce plan
	Engage in development of a public health system equity plan
Local public health authorities	Maintain workforce capacity to support bolstering of foundational capabilities and programs
	Co-create health-related interventions with the community
	Retain staff for culturally and linguistically responsive activities (for example, health services navigator, community liaison, communications specialists, research staff)
	Engage in development of a statewide public health workforce plan
	Engage in development of a public health system equity plan
	Develop comprehensive local modernization plans, as required in Oregon statute
Tribal public health authorities and NARA	Strengthen partnerships with local and federal public health agencies
	Improve data collection, management and reporting infrastructure so Tribes can easily access their unique data to inform health improvement assessment, planning and programs implementation
	Limited development of tribal-specific data hub

	Limited expansion of capacity for Tribal emergency preparedness and all hazards readiness
	Ensure opportunities for Tribal collaborations for public health modernization
	Train Tribal public health staff in core public health functions, including health equity
Community-based organizations	Ensure alignment with goals to eliminate health inequities and support community resilience and recovery
	Engage in development of a statewide public health workforce plan
	Build capacity for advocacy for community-centered policy development
	Engage in development of a public health system equity plan
Reproductive health clinical delivery system partners	Build operational infrastructure to support patient access to comprehensive reproductive health services

Foundational Programs	
Oregon Health Authority-Public Health Division	Provide epidemiology support by region
	Implement statutorily required environmental health regulations
	Provide subject matter expertise on environmental health risk mitigation
	Collect and report population health data for the public health system and its partners
	Invest in state public health workforce development, retention and wellness initiatives
	Coordinate acute and communicable disease outbreak investigations, including communicable disease testing at the OSPHL.
	Monitor and regulate environmental health risks within communities

Local public health authorities	Continue to provide subject matter expertise that supports climate change resilience and mitigation
	Convene local partners to develop, exercise and implement emergency preparedness plans
	Sustain culturally-relevant communicable disease interventions i
Tribal public health authorities and NARA	Complete environmental public health assessments with each federally-recognized Tribe in Oregon
Community-based organizations	Co-create culturally and linguistically responsive public health interventions; partner with local public health authorities and other public health system entities on issues such as communicable disease, climate change, emergency preparedness and upstream prevention initiatives.
	Collaborate on or lead environmental justice initiatives
Reproductive health clinical delivery system partners	Support equitable access to reproductive health services

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

This policy package seeks to directly change systems and environments with the goal of eliminating health inequities. Investments in public health modernization ensure that governmental public health and community public health partners have the resources necessary not only to solidify a foundation upon

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

which to identify health inequities, but also to build and redesign systems that eliminate those inequities. By funding a breadth of local agencies and organizations, investments in public health modernization would further shift resources and power to communities. In addition, continued investments provide meaningful, centralized systems (for example, data, technical assistance, training, fiscal oversight, and contracting) that support statewide collaboration. These efforts, driven by lessons learned during the COVID-19 pandemic, aim to achieve health equity and equitable health outcomes for all people in Oregon.

More specifically related to health equity, this policy package means:

- Substantial investment in local public health and communities to sustain capacity to co-create, plan and lead interventions to address public health threats.
- Progress toward eliminating inequitable health outcomes and anticipated reductions in healthcare costs related to communicable diseases.
- Solidified partnerships with other governmental agencies and partners to address and respond to inequities related to the social determinants of health[iv].
- Investing in antiracist governmental and community public health initiatives that engage Oregonians directly
- A public health workforce representative of the communities served.

Quantifying results

4. What are the long-term desired outcomes?

The long-term outcomes are to eliminate health inequities and to establish a structure of continued support to ensure sustained equity. OHA recognizes the need to work with communities to equitably distribute or redistribute resources and power. To achieve long-term outcomes, this policy package includes adjustments to public health modernization efforts based on feedback from community organizations,

LPHA, Tribal governments and other partners. In addition to ongoing engagement to co-create public health programs with communities, this policy package modestly increases direct investments in community, centers community priorities and modestly increases investments in local public health workforce infrastructure

5. How will OHA measure the impacts on health inequities of this policy package?

OHA would measure the success of this policy package through achievement of established public health accountability metrics, which are collected and reported annually. At the proposed funding level, OHA-PHD would provide incentive payments to local public health authorities based on their achievement of process measures established within the funded areas.

Public health accountability metrics continue to shift to reflect community priorities and focus attention on the economic and social injustices that result in health inequities. OHA-PHD expects new metrics that reflect this shift to be in place in 2023. This policy package also includes resources for ongoing evaluation by OHA-PHD and LPHA, CBO and TPH to identify successes and areas for improvement.

Finally, OHA-PHD would identify the public health system's progress toward eliminating health inequities through annual reporting of key population health measures.

- Workforce development opportunities provided and participation in learning or training opportunities
  - Anti-racism training for PHD employees with affinity spaces and conversations to support staff of color.
  - Percent of management reviews completed each year.
  - Percent of staff reviews and performance goal-setting opportunities completed each year.
  - Employee retention by REALD.
- Public health system workforce recruitment and retention (State, local, community, Tribal)
- Total funding allocation and distribution to local health authorities, Tribal governments and CBOs

- Number of multi-drug resistant organisms investigated in long term care facilities with evidence of transmission
- Number of birth or death records processed each year by the vital records modern informatics systems meeting national timeliness and quality performance measures allowing more timely assessment of excess deaths, out of hospital births, births, and deaths associated with emerging infections, suicide, and opioid addiction by race, ethnicity and location.
- Number of laboratory records processed each year by OSPHL (to measure Modernized informatics capacity for Oregon State Public Health Laboratory to efficiently process increasingly complex laboratory information system data)
- Within each region:
    - Number of communicable diseases investigated by regional epidemiologists categorized by race.
    - Number of outbreaks investigated by regional epidemiologists categorized by race
    - Vaccine preventable disease (such as acute hepatitis A and B, pertussis, measles, mumps) rates categorized by race
    - Foodborne disease (such as shiga toxin-producing E. Coli, salmonella and shigella) rates categorized by race.
    - Vaccine preventable diseases and foodborne bacteria rates among houseless populations

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In the 2017-19, 2019-21 and 2021-23 biennia, OHA-PHD leveraged federal grants and restructured existing positions to expand the reach and impact of the 2017-2023 legislative investments in public health modernization. OHA-PHD also quickly adjusted positions and funding to respond to the COVID-19

pandemic, demonstrating the benefit of a modernizing public health agency. Through this process, OHA-PHD identified gaps and areas for improvement which this policy package seeks to address.

Distribution of legislative investments since 2017:

	2017-19	2019-21	2021-23
LPHAs	$3.9 million	$10.3 million	$33.4 million
Tribes and NARA	-	$1.1 million	$4.4 million
CBOs	-	-	$10 million
OHA	$1.1 million	$4.2 million	$12.8 million
Total	$5 million	$15.6 million	$60.6 million

- In 2017-19 most funds were allocated to eight regional partnerships of LPHA and their key partners, reaching 33 counties.
- In 2019-21, in addition to funding regional models, funds were allocated to each LPHA. For the first time, funds were distributed to most Tribes, the Native American Rehabilitation Association (NARA), and the Northwest Portland Area Indian Health Board. Using innovative service delivery models, funding reached communities most likely to experience health inequities or gaps in access to public health services.
- In 2021-2023, funds were distributed to LPHAs, tribes and tribe-serving organizations. OHA-PHD distributed funds to 147 community-based organizations and established a community engagement program at OHA-PHD.
    - Funds to LPHAs support efforts to plan for local and regional public health interventions that support equitable climate adaptation, building capacity for cross-sector engagement in climate and community health improvement plans and continuing to track cases of acute and communicable diseases.

- Funds to CBOs support communities with information and messengers that are trusted and culturally and linguistically responsive to community needs. This includes support for wraparound services during the COVID-19 pandemic.
- OHA-PHD continues to work closely with Tribal governments and organizations serving Tribes to support building of public health infrastructure carrying out community health assessments and improvement plans.

7. What alternatives were considered and what were the reasons for rejecting them?

OHA-PHD has explored whether additional federal funding might be available for this policy package. OHA-PHD has requested permission from the Legislature to apply for a new grant from the Centers for Disease Control and Prevention. The funding opportunity, called Strengthening U.S. Public Health Infrastructure, Workforce, and Data Systems, is an important yet insufficient investment to fill the gaps in public health infrastructure across the entire state over the five-year grant period.

Separate from this request, OHA will continue to align its funding streams to further support public health modernization to the extent possible based on federal funding restrictions.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

The PHAB, a committee of the Oregon Health Policy Board, guides this policy package by setting overarching priorities.

OHA-PHD partnered with community-based organizations to understand community priorities and ensure they are included in this policy package. This has been done through a series of meetings with the CBO Advisory Board, and with a joint LPHA/CBO workgroup structure. OHA-PHD partnered with a workgroup of

local public health leaders to develop priorities and anticipated outcomes for an increased investment. All LPHA have been engaged also through the Conference of Local Health Officials and federally-recognized Tribes will be engaged through the Senate Bill 770 Health Cluster meeting and, if requested, formal consultation. OHA met with the Tribal Health Director of each federally-recognized Tribe and Urban Indian Program to identify each Tribe and NARA's unique 2023-25 public health needs.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    This policy package invests in Oregon's public health system, with targeted investments in LPHA, TPH and in CBOs. LPHA and TPH efforts include public health responsibilities related to the seven foundational capabilities listed above. CBO efforts include the co-creation of public health interventions grounded in equity and partnership with other public health system partners to inform actions and solutions that work for communities. For OHA-PHD's work funded in this policy package to be successful, OHA-PHD would collaborate with several state and local agencies and the sectors they support, and with coordinated care organizations and other health systems partners.

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

- Public health will be partially funded to address the needs of people in Oregon through this policy package
- OHA-PHD will have sufficient revenue to address outbreaks, communicable disease prevention and disparate health outcomes for state, local, Tribal and community work.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Yes.

Public Health

OHA-PHD would be responsible for overseeing all contracts and grants included in this policy package in addition to implementing the state-level public health functions needed to improve health outcomes related to the foundational capabilities and programs. Other new responsibilities include:

- Support community outreach and listening sessions, systemic integration of community feedback and technical assistance, guided by the new PHD Equity Office.
- Technical assistance and subject matter expertise on climate and health strategies

- Support regional collaboration for emergency response with regional all-hazards epidemiologists.

Office of Information Services
The Office of Information Services would continue to support technology needs related to Public Health Modernization funding in the Center for Protection.

OHA-PHD has consulted OIS on development of this proposal and has included one OIS position to support the work.

Program Design and Evaluation Services
PDES would be responsible for supporting modernization efforts for the Student Health Survey and Oregon's Behavioral Risk Factor Surveillance Survey input, including coordinating participation of community organizations and TPH.

OHA Equity and Inclusion Division
OHA-PHD would continue partnership with the division on REAL-D and SOGI data efforts and coordination on public health equity work overall.

Human Resources
Human Resources support hiring of staff under this policy package, as needed. No additional positions requested.

Office of Contracts and Procurement
OC&P will continue to support contracts for Public Health Modernization funding under this policy package. No additional positions requested.

Office of Financial Services
OHA-PHD has proposed one position in OFS to support payroll needs as a result of this policy package.
Health Policy and Analytics
Staff within HPA would provide consultation to OHA-PHD on opportunities to align public health accountability metrics with CCO incentive metrics.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Yes. OHA-PHD anticipates a modest increase in the level of service to residents of Oregon and visitors through slight increases in investments in state, LPHA and TPH. In addition, OHA-PHD anticipates modest increases in levels of service to people in Oregon through slight increases in investments in community-based organizations. For example, in the 2021-23 biennium, OHA-PHD provided funds to 68 community-based organizations with public health modernization funding. With modest increase in investment through this policy package, OHA-PHD expects slightly broader (geographically and focus area) and more in-depth services throughout the state.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

The following full-time, permanent positions require **position authority and General Fund** and are priced at 18 months for the 2023-25 biennium unless otherwise specified:
Accounting Technician 3: (1) position (OFS)

Epidemiologist 2: (4) positions
Fiscal Analyst 1: (1) position

Fiscal Analyst 2: (1) position
Information Systems Specialist 8: (1) position (OIS)
Manager 1: (1) position, 1.0 FTE, 24 months
Manager 2: (1) position, 1.0 FTE, 13 months
Operations and Policy Analyst 2: (4) positions
Operations and Policy Analyst 2: (4) positions, 1.0 FTE, 13 months
Operations and Policy Analyst 3: (4) positions
Operations and Policy Analyst 3: (4) positions, 1.0 FTE, 13 months
Operations and Policy Analyst 4: (1) position, 1.0 FTE, 13 months
Project Manager 2: (1) position
Public Health Educator 2: (1) position, 1.0 FTE, 13 months

The following permanent position requires **General Fund only**:
Operations and Policy Analyst 3: (1) position, 1.0 FTE, 24 months
Existing permanent position with changes to classification and/or funding source:
Manager 2: (1) position, 1.0 FTE GF, 24 months, Manager 1 to Manager 2 reclassification
Program Analyst 2: (1) position, 1.0FTE GF, 24 months

The following position will be established and funded by Federal Funds:
Manager 2 (1) position, 1.0 FTE, 24 months

16. What are the start-up and one-time costs?

New positions require a computer, phone and routine software packages that are included in the Services and Supplies line for each newly established position.

17. What are the ongoing costs?

Ongoing costs are associated with personal services and contracts for workforce development, program evaluation, grants management, legal fees, data system upgrades, translations, interpretation and ADA accessibility. Ongoing costs include special payments to local public health authorities ($16,950,000), community-based organizations and ($16,950,000), federally recognized Tribes ($5,300,000,), and the reproductive health provider network ($3,400,000).

Software license, phone services, in office rental costs, IT maintenance and operations.

18. What are the potential savings?

An investment in the prevention of disease and disability is proven to yield significant savings to Medicaid and other payers by decreasing the need for costly health care. Indeed, just a 10 percent increase in per capita public health spending in Oregon would:

- Lower infant mortality rates from 5.0/1,000 to 4.6/1,000.
- Lower diabetes death rates from 24.1/100,000 to 23.8/100,000.
- Lower heart disease death rates from 132.9/100,000 to 128.6/100,000.
- Lower cancer death rates from 167.3/100,000 to 165.4/100,000.

19. What are the sources of funding and the funding split for each one?

This policy package includes General Fund that would continue environmental public health and health equity work that are essential to meeting the intent of this policy package due to declining Federal Funds revenue. The decline of Federal Funds revenue represents grants that will end during the course of the biennium (the CDC National Initiative to Address COVID-19 Health Disparities grant) and reductions to core CDC environmental public health grants (Environmental Public Health Tracking and ASTDR's

Partnership to Promote Local Efforts to Reduce Environmental Exposure (APPLETREE)). Existing permanent positions are still needed to support the work in this policy package.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$4,956,491	$0	$0	**$4,956,491**	30	20.69
Services & Supplies	$4,143,509	$0	$0	$4,143,509		
Capital Outlay						
Special Payments	$40,900,000	$0	$0	$40,900,000		
Other						
Total	**$50,000,000**	**$0**	**$0**	**$50,000,000**	**30**	**20.69**

[i] Lori Tremmel Freeman, "COVID-19—The Historical Lessons of the Pandemic Reinforce Systemic Flaws and Exacerbate Inequity", American Journal of Public Health 111, no. S3 (October 1, 2021): pp. S176-S178. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2021.306543

[ii] DeSalvo, K., B. Hughes, M. Bassett, G. Benjamin, M. Fraser, S. Galea, N. Garcia, and J. Howard. 2021. Public Health COVID-19 Impact Assessment: Lessons Learned and Compelling Needs. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202104c

[iii] Trust for America's Health. Issue Report. The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2019. https://www.tfah.org/wp-content/uploads/2020/03/TFAH_2019_PublicHealthFunding_07.pdf

[iv] Healthy People 2030 website. Social Determinants of Health. https://health.gov/healthypeople/priority-areas/social-determinants-health

Oregon Health Authority
2023-25 Policy Package

Division:	Health Systems Division
Program:	Program Support and Administration, Medicaid
Policy package title:	Early and Periodic Screening, Diagnostic, and Treatment (ESPDT)
Policy package number:	414
Related legislation:	None

Summary statement:

This policy package is in response to strong community feedback that Oregon's longstanding Medicaid waiver from federal Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) requirements is harmful and needs to end. EPSDT is a critical federal standard to ensure state Medicaid programs meet the health care needs of children ages 0-21. Additionally, OHA recognizes that the waiver is a barrier to meeting the agency's goal to eliminate health inequities by 2030. Effective January 1, 2023, this waiver ends. This policy package funds the staff and system updates necessary for OHA to build an EPSDT program that will meet federal regulations and ensure children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services that EPSDT entitles them to and are necessary to meet our health equity goals.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$1,054,648**	**$0**	**$1,570,934**	**$2,625,582**	**9**	**6.75**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) is a federal standard that requires state Medicaid programs to cover all medically necessary services for children. Oregon has had a long-standing waiver from these requirements through its 1115 Oregon Health Plan Demonstration Waiver (OHP waiver). OHA engaged in dialogue with our community and the Centers for Medicare & Medicaid Services (CMS) regarding our upcoming OHP waiver renewal and we heard clearly that Oregon's waiver from federal EPSDT requirements is problematic for children and families. Our waiver has been particularly problematic for children with disabilities and special healthcare needs. Because of this waiver, Oregon's Medicaid program has not made individual considerations to meet the needs of children with unique circumstances. The program has applied hard limits that determine which services are covered for children under the Oregon Health Plan. With the current waiver of EPSDT, when children's health needs don't fall above the coverage line on the Prioritized List, Oregon has been waived from federal requirements to make case-by-case considerations and cover all medically appropriate care.

As a response to the strong community feedback that we heard, OHA has reversed this long-standing and harmful waiver. OHA will adopt the important federal EPSDT requirements that protect children, effective January 1, 2023. To fully support this policy change, OHA must build and maintain an EPSDT program to effectively serve Oregon's children on the Oregon Health Plan ages 0-21.

2. What would this policy package buy and how and when would it be implemented?

This policy package seeks administrative funding for the positions needed to build and maintain an EPSDT program and MMIS updates that are needed for complying with CMS requirements. These

positions would make it possible to rollout and maintain a robust and compliant EPSDT Program. Children's health needs touch all aspects of Medicaid services and programs, including foster care, school-based programs, behavioral health, dental, physical health, developmental disabilities, home health, maternal health, institutionalized youth, etc. The staff funded in this policy package are needed to listen to communities and monitor outcomes. They are also needed to develop policy, operational processes, IT system changes, and contractual requirements, conduct oversight and quality assurance activities, and manage efforts to improve the Oregon Health Plan to better meet the needs of children.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   EPSDT serves all children on the Oregon Health Plan ages 0-21. The EPSDT program is a critical avenue for OHA to identify and close the gaps based on historical racism that impact children. OHA will focus on where gaps exist as resources are prioritized in the program. Community partner and Tribal engagement is included in the program design plans. In anticipation, OHA has identified a need to acknowledge and reduce the limitations of the existing bodies of evidence, and the relationships between the scientific community and under-represented communities that we use in setting policy in the Medicaid program.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Quantifying results

4. What are the long-term desired outcomes?

Long term, OHA will work towards a robust and fully compliant EPSDT program that serves children and families well. The program must meet CMS regulatory requirements but OHA will also strive to develop a program through continual family feedback that helps produce better health outcomes and reduces health inequities for children. OHA will need to ensure that families are well informed about their EPSDT benefits. OHA will need to have sound oversight of CCO contractors and the fee-for-service (FFS) program.

5. How will OHA measure the impacts on health inequities of this policy package?

OHA will evaluate the program design to ensure that structures are in place to specifically address the impacts of health inequities before implementation. OHA will use already established outcome measures, such as CCO metrics and required CMS EPSDT reporting, to evaluate whether the program is achieving intended outcomes. OHA will work with community partners, OHA Equity and Inclusion Division, Ombuds Program, and interested parties to ensure that we receive feedback from traditionally under-represented populations whose voices may not otherwise be identified in our data. OHA may need to develop new measures or analyze existing measures in a new way over time.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA have hired Oregon's first EPSDT Policy Analyst to join the HSD Medicaid team. Every other state, including DC, has a full EPSDT program. Oregon is the last state to take up this work due to

the long-standing waiver. Staff from HSD and HPA have organized a project and begun the work needed to make Oregon compliant with federal EPSDT requirements by January 1, 2023. HPA staff are on track to make necessary updates to the Prioritized List, which defines the covered benefit for children. HSD staff are on track to make needed CCO and other care coordination entity contract and MMIS system changes; however, this is not sufficient staffing to sustain the program over time and ensure that inequities for children are continuously being evaluated and addressed.

7. What alternatives were considered and what were the reasons for rejecting them?

Because of CMS requirements, there were no alternatives considered.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

OHA is collaborating with the following programs and entities: Title V Maternal and Child Health, Oregon Law Center, Health Evidence Review Commission (HERC), Oregon Health & Science University – Oregon Center for Children & Youth with Special Needs, Children' Behavioral Health, ODHS – Child Welfare, ODHS – Office of Developmental Disabilities Services.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No, OHA has sufficient statutory authority to establish the EPSDT program.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

OHP will be better positioned to assist Tribal and local governments as they work to take care of their community members' needs particularly children's needs.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): January 1, 2023

End date (if applicable): N/A

12. What assumptions affect the pricing of this policy package?

This policy package assumes that the budget to pay for medical claims through the Oregon Health Plan is sufficient to accommodate these program changes. OHA is requesting staff to address critical quality issues for children on the Oregon Health Plan and funding for enhancements to our MMIS, but assume there is no need to increase the budget needed to pay for additional utilization of services by members. The new staff in this policy package will increase HSD's manager to employee ratio. There is an assumption that EPSDT will be able to leverage the CCO compliance need and CMS requirement through other Medicaid policy packages.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

OHA will now be required to review requested services for medical appropriateness and approve those that meet EPSDT criteria for children 0-21. Requested services that previously would have been denied because they are not covered (our hard limits) will now need to be reviewed for case-by-case consideration. This affects both CCOs and FFS.

OHA will have new CCO contract oversight responsibilities to ensure that the EPSDT program is administered through out all parts of the Oregon Health Plan consistently and that children's needs are being met.

OHA will need to write administrative rule, new contract language, and issue guidance to administer the program. OHA will need to create member facing materials to ensure the members are informed of the benefits and can use them.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No anticipated change in client caseloads. This change won't add anyone new to OHP.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

To implement this policy package, OHA needs an Operations and Policy Analyst 3 position for the following duties:

- Meet with families, advocates, Tribes, and partners to explain the program, to listen, and take direction for the program.
- Stand up the initial program
- Develop continuous improvement plans and manage improvement activities.
- Write administrative rule, contracts, and guidance to ensure the program remains compliant with federal requirements.
- Issue guidance for providers and CCOs to ensure they understand what is needed.
- Act as contract administer for agreements with primary care providers in the FFS program.
- Conduct oversight and compliance activities with CCOs and other contractors.

To implement this policy package, OHA needs the following positions:

- To design and implement needed changes in MMIS including assigning children in the FFS program to a PCP who will be responsible for managing their care, OHA needs 1 OPA3 level staff for our MMIS team.

- To receive and review individual cases and make coverage determinations to address the needs of children with unique circumstances, OHA needs 2 additional Medical Review Coordinators.

- To ensure families are well informed of their benefits, OHA needs 1 Public Affairs Specialist 3 staff. This position will coordinate communications and public outreach and create family friendly communications for handbooks, fliers, and websites.

- To support the many activities required to stand up and operate the program, OHA needs 1 OPA 1 level staff for project management. After the initial rollout, OHA will need to take up

many program improvement and refinement efforts as we listen to our community and work to close gaps in health outcomes. The purpose of this position is to be able to support the implementation of the EPSDT program. This position will gather information from internal and external stakeholders to provide analysis of gaps in services and systems to help coordinate and prioritize system improvements. EPSDT is a program that crosses through all aspects of Medicaid and this individual will be expected to work with other OHA teams, not just HSD, to coordinate EPSDT projects. Will develop PowerPoint presentations, work with and maintain Smartsheet spreadsheets to track work assignments, provide assistance with document development and would be able to provide scheduling assistance as needed for project coordination. This position is expected to help identify and work toward the elimination of health inequities as part of the EPSDT Program.

- To provide ongoing child and adolescent content expertise, direction, and advice to the agency and the Legislature in support of and in partnership with the ESPDT program, the Health Policy & Analytics (HPA) Division would need one OPA4 position. The position will evaluate the broader implications of initiating a comprehensive EPSDT benefit on equitable access to care for children in the Medicaid program.

- To monitor and track implementation of EPSDT by developing and designing analyses and evaluations, a RA4 in HPA is necessary. This position will track ESPDT claims and denials stratified by REALD indicators to ensure there are no inequities in access and outcomes. Additionally, the position would monitor against national trends, as well as state trends outside of the Medicaid program, and prepare technical reports in partnership with the EPSDT program to further inform program rollout and improvements.

16. What are the start-up and one-time costs?

We need a one-time upgrade to the MMIS system to add functionality for approving EPSDT reviews in the FFS program and assigning children to a PCP responsible for delivering the EPSDT benefit.

17. What are the ongoing costs?

Staff salaries and benefits are the ongoing costs.

18. What are the potential savings?

There are potential savings though they are unquantifiable. The program focuses on screening and prevention, which should move the burden to providing health care services upstream potentially preventing more expensive costs later in the child's life.

19. What are the sources of funding and the funding split for each one?

This policy package is 40.8 percent General Fund and 59.2 percent Federal Funds from Medicaid match.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$767,399		$854,277	$1,621,676	9	6.75
Services & Supplies	$287,249		$716,657	$1,003,906		
Capital Outlay						
Special Payments						
Other						
Total	**$1,054,648**	**$0**	**$1,570,934**	**$2,625,582**	**9**	**6.75**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Systems Division
Program:	Non-Medicaid Behavioral Health
Policy package title:	Adult Intensive Services & Diversion
Policy package number:	415
Related legislation:	None

Summary statement:

This policy package would improve mental health services through the strategic funding of mental health diversion programs: jail diversion and civil commitment. These programs seek to decriminalize mental illness and work to move these individuals into appropriate treatment settings for more equitable outcomes. Jail diversion and civil commitment center health equity for people who live in rural or frontier areas and people of color. Without these services individuals may otherwise enter the justice system which would result in continued growth of the Oregon State Hospital census and disproportionally cause negative health outcomes for these populations.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$4,936,539**	**$8,631**	**$1,551,419**	**$6,496,589**	**7**	**5.25**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. **Why does OHA propose this policy package and what problem is OHA trying to fix or solve?**

   This policy package aims to address inequities in access to and quality of mental health and substance use treatment for Oregonians at risk of entering the criminal justice system through the expansion of jail diversion programs and an overhaul of the civil commitment system.

   Criminalization of mental illness and inequitable access to healthcare. People of color are incarcerated at higher rates than their white peers. Communities without equitable access to jail diversion programs, such as diversion or mental health courts, and rapid evaluations, have more frequent interactions with law enforcement, are chronically marginalized, and struggle to access appropriate care across multiple systems. There are currently seven rural counties in the state that do not receive OHA funding for jail diversion programs. This lack of funding is a barrier to providing services and interventions that 1) divert individuals with mental illness from jail into the appropriate behavioral health system, 2) respond to the overrepresentation of people of color in the justice system and 3) provide equitable and quality behavioral health services for all Oregonians.

   Underutilization of civil commitment. This policy package would ensure Oregonians civilly committed under ORS 426.130 would get their treatment needs met in an appropriate care setting that is the least restrictive environment possible. It would also strive to standardize non-hospital civil commitment practices and procedures across the state and ensure that Community Mental Health Programs (CMHPs) are equipped to have more efficient and effective operations.

   Extraordinary lengths of stay in acute psychiatric care settings. The wait list for civilly committed patients at Oregon State hospital has increased 190 percent between 2017 and 2021,

from 20 days to 38 days, and these patients have no option but to remain in acute psychiatric care hospitals. This policy package would provide capacity for OHA to work closely with acute care hospitals to identify resources and assist with identifying barriers and limitations to discharge.

Lack of standardization of trial visit. Following stabilization during a hospitalization, individuals under civil commitment are eligible for a trial visit, which is an opportunity to step down to a lower level of care outside of the hospital setting while remaining under civil commitment. They are beneficial for those who no longer require a hospital level of care but could still be supported by ongoing monitoring and possible court intervention to remain stable. In 2021, there were 28 trial visits reported in the Acute Care Reporting database, where all civil commitment related data is held. In 2020, there were 38 trial visits reported and in 2019, before the pandemic, 216 trial visits were reported. In 2019, trial visits were just 16 percent of the total 1,282 civil commitment cases that year. And in 2020 and 2021 they made up 5 percent and 4 percent respectively of all civil commitments those years. Trial visits could be the primary mechanism by which CMHPs could step people down from an acute care hospital setting. This team would standardize the commitment process, including trial visit, which would make it easier to step individuals into less restrictive levels of care, thus freeing up space in acute care settings to treat individuals in the most need.

Pre-commitment caseloads are not budgeted as a mandated population. Per ORS 426.070(3)(c), CMHPs are required to begin a pre-commitment investigation upon receiving a Notice of Mental Illness, for every Notice of Mental Illness within its county jurisdiction(s). A pre-commitment investigation can take at minimum 72 hours of intensive services and, for a diversion case, up to 14 calendar days. This requires a substantial amount of dedicated work to both move toward a civil commitment hearing or determine a person does not meet criteria. At this time, CMHPs are not compensated by OHA or any other payor for this work through the mandated caseload budget

process, putting them at a financial disadvantage to build out dynamic, comprehensive community-based commitment programs.

Insufficient support for CMHPs to comprehensively implement all civil commitment programs. At this time, OHA has one position, seated in Licensing and Certifications, tasked with managing community and advocate questions and concerns, conducting trainings to certify examiners and investigators, executing all licenses and certifications for hospital and non-hospital placements for civil commitment, serving as subject matter expert for the Division, and more. The current structure of and allocations for civil commitment oversight are insufficient to serve the entire state, which, pre-pandemic, civilly committed nearly 1,300 Oregonians.

Unbalanced investments in adult intensive services. Investments in Aid and Assist have inadvertently ushered CMHPs to pursue civil commitment less often. The lack of capacity in the civil commitment system has led CMHPs to believe the more reliable door into mental health treatment is through criminal charges and then clients being found unfit to proceed. The courts, community providers, and law enforcement are not utilizing diversion methods sufficiently enough to keep those with mental illnesses out of jail. Further complexity includes the continued marginalization of people of color who continue to be overrepresented in Aid and Assist and other criminal justice programs.

2. What would this policy package buy and how and when would it be implemented?

This policy package would buy programs, staffing, and financial incentives. All would be slated for implementation beginning January 1, 2024.

Jail diversion programs
This policy package would improve behavioral health services, in seven counties, for residents of rural areas that could otherwise enter the criminal justice system and/or the Oregon State Hospital (OSH). This funding would provide services not covered by Medicaid that can be used for early intervention and diversion services. Jail diversion services, such as diversion and mental health courts, community outreach, rapid evaluations, and housing coordination are services designed to keep individuals with mental illness out of the criminal justice system and, instead, supported by the appropriate community-based services. These services are intended to reduce the number of individuals with mental illness in the criminal justice system, jails, and OSH.

Staffing for a civil commitment program team
This policy package would establish a civil commitment program team to be housed in Intensive Services Unit. Specifically, it includes the following positions:

- Operations & Policy Analyst 4: Program implementation lead
- Operations & Policy Analyst 3: Complex systems consultant
- Operations & Policy Analyst 1: Program support
- Fiscal Analyst 2: Data and budget analysis

Information technology support and management
This policy package would also secure three new positions to manage ongoing data and information technology needs for the intensive services teams. More specifically, it would secure one informational technology manager, one OPA3 position, and one RA3 position.

- Information Technology Manager 1: Manage the Compass team
- Operations & Policy Analyst 3: Identify data needs, facilitate data access, and integrating data into the data warehouse
- Research Analyst 3: Establish evaluation tools and support program analysis and reporting

Technical assistance & program development
ORS 426 and OAR 309 mandate that certified investigators seek the least-restrictive option possible when investigating whether a person is a person with mental illness. However, providers and community members report that trial visits are rarely done, assisted outpatient commitment is virtually non-existent, and there is a standardization issue across the state among the civil commitment programs with CMHPs interpreting and executing the statues and rules in different ways. This POP will result in a rulemaking process for Chapter 309 of the Oregon Administrative Rules to update rules to reflect current practices and procedures as well as a community engagement plan to enhance current rules around outpatient commitment and trial visits. This rulemaking process will also spark increased collaboration and partnership between OHA, community members at large, and advocate groups such as Disability Rights Oregon.

Financial compensation for CMHPs
This policy package would increase engagement, cooperation, and collaborative decision-making between the Behavioral Health Division and relevant stakeholders including the CCOs, CMHPs, Department of Administrative Services, and others to determine how to most efficiently and equitably expand the mandated caseloads to incorporate this population, from pre-commitment through post-commitment.

Overall, this policy package aims to shift focus back to community-based treatment and recovery for Oregonians who become civilly committed and those at risk of entering the criminal justice system. The collective efforts of the newly established team would create cost efficiencies via decreases in unnecessary lengths of stay and more efficiently transitioning care to community-based options, such as trial visit. And investments in jail diversion programs would support and empower local communities to better serve those in need.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

OHA's mission guides the agency's work toward helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality affordable health care. It is well known that the criminal justice system has disproportionally impacted people of color, in addition to other groups that have been economically and socially marginalized. Without robust, functional jail diversion and civil commitment programs, these communities will continue to be ushered into the criminal justice system, further exacerbating poor health outcomes related to weathering, stigmatization, and criminalizing mental illness. This policy package, by way of destigmatizing and decriminalizing mental illness through development of and ongoing support for programs that divert individuals from OSH and jail, helps to bring OHA closer to eliminating health disparities in Oregon.

As it stands today, roughly 5 percent of civil commitments are completed as step-downs into trial visits, and virtually none are completed by assisted outpatient treatment. Currently CMHPs are not adequately supported by OHA's infrastructure for civil commitment and, as such, the outpatient commitment programs across the state are not meeting the need. All Oregonians, including those who are civilly committed and under OHA's care, deserve to heal, recover, and thrive in their own communities. Today, that reality is not equitably distributed across the state. This policy package would increase capacity to develop and sustain more robust community-based commitment programs to close this gap.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

In recent years, the overall trends for Oregonians civilly committed under ORS 426.130 have shown access to the state hospital to be significantly more challenging. In a six-year period, OSH admissions for this population decreased roughly 1,100 percent between 2017 and 2021 and the average length of stay (LOS) increased 186 percent. The need for the most restrictive level of care at OSH has not dissipated, it has only been displaced. Today, many civilly committed Oregonians are sitting in inappropriate levels of care that are more restrictive than necessary. Similarly, Oregonians in seven counties – Baker, Clatsop, Jefferson, Lincoln, Tillamook, Wallowa – do not have access to jail diversion programs that provide community-based supports and treatment in the least restrictive setting possible. These are unjust hardships that result from inequitable access to resources.

Due to current inequities in access across Oregon, like the ones previously discussed, the Oregon State Hospital is beyond capacity, and it is now unable to fulfill its full scope. Despite state hospitals being designed to serve and treat those needing civil commitment, just over 2 percent of the Oregon State Hospital census is comprised of civil commitment patients. This has resulted in civil commitment patients being held at acute care hospitals for extended lengths of stay, preventing Oregonians with complex care needs from access to the necessary treatment for recovery. Jail diversion and civil commitment help counter the consequences of criminalizing individuals with mental illness.

With a revamp of Oregon Administrative Rules to bolster community-based approaches to civil commitment on a long-term basis and as a statewide cultural shift in treatment, this policy package expands access to appropriate treatment, diverts clients from incarceration and the justice system, and decreases likelihood of adverse health outcomes related to a person’s identities.

Quantifying results

4. What are the long-term desired outcomes?

As diversion programs, jail diversion and civil commitment encourage communities to use the least restrictive environments for treatment and recovery, reducing reliance on and use of incarceration for those living with mental illnesses. Both programs support access to appropriate care in the community and work to destigmatize mental illness through de-institutionalizing and de-criminalizing mental illness. As such, this policy package's long-term desired outcomes underscore OHA's goals of improving quality of life; increasing availability, use, and quality of community-based, integrated health care services; increasing the effectiveness of the integrated health care delivery system; and increasing the efficiency and effectiveness of the state health care system.

- Equitable access to jail diversion programs and community-based services for all Oregonians with mental illness.
- Decrease in jail admissions for Oregonians with mental illness.
- Decreased lengths of stay in jail for Oregonians with mental illness.
- Decrease in recidivism through the availability of alternative community-based services and programs for individuals with mental illness, particularly those with intensive services needs and people of color.
- A reduction in the overrepresentation of people of color in the criminal justice system and OSH.
- Equitable access to appropriate levels of care for Oregonians who are civilly committed.
- Reduced lengths of stay for civilly committed patients being treated in the acute care setting.
- Increased utilization of non-hospital based civil commitment rules and statues to support community-based treatment and recovery.
- OARs, Chapter 309, would be completely updated, brought current, and include policies and procedures that standardize processes across the state.

- An understanding of how pre-commitment work could fit within the County Financial Assistance Award (CFAA) funding package for increased financial support for CMHPs to complete this vital work.

5. How will OHA measure the impacts on health inequities of this policy package?

Current MHS 09 (Jail Diversion) quarterly reporting requirements would be used to monitor the success of Oregon's expanded jail diversion programs. The Jail Diversion data could be further enhanced with the use of REALD & SOGI data, and at this time HSD does not have reliable access to these data.

Currently, available data include:

- Race and ethnicity as identified by individual
- Gender as identified by individual
- Diversion type (pre or post booking diversion)
- Types of diversion services received
- Number of charges dismissed
- Number of new arrests

Civil commitment data primarily comes from two reporting systems: MOTS and the Acute Care Reporting systems. In addition, civil commitment data specific to OSH can be obtained from the state hospital staff and the Oregon Judicial Department (OJD) tracks data internally as well. These two databases plus the OSH and OJD data, however, do not fully capture the full scope of civil commitment work, from pre-commitment to the commitment period to post-commitment. Additionally, these siloed data systems could benefit from synthesis and re-imagining to maintain more reliable,

trustworthy data on civil commitment in the state. At this time, OHA would be able to capture the following data points to measure program progress and its impact on health inequities:

- Number of new civil commitment patients admitted to OSH.
- (Anticipated) Decrease in regional acute care hospital lengths of stay for civil commitment patients.
- Increase in number of civilly committed patients completing commitment in the community through trial visit or other avenues as appropriate.
- Attendance at and number of community sessions soliciting community, provider, client, and family input on rule change(s).
- OARs for civil commitment (Chapter 309, Division 33) reviewed, updated, and changed to increase and encourage community-based commitment capacity; re-purpose trial visit to include both hospital step-down and direct placement from hearing; and standardize practices across the state.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

- Minor changes to Chapter 309 of the Oregon Administrative Rules were made periodically between 1999 and 2016 to keep up with legislative changes related to criteria, custody transfers and transport, and some definitions in 2016 to support the legislative changes related to “ability to meet basic needs” becoming a criterion for civil commitment, and the previous major overhaul was in 1998. No major changes to the community-based commitment options have been seen, and many CMHPs have reported minimal support for these options and hospitals report inconsistent use and understanding of these options. Support from OHA is needed to ensure accurate information is leading to appropriate interpretation of OAR so that effective programs can grow.

- In the 2021-23 biennium, an adjacent program in the Intensive Services Unit, Aid and Assist, received a great deal of financial support to increase community-based treatment options and reduce the census at OSH. According to House Bill 5024 — apart from Emergency Board and separate housing funds, as well as FTE increases — Aid and Assist received a total of $19.2 million in the 2021-23 biennium, to be invested in community restoration and evaluation services. While these funds are intended to increase community-based treatment options, it will take time for these programs to take full effect. The OSH census on the Salem campus continues to remain at roughly 70 percent Aid and Assist, and 1.7 percent Civil Commitment, with PSRB making up the difference. These community restoration investments have not created any meaningful room for civil commitment patients to gain access to OSH. One community hospital recently cited that in the last 29 months they have had 1 person get admitted to OSH, whereas historically 25–30 patients per year were able to admit. The community continues to report that, despite increased community options for Aid and Assist, they are experiencing increasingly worse access to OSH for all programs.

- Various regional workgroups and meetings regarding complex cases and lengths of stay at regional acute care hospitals centers have been established to explore OSH admissions issues and serving this population in the community. These meetings and workgroups have too often remained focused on the individual level and have rarely taken the systems perspective in regard to civil commitment. For example, a complex case consultation would be requested for one patient with an extraordinary length of stay in an acute psychiatric care setting; however there has been little-to-no bandwidth and little investment in looking at the threads between each one of these cases to address civil commitment as a statewide issue.

7. What alternatives were considered and what were the reasons for rejecting them?

Leaving it as is. OHA could not bring jail diversion programs to the seven counties without these programs. However, that would not be in line with achieving health equity and reducing disparities for all Oregonians. The civil commitment rules appear to have last had a major overhaul in 1998 – nearly 25 years ago. It is time OHA's rules reflect changes in our society's perspectives, views, and understanding of mental health, mental illness, and wellness. Without adding these programs and updating operating guidelines, Oregon will maintain current inequitable access to adequate and appropriate treatment.

Monthly complex case group. The unit considered bringing hospitals together on a regular basis to discuss patients with extraordinary lengths of stay, identify barriers and solutions, and transition people out of hospitals and back into the community. In preliminary, exploratory conversations with providers, it became apparent that these types of groups were being held internally at some hospitals and then regional meetings did occur as well. We also learned that coordinated care organizations were also holding internal consult groups about these patients and actively working with hospitals, CMHPs, and other providers to find remedies. Using this as one of the few avenues to increasing equity in behavioral health maintains the narrow focus on individuals or clusters and does not address the systemic issues that could reach Oregonians as a whole.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

- Licensing and Certifications Unit, Health Systems Division
- Complex Systems Consultations with the various acute care hospitals across the state
- Community Mental Health Programs
- Circuit courts in the seven counties currently without jail diversion programs

- Local Public Safety Coordinating Councils
- Coordinated care organizations

Once the jail diversion programs and civil commitment group within intensive services are established and operational, they would be collaborating with additional community advocacy groups like Disability Rights Oregon to continually improve and enhance services to clients.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

It does not require a change to statute.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

- County governments operating as CMHPs as well as non-governmental CMHPs would be impacted. CMHPs are expected to provide and are responsible for the oversight of community-based jail diversion and commitment programs, including having staff to monitor operations and compliance.
- The circuit courts would be required to understand and carry out statutes related to community-based commitment options. Courts across levels in the seven additional counties would be tasked with integrating new program operations and workflows, which would require increase collaboration with law enforcement and jails. The courts would also have to possibly staff additional FTE to manage increase in workload.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): January 1, 2024

End date (if applicable): Not applicable.

12. What assumptions affect the pricing of this policy package?

- Jail Diversion assumed to be operating at 24 months.
- All FTE are priced at 18 months; this assumed recruitment will begin right away but could take up to six months for positions to be filled.
- Budgets for Jail Diversion are based on the budgets submitted by Baker, Clatsop, and Jefferson counties. The other four counties did not submit budgets within the policy package's timeline. These budgets were summed, then averaged, and then multiplied by county population to get assumed costs creating a cost per person. That figure was then multiplied by county population for the remaining four counties to come up with an estimated cost per county.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

- **Jail Diversion Services:** This policy package would provide funding for seven counties that currently don't receive jail diversion funds. This would increase the amount of reporting and data collection currently received.
- **CFAA administration:** Additional service elements would need to be added to seven CMHPs.
- **Intensive Services Unit:** This policy package would create a specific civil commitment specialty within the Intensive Services unit. It would share some responsibilities with the Licensing and Certification unit, while also providing training, technical assistance and legislative support to internal and external partners.
- **Business Information Systems Coordination:** Additional data collection and data sharing would be required for civil commitment to get an accurate assessment of number of investigations, acute care hospital stays and access to community resource.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Yes, this policy package would likely have impact on client caseloads and/or services provided.

Jail Diversion Impacts. The desired changes would create jail diversion caseloads in the seven counties that do not currently have jail diversion programs. These services could increase caseloads by 150 clients per county. It is anticipated that this would reduce Aid and Assist caseloads by decreasing the numbers of individuals entering the criminal justice system and diverting them to appropriate community-based services.

Civil Commitment Impacts. With the anticipated practices and policies standardization as well as changes to Division 33 of Chapter 309 of the Oregon Administrative Rules, it is possible that caseload numbers for pre-commitment services and for trial visit could increase. These rules are primarily related to discharges and trial visit. The number of individuals on trial visit was over 1,200, pre-pandemic. That number decreased to 28 in 2021 due to Covid restrictions. Going forward, OHA expects numbers to grow to 2,400 due to changes in accessibility and support for trial visits.

Dual Impacts. It is anticipated that the new jail diversion programs and the enhanced civil commitment programs would increase the number of Oregonians living with behavioral health conditions remaining in the community for treatment, rather than using inpatient acute psychiatric care beds or ending up in jail. This community-based diversion for treatment supports people to maintain stabilization in their usual environment, which is correlated to longer term recovery. That recovery is also supported by crisis services. Crisis services teams are able to quickly assess people in the community before they substantially decompensate and require a hospital level of care for stabilization or potentially get charged with criminal offenses resulting in jail bookings. OHA anticipates that services provided under crisis services would increase.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

All positions would support development of the 360 degree of Oregonians receiving services to identify inequities, focus efforts on eliminating those inequities, and connect information across the continuum of care. All positions would be new, permanent positions.

- Operations & Policy Analyst 4 (OPA4) – Lead implementation of the civil commitment program expansions and statewide standardization, oversee rulemaking process, build relationships with

key internal and external partners, recommend pathways to improved communications and relationships to advance program goals

- Operations & Policy Analyst 3 (OPA3) – Support providers in the community with complex systems issues that are preventing the flow through the courts and care settings, provide technical assistance
- Operations & Policy Analyst 1 (OPA1) – Coordination and administrative support to team
- Fiscal Analyst 2 (FA2) – With thorough knowledge of state and federal budget processes, provide support and project management skills to a wide range of budget analysis activities including monitoring, development, forecasting, and evaluation
- Information Technology Manager 1 – Manage a Compass team responsible for improving access to data needed by behavioral health teams
- Operations & Policy Analyst 3 (OPA3) – Identify data needs, facilitate data access, and integrate the data into the behavioral health data warehouse
- Research Analyst 3 (RA3) – Working with behavioral health programs and health analytics, identify appropriate metrics and data needs for reporting program outcomes, and support improving reporting and program analysis resources.

16. What are the start-up and one-time costs?

This policy package does not include any one-time costs.

17. What are the ongoing costs?

Positions and corresponding services and supplies are all ongoing costs, including:

- Seven positions for full team described above.
- System changes for the Compass program as it relates to the specific program.

18. What are the potential savings?

- **Acute care hospital admission bed usage may decrease.** With a more efficiently moving acute psychiatric care network in the state, including a more robust and standardized community-based commitment option, lengths of stay in acute care hospitals would decrease, allowing for more Oregonians to access the acute care psychiatric setting for treatment.
- **Anticipated decreases in the use of and length of stay in jail beds.** Diverting individuals with mental illness from jail to community-based resources and programs is the focus of diversion programs. Serving individuals in the community is less expensive than housing them in jails.
- **Reducing potential liability to state.** By increasing diversion services, both jail diversion and civil commitment, fewer people would be charged with crimes and would therefore not be as likely to enter the criminal system altogether. This could decrease the number of people at risk of entering the Aid and Assist system, decrease the likelihood they board in jails without access to OSH, and decrease the likelihood that this could result in legal action against OHA. The decrease in Aid and Assist cases across the state could also decrease the demand for OSH beds for that population, opening up beds for the civil commitment and PSRB populations, thus likely reducing the likelihood of lawsuits related to lack of access to OSH, or placement in inappropriate levels of care, for these two populations.

19. What are the sources of funding and the funding split for each one?

Most of the costs will be funded with General Fund. Some support staff will be allocated over multiple funding sources through the cost allocation system. Information Technology costs will be funded with enhanced Medicaid funding allocated for Compass.

Oregon Health Authority: 2023-25 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$722,809	$7,729	$467,827	$1,198,365	7	5.25
Services & Supplies	$404,047	$902	$1,083,592	$1,488,541		
Capital Outlay						
Special Payments	$3,809,683			$3,809,683		
Other						
Total	**$4,936,539**	**$8,631**	**$1,551,419**	**$6,496,589**	**7**	**5.25**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Center for Public Health Practice
Policy package title:	Regional Resource Hospitals for Disaster Response
Policy package number:	422
Related legislation:	None

Summary statement:

In local or statewide emergencies where the statewide health care system is stressed to capacity, hospitals and emergency medical services (EMS) have limited ability to efficiently coordinate patient distribution beyond normal operations or normal seasonal hospital surges. With temporary federal grant funds, OHA and partners built upon existing Health Care Coalitions and established Regional Resource Hospital systems and collaborated to develop situational communication, patient distribution and resource sharing capacity. OHA also worked with the Oregon Medical Coordination Center to ensure appropriate care no matter where you live in Oregon. These efforts support better and equitable access to all levels of hospital care during major health system surges. Oregon needs a sustained and robust operational system of communication and clinical coordination for current and future emergencies that isn't dependent on temporary federal COVID-19 pandemic related grant funding.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$0**	**$186,908**	**$0**	**$186,908**	**1**	**0.75**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

In disasters and other emergencies stretching beyond normal business operations or seasonal hospital surges, the statewide Oregon health care system is drastically affected by a limited ability to coordinate between hospitals, EMS, and other resources. Oregon's rural communities lack the density of resources and access to the level of care needed, leaving rural communities with limited access to emergency patient distribution capacity and response resources. This limited rural capacity can result in additional burden to large health systems in populated urban areas that have access to higher care levels. Access to the highest level of care is especially disruptive and inequitable for citizens in areas served by rural and frontier hospitals when the surge is statewide and more resourced hospitals and health systems are stressed to capacity. Oregon needs a robust operational system of regional and inter-hospital situational communication, along with acute and critical care clinical coordination, that can be sustained for the current and future emergencies and disasters.

2. What would this policy package buy and how and when would it be implemented?

This policy package would allow for funding of OHA staff to provide project support for Regional Resource Hospitals and the Oregon Medical Coordination Center to plan, implement and operationalize collaborative situational communication, resource sharing, and high-level clinical coordination. This package would fund coordination to continue building statewide regional resource hospital network coordination capacity to confront all types of hazards and health care system crises by coordinating the following efforts which may be supported by other funding streams:

- Serve as lead point of contact between OHA and the Oregon Medical Coordination Center, which may be supported through separate legislative funding streams. The Oregon Medical Coordination Center was initiated by Oregon Health & Science University (OHSU), Providence, Kaiser and Legacy in partnership with the other identified Regional Resource Hospitals and sponsored by OHA Health Security Preparedness and Response. The Oregon Medical Coordination Center would provide statewide operational patient transfer coordination during emergencies, events of high consequence and resource constrained situations.
- Maintain intergovernmental and regional agreements for the six Regional Resource Hospitals and the Oregon Medical Coordination Center that work across health systems and normal business operations to support health care system capacity and better patient outcomes in resource constrained situations. Other legislative funding may provide workforce staffing dedicated to collaborative regional emergency planning, communications technology, project management and the development and hardening of emergency operations plans, and OHA would provide coordination and technical assistance. Activities will incorporate established goals of improving health outcomes for improved access to care and otherwise advance health equity in Oregon.
- Coordinate operational plans for the Oregon Medical Coordination Center with the five existing Health Care Preparedness Coalitions, centered around permanently establishing the six Regional Resource Hospitals, which bring multiple healthcare partners together geographically from hospitals, EMS, long-term care, federally qualified health centers (FQHCs), emergency management, pharmacies, public health, and others. Other legislative funding may provide operational cooperative response planning and exercise, equipment and activities, which incorporate medical surge and mutual aid between health care sectors. Activities would incorporate established goals of improving health outcomes for improved access to care and advance health equity in Oregon.

- Coordinate with Oregon Medical Coordination Center and regional resource hospitals on other grant or funding opportunities to improve and institutionalize the program developed under the currently proposed funding.
- Participate with OHA behavioral health and EMS programs to collaborate on patient movement initiatives that may be associated with the Oregon Medical Coordination Center for future development.
- Liaise with the OHSU Oregon Medical Coordination Center clinical advisor to who will provide ongoing expert clinical input to OHA Emergency Support Function (ESF)-8 and regional coalition response planning and response activities.
- Analyze performance data provided OHSU: The Oregon Medical Coordination Center will provide and inform statewide collaborative response systems and planning development with health care access data metrics, with the goals of improving health outcomes, access to care, and advancing health equity in Oregon.
- One permanent position for OHA within the Health Security Preparedness and Response Program at Public Health for project management and coordination on this initiative. Funding would provide for OHA staffing of Regional Resource Hospital and Oregon Medical Coordination Center projects and grant management.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

Based on the recommendation of the Governor's Joint Task Force for COVID-19, the Regional Resource Hospital charter was officially established in July 2020, with a mission grounded in principles of health equity, focused on minimizing health inequities. The overarching goals of the charter are to identify challenges, address any barriers, and facilitate information sharing in preparation for any existing or potential significant surge of patients into Oregon hospitals in order to

prevent any negative effects to patient care, while centering communities with less access to services. This policy package would help rural communities to have increased access to emergency patient distribution capacity and response resources while limiting burden on other hospitals struggling to meet the highest needs of care for their vulnerable populations. This work led to the initiation of complex urgent work of the Oregon Medical Coordination Center, with an overarching goal of ensuring that all Oregonians always have timely and equitable access to the highest level of life-saving care available to any anyone in Oregon during emergencies. This work will contribute towards OHA's mission to ensure all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

Quantifying results

4. What are the long-term desired outcomes?

The long-term goal of this policy package is sustainability of the Regional Resource Hospital Collaborative network and Oregon Medical Coordination Center for all-hazards response. With the increasing pace of emergencies and disasters in Oregon, this coordination adds an organized strategy for equity in health care access at the forefront for health care systems delivery, which needs to be ongoing in order to address current and future needs.

5. How will OHA measure the impacts on health inequities of this policy package?

The Oregon Medical Coordination Center will provide and inform statewide collaborative response systems and planning development with health care access data metrics with the goal of improving health outcomes by improving access to care and advancing health equity in Oregon. Through evaluation of the metrics described above, in partnership with the OHSU Oregon Medical

Coordination Center, OHA will evaluate the impact of patient transfers that would not have otherwise occurred.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Regional Resource Hospital Collaborative: On March 23, 2020, Governor Brown issued a Joint Task Force for Health Care Systems Response to COVID-19, which jump started the implementation of what is now known as the Regional Resource Hospital Collaborative. The Joint Task Force recommended the adoption of a regional model based on the already established Area Trauma Advisory Board (ATAB) and OHA Health Security Preparedness and Response Health Care Coalition regions. Each region designated a Regional Resource Hospital. By the summer of 2020, OHA completed agreements establishing six Regional Resource Hospitals. These Regional Resource Hospitals service the Regional, Inter-Regional, and Statewide Regional Resource Hospital Hub framework to support mutual aid, patient information, coordination, flow, and distribution during a declared disaster or emergency.

Oregon Medical Coordination Center: OHA established a regional collaboration, as an operational extension of the Regional Resource Hospital Collaborative, to include all major health systems in the Portland area, who also serve as the only providers of quaternary intensive care in Oregon in response to a severe surge of patients to a limited amount of hospital quaternary care bed capacity during the Delta COVID-19 variant in August 2021. As the statewide capacity decreased for tertiary and quaternary critical care, the Oregon Medical Coordination Center was created to improve equitable access to these critical care services and decrease duplicative work. The center participation was then broadened, to include all of the state's Regional Resource Hospitals. OHA

used the statewide center to coordinate placement of patients needing ICU care in the closest hospital with the capability and capacity to provide this care. Oregon also established a partnership with the Washington Medical Coordination Center to refer patients to their home state's system and avoid interstate transfers. Together, these collaborative efforts allowed Oregon to avoid extended delays for ICU care during surges. The Oregon Medical Coordination Center is modeled from the Medical Operations Coordination Cell framework utilized by the U.S. Department of Health and Human Services, FEMA, and other states.

7. What alternatives were considered and what were the reasons for rejecting them?

This work was implemented during the COVID-19 pandemic as the result of the Governor's Joint Task Force recommendations. The need for this patient transfer work continues due the ongoing strain on Oregon's hospitals and local and regional capacity limitations. Those limitations cannot be overcome without extraordinary investments to increase individual hospitals' staffing and beds.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Other partners include all hospitals in Oregon,EMS agencies, and federal partners providing technical support.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

None known.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

None known.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

Position start date of January 1, 2024.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

None known.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

None known.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

One Operations & Policy Analyst 3 position (Regional Emergency Coordinator) for project management and coordination. Funding to provide for OHA staffing of Regional Resource Hospital and Oregon Medical Coordination Center projects and grant management.

16. What are the start-up and one-time costs?

Purchase computer, cell phone and standard supplies for new position estimated at $5,000 year one and then $4,000 annually.

17. What are the ongoing costs?

Travel costs to support staff to attend and facilitate meetings for the project and attend two National Conferences and trainings estimated at $10,000 annually.

18. What are the potential savings?

Unknown.

19. What are the sources of funding and the funding split for each one?

OHSU is providing the Other Funds for the position.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$186,908		$186,908	1	0.75
Services & Supplies						
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$186,908**	**$0**	**$186,908**	**1**	**0.75**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Systems Division
Program:	Behavioral Health Non-Medicaid
Policy package title:	988 & Behavioral Health Crisis System: Payor Parity for BH Crisis Services
Policy package number:	429
Related legislation:	House Bill 2417 (2021), House Bill 3046 (2021)

Summary statement:

In 2021, the Legislature directed the Oregon Health Authority in House Bill 2417 to implement, expand and enhance Oregon's 988 & behavioral health crisis system (988 & BHCS). This includes enhancing existing services and expanding the current system to provide a "no wrong door" approach that ensures individuals in crisis receive the appropriate level of care through three programs: a statewide 988 call center, expanding mobile crisis team outreach, creating crisis stabilization centers (CSCs), and developing a seamless continuity of care through follow-up service referral and tracking. This policy package addresses payor parity for BHCS by commercial payors. Though Medicaid is the only payor that covers behavioral health crisis services, these services are required to be accessible and be delivered to all regardless of insurance type or status. Payor parity is essential for long term fiscal sustainability of behavioral health crisis services including crisis service workforce in Oregon.

Oregon Health Authority: 2023-25 Policy Package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$191,854**	**$1,927,355**	**$0**	**$2,119,209**	**1**	**0.75**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Currently, behavioral health crisis services, including the crisis call line, mobile crisis services and stabilization services, are paid for by Medicaid Federal Funds and state General Fund and are not paid for by commercial insurers. As a result, state General Fund must be used to cover the full cost of crisis services delivered to individuals (including children) who are covered under commercial insurance, uninsured or underinsured. This continues to impact the workforce reimbursement, 24/7 availability, and in general the quality of service for Community Mental Health Programs, especially rural and frontier ones, who are the primary providers of behavioral health crisis services. Providing crisis services to children, youth, and young adults, providers are not just treating the individual but the entire family to provide person/family centered service. While this is the ideal way to provide crisis services, it also further incurs cost on the provider.

Recently, Oregon has seen federal and state investments to enhance and improve the behavioral health crisis system and services; however, the ongoing state fiscal impact will be significant, in part due to the lack of payor parity for behavioral health crisis services. An independent consultant found Oregon would pay approximately $1.0 million per year in mobile crisis services and $11.3 million per year in stabilization services for individuals with commercial insurance coverage. Establishing payor parity would help ensure the long-term fiscal sustainability of a robust behavioral health crisis system of care in Oregon.

Reimbursement being available only through Medicaid makes it difficult for crisis service providers to maintain a multidisciplinary team of behavioral health staff qualified to do assessment, diagnosis, and treatment. CMHPs eventually end of losing one or more staff who are part of crisis services team and some even have to cut down crisis service hours to less than 24/7. This often leads to after hour behavioral health crisis response being entirely comprised of law enforcement and therefore communities less inclined to seek behavioral health crisis services, especially those communities who have historically been traumatized by law enforcement response to their crisis due to structural racism and bias. Communities who don't have consistent access to behavioral health crisis service teams seek care at emergency departments when they experience behavioral health crisis.

Payor parity for behavioral health crisis services would mean mandating all payors to cover behavioral health crisis services provided in the following settings: (a) A crisis walk-in facility; (b) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Oregon health Authority; (c) all agencies licensed or certified by the OHA that provide outpatient crisis services; (d) An agency that provides medically managed or medically monitored withdrawal management services; or (e) A mobile crisis team that provides crisis response services in the community.

2. What would this policy package buy and how and when would it be implemented?

This policy package includes one Operations & Policy Analyst 3 position to coordinate and administer the potential new statutory requirements, in collaboration with Department of Consumer and Business Services (DCBS). The policy package also covers the cost for PEBB and OEBB to cover behavioral health crisis services for their members.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

Since only Medicaid covers behavioral health crisis services, the state uses more General Fund to cover individuals who seek crisis services but are not Medicaid members. This continues to impact the workforce reimbursement, 24/7 availability, and in general the quality of service for Community Mental Health Programs, especially rural and frontier ones, who are the primary providers of behavioral health crisis services. While providing crisis services to children, youth, and young adults, providers are not just treating the individual but the entire family to provide person/family centered service. While this is the ideal way to provide crisis services, it also further incurs cost on the provider.

Reimbursement being available only through Medicaid makes it difficult for crisis service providers to maintain a multidisciplinary team of behavioral health staff qualified to do assessment, diagnosis, and treatment. CMHPs eventually end up losing one or more staff who are part of crisis services team and some even have to cut down crisis service hours to less than 24/7. This often leads to after-hour behavioral health crisis response being entirely comprised of law enforcement and therefore communities less inclined to seek behavioral health crisis services, especially those communities who have historically been traumatized by law enforcement response to their crises due to structural racism and bias. Communities who don't have consistent access to behavioral health

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

crisis service teams seek care at emergency departments when they experience behavioral health crisis.
Therefore, this policy package directly aligns with OHA's strategic mission to eliminate health inequity for communities who have been impacted due to historic injustice and systemic racism.

Quantifying results

4. What are the long-term desired outcomes?

The development of the statewide coordinated crisis system is intended to increase access across Oregon. OHA anticipates the following outcomes:

- Payor equity to increase sustained coverage of behavioral health crisis service costs
- Remove barriers to accessing quality behavioral health crisis services
- Prevent suicide deaths
- Improve equity in behavioral health treatment and ensure culturally, linguistically, and developmentally appropriate responses to individuals experiencing behavioral health crises, in recognition that, historically, crisis response services placed marginalized communities at disproportionate risk of poor outcomes and criminal justice involvement
- Decreased emergency department boarding
- Higher quality crisis services workforce with higher competency as well as increased staff retention in crisis services due to better reimbursement models

5. How will OHA measure the impacts on health inequities of this policy package?

OHA would look at measures that would be disaggregated by REALD & SOGI requirements.
Measures that would be tracked and monitored include:

- Fee schedule for commercial payors for behavioral health crisis services.

- Number of people on commercial insurance who accessed behavioral health crisis services.
- Number of people on commercial insurance who avoided emergency department by receiving crisis services.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Lack of payor parity for behavioral health crisis services has always been a cause of concern especially among crisis service providers who must cover the cost. Currently, OHA must seek legislatively appropriated General Fund to help providers (specifically CMHPs) to cover all individuals who are not on Medicaid and seek behavioral health crisis services. Through a combination of funding appropriated under House Bill 2417, and one-time federal grant funds, OHA has made investment to enhance the crisis system.

7. What alternatives were considered and what were the reasons for rejecting them?

Legislative pathway to address statute change is the only alternative identified to address lack of payor parity in behavioral health crisis services. House Bill 3046 addresses payor parity for behavioral health services at large, however, behavioral health crisis services are still only covered by Medicaid but are required to be available for everyone regardless of insurance. This creates unstable funding and workforce attrition for behavioral health crisis services, which in turn impacts the standard and quality of crisis services to all Oregonians. While OHA has put in significant investment, CMHPs continue to struggle to have a 24/7 multidisciplinary team of crisis workforce.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   Collaboration on this policy package includes but is not limited to Department of Consumer and Business Services (DCBS), the nine-federally recognized Tribes and Urban Indian Health Program, consumers and those utilizing services, Medicaid providers, coordinated care organizations (CCO), peer-delivered services community, local community mental health programs (CMHPs), Oregon Council Behavioral Health (OCBH), Crisis System Advisory Workgroup (CSAW), CSAW Steering Committee, Medicaid Advisory Committee (MAC), Oregon Consumer Advisory Council (OCAC), Health Policy Board, Alcohol Drug Policy Commission (ADPC), Addictions and Mental Health Planning and Advisory Council (AMPHAC), Oregon Association of Hospitals and Health Systems (OAHHS), National Alliance on Mental Illness (NAMI), law enforcement, emergency medical services, 911 programs, and other first responders.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   OHA put forward legislative concept 44300-023. There may be requirement of a new statute, or changes can be made to ORS 414.766, 743A.168 and 743B.505.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    This policy package could impact DCBS as the regulatory agency for commercial payors. All community mental health programs and CCOs would also see the positive impact of cost savings due to commercial payors picking up their share of crisis services in the community. This will be especially visible among children, youth, young-adult population.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable.

12. What assumptions affect the pricing of this policy package?

- Commercial payors will identify and recognize the lower cost of covering crisis services compared to inpatient services.
- Commercial payors will make changes to their fee schedules and contracts with Community Mental Health Programs to reflect behavioral health crisis services as a covered benefit for their clients.
- Medicaid and legislatively appropriated funds will continue at level funding to support the crisis system.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There may be a need to shared responsibilities to be coordinated between OHA and DCBS.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Not applicable.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Operations & Policy Analyst 3
The purpose of this position is to provide development, implementation, and accountability of the implementation, of any new statute and rules associated with this policy package. The employee would focus specifically on coordinating with DCBS and commercial payor partners, providers responsible for delivering behavioral health crisis services, and other community partners. This would be done by identifying key stakeholders, design the scope of work as outlined initiative, develop associated policy and program materials, facilitate weekly/monthly meetings, as well as monitoring system performance and outcomes as a result of statute change. Associated work would include acting as a subject matter expert to support the 988 & BHCS leadership in preparing recommendations for Legislative Session work, Government Relations, OHA leadership and community partners. This position must understand the intent, planning and priorities of the behavioral health crisis services.

Internally, the position would require extensive partnership, collaboration, and program design with the 988 call centers, Community Mental Health Programs, and CCOs as it relates to the regional crisis system implementation across the state. The position would represent the Health Systems Division in this cross-divisional work and be astute at determining when additional leadership is required.

The person in this position would identify system performance and system development needs, including administrative, legislative, and funding changes to improve the effectiveness of services.

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

According to the PEBB/OEBB consultant, the increased cost would result in an estimated 0.05 percent premium increase in PEBB's and OEBB's medical/rx plans. The premium increase would result in a fiscal impact of $1.1 million to PEBB and $0.8 million to OEBB through Other Funds Special Payments during the 2023-25 biennium. This assumes a statutory effective date of July 1, 2023. Total ongoing cost would be $2.1 million per biennium.

18. What are the potential savings?

Payor parity with commercial payors would save Oregon approximately $1.0 million per year in mobile crisis services and $11.3 million per year in stabilization services annually, according to an independent consultant contract by OHA.

19. What are the sources of funding and the funding split for each one?

General Fund for position costs in HSD. For PEBB and OEBB, the Other Funds revenue comes from administrative fees assessed on PEBB and OEBB Core Benefits. The administrative fee is paid by members and state agencies through an assessment added to medical and insurance premiums and premium equivalents.

Oregon Health Authority: 2023-25 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$173,757			$173,757	1	0.75
Services & Supplies	$18,097	$1,110,916		$1,129,013		
Capital Outlay						
Special Payments		$816,439		$816,439		
Other						
Total	**$191,854**	**$1,927,355**	**$0**	**$2,119,209**	**1**	**0.75**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Policy and Analytics
Program:	Health Policy & Delivery System Innovation, Office of Health Analytics
Policy package title:	Support for the Health Care Market Oversight Program
Policy package number:	430
Related legislation:	ORS 415.500 et seq.

Summary statement:

This policy package includes General Fund to support the Oregon Health Authority's (OHA) administration of the Health Care Market Oversight (HCMO) program in the 2023-25 biennium. Through the HCMO program, OHA reviews and approves health care consolidation in Oregon, ensuring that health care mergers and acquisitions support statewide goals related to cost, quality, access, and equity. Without this policy package to support the HCMO program, health care in Oregon could become more consolidated, resulting in higher prices without improved quality, and access issues, particularly for low-income communities, rural communities, and communities of color. This package funds four full-time, permanent positions and program expenses.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$1,240,524**	**$0**	**$0**	**$1,240,524**	**4**	**4.00**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

In Oregon and nationwide, health care consolidation has become increasingly common, resulting in more markets being dominated by large, national companies and fewer independent and local health care providers. Research shows that when health care corporations combine, it can lead to higher prices without improving quality or health outcomes. Health care consolidation can affect access to care, particularly for low-income communities, communities of color and rural communities.

Health Care Market Oversight is a legislatively mandated program (per ORS 415.500 et seq.) and a key strategy to achieve OHA's goals related to containing health care costs. In 2021, the Oregon Legislature passed House Bill 2362 to address health care consolidation in the state. This law directs OHA to review proposed transactions, such as mergers and acquisitions, that involve health care entities, including hospitals, health insurance companies, and provider groups. The program ensures that health care transactions in Oregon are transparent and support lower costs, increased equity and access, and better quality. Through the program and per the legislation, OHA also monitors, evaluates, and reports on the statewide impacts of health care consolidation. The HCMO program launched March 1, 2022.

This policy package would ensure that program operations can continue uninterrupted. In the 2021-23 biennium, the Legislature funded the program with 100 percent General Fund with the intention that fees collected would sustain the program long-term. Delays in the ability to establish and collect fees have created a revenue shortfall for the 2023-25 biennium. In 2023, OHA plans to begin collecting fees to conduct reviews of planned health care transactions; however, OHA has not yet obtained authorization to collect fees, the timing and number of reviews is unpredictable, and the

effort required to review transactions will vary. This package therefore includes full funding for the program for the 2023-25 biennium.

2. What would this policy package buy and how and when would it be implemented?

This policy package would provide General Fund in the 2023-25 biennium to cover HCMO program costs. It provides resources for four existing permanent positions to support the following statutorily required work:

- Conduct reviews of proposed health care transactions, including gathering materials and information, acquiring data, coordinating with entities involved in the transactions, overseeing the work of outside advisors, and conducting qualitative and quantitative analyses, and making determinations about whether the transaction should be approved, approved with conditions, or rejected. OHA will also conduct follow-up reviews of approved transactions one, two, and five years after the deal is completed.
- Implement a robust public input process, including engaging interested parties from the health care industry and advocate groups, using inclusive best practices to solicit comments and input from the public, and developing public facing-materials to build awareness and transparency. OHA may convene a community review board, comprising patients, plan members, and community members to inform reviews and provide recommendations about whether to approve transactions.
- Administer the program, including providing technical assistance to health care entities considering a transaction, overseeing vendor contracts, and coordinating with other related efforts in Oregon and nationally.
- Monitor consolidation in Oregon through ongoing tracking and reporting of health care transactions and evaluating the impacts of health care transactions. HCMO's governing statute directs OHA to publish a report on the state of consolidation every four years.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

HCMO supports OHA's strategic goal of lowering or containing the costs of health care. As the COVID-19 public health emergency unwinds, efforts must continue that help ensure that health care consolidation does not further destabilize the health care system.

HCMO does not just focus on cost and market impact of health care consolidation; it also has an explicit focus on equity in its rules and statute. Equity is a core component of all transaction analyses and reviews, and the program supports robust public and community engagement. HCMO processes require health care entities to consider the health equity implications of their actions. And moreover, OHA may not approve transactions that are likely to have a negative impact on health equity, which positions HCMO as an effective initiative to improve health equity over the long term in Oregon.

Quantifying results

4. What are the long-term desired outcomes?

The desired long-term outcome of this program is a health care system with competitive markets that support affordable prices and access to essential services. The program seeks to deter health care corporations from creating monopolies and anti-competitive markets. ORS 415.510 directs OHA to conduct a study of the impact of health care consolidation in the state every four years. This study,

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

along with ongoing monitoring efforts, will examine trends in consolidation and the impact of consolidation on health care markets, costs for consumers and payers, quality of care, population health management, and health outcomes.

5. How will OHA measure the impacts on health inequities of this policy package?

For each transaction review, OHA will measure quality outcomes and access to care, stratified by community and patient demographics, including race, ethnicity, age group, gender, and geography, as available. OHA will also examine community engagement and availability of equity-enhancing services.

ORS 415.510 directs OHA to conduct a quadrennial study of the impact of health care consolidation in the state. Through this study, OHA will assess the impact of consolidation on costs for consumers and payers, quality of care, population health management, and health outcomes, particularly for uninsured individuals, low-income individuals, and people living in rural communities.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

The HCMO program launched March 1, 2022. The program waived fees for the first nine months of operations in response to public and stakeholder input. Program staff are now engaging in rulemaking that will allow the program to implement fees in 2023. Because the volume and timing of reviews is unpredictable, especially given the disruption of the COVID-19 pandemic, the Governor's Budget includes this policy package to ensure that program operations can continue uninterrupted as the program continues to grow. It is funded with General Fund to cover the program expenses;

however, if any program fees are collected, they will be used to cover budgeted program expenses and offset General Fund.

7. What alternatives were considered and what were the reasons for rejecting them?

The Legislature fully funded the program with General Fund for the 2021-23 biennium. OHA will propose in rule for fees to begin in 2023. OHA is proposing a tiered fee structure of realistic fees, avoiding fees that are too high for entities to abide. Due to the unpredictability of how many reviews will be conducted and the type of reviews, however, funding the program completely with fees is not a viable option.

OHA plans to revisit fee amounts for the 2025-27 biennium with a better understanding of the number and type of transactions that may come in over time; future fees may be sufficient to fully fund the program in future budget cycles.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

No other agencies or programs are collaborating on this policy package.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No. This policy package would not require any changes to ORS 415.500 et seq, HCMO's governing statute.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

OHA partners with the Department of Consumer and Business Services (DCBS) and the Department of Justice (DOJ) to align regulatory oversight of reviewing proposed health care transactions. This policy package would allow for continued partnership. Local and tribal governments would not be directly affected by this policy package. All Oregon residents and all purchasers of health care would indirectly benefit from ensuring that market consolidation does not result in cost increases or reduced access to services.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

OHA anticipates implementing program fees, but since OHA has not yet obtained authorization to collect fees, this policy package does not include estimated fee amounts. Any fees the program collects in the 2023-25 biennium will be used to offset General Fund budgeted to cover program expenses.

OHA plans to finalize the fee schedule after a formal rulemaking process and obtaining fee authorization. The proposed fee schedule includes flat fees for emergency and preliminary (30-day) reviews. There are tiered fees for comprehensive (180-day) reviews, based on the revenue of the second largest entity involved in a transaction. Based on the experiences of other states with similar programs, OHA anticipates that most transactions will not require a comprehensive review. (See proposed fee schedule below.)

Fee Name	Current Fee	Proposed 2023-25 Fee
Emergency Review	0	$2,000
Preliminary Review	0	$2,000
Comprehensive Review - Revenue $10M - $50M	0	$25,000
Comprehensive Review - Revenue $50M - $200M	0	$80,000
Comprehensive Review - Revenue $200M - $500M	0	$90,000
Comprehensive Review - Revenue >$500M	0	$100,000

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No new responsibilities.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Not applicable.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package would support four existing permanent staff positions:

- One Operations & Policy Analyst 4 to lead and oversee program policies and processes, transaction reviews, and the study of health care consolidation
- One Operations & Policy Analyst 4 to oversee program administration, operations, community engagement and health equity, and vendor contracts. This existing position was previously budgeted in the 2021-23 biennium as an OPA 3; OHA is requesting a reclass of this position (see below).
- One Research Analyst 4 to analyze data and support transaction review analyses
- One Economist 3 to conduct market and cost analyses and support transaction review analyses

OHA is requesting to reclass the Operations & Policy Analyst 3 position to an Operations & Policy Analyst 4. Upon implementation, OHA identified the need for this position to provide higher-level expertise and more independent support for the program. The initial fiscal analysis did not account for the level of effort required to support administrative and operational aspects of the program. In alignment with OHA's agency efforts to advance health equity and recent state laws to support equity, the program seeks to develop more robust community engagement and equity assessment, which requires additional expertise and skills to implement equity-focused processes and support broader outreach and communications.

16. What are the start-up and one-time costs?

Not applicable.

17. What are the ongoing costs?

Ongoing costs include resources to support staffing, services, and supports. The HCMO program includes four permanent positions. Additional services and supports include funds for public engagement and DOJ support. All transaction reviews will have a public engagement process and comprehensive reviews may convene a community review board. This policy package would provide funding to support public engagement activities, including translation, interpretation, and outreach, as well as compensation for qualifying community review board members, as required by House Bill 2992 (2021). This policy package also includes resources for ongoing support from DOJ to review transaction decisions, assist with pre-filing technical assistance, and support rules updates.

Budget Category	**2023-25 budget**
Personal Services	$1,111,190
Services & Supports	$129,334
Public Engagement	$81,334
DOJ support	$48,000
Total	**$1,240,524**

18. What are the potential savings?

Any fees the program collects in the 2023-25 biennium will be used to offset General Fund budgeted to cover program expenses.

19. What are the sources of funding and the funding split for each one?

General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$1,111,190			$1,111,190	4	4.00
Services & Supplies	$129,334			$129,334		
Capital Outlay						
Special Payments						
Other						
Total	**$1,240,524**	**$0**	**$0**	**$1,240,524**	**4**	**4.00**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Policy and Analytics
Program:	Public Employees' Benefit Board & Oregon Educators Benefit Board
Policy package title:	Benefits Management System (OEBB-PEBB BMS) Replacement
Policy package number:	435
Related legislation:	Senate Bill 1067 (2017)

Summary statement:

The current benefit management systems (BMS) used by the Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB) no longer support all current business needs since their respective introductions in 2008 and 2003. OEBB and PEBB are seeking to continue the BMS replacement project to improve user experience and customer care. The new BMS would facilitate the potential collection of REALD & SOGI data and provide a mobile app experience that has a better chance of members, including those in underserved communities, having better access to enroll in benefits, utilize benefit tools and wellness programs, and make informed benefit choices. Not prioritizing and supporting a replacement effort for the current system would result in canceling a contract signed with new vendor, discontinued implementation efforts, and continued use of end-of-lifecycle technology that is fragmented, non-standard, difficult to support, and is not scalable. Approximately 300,000 covered lives would be at risk for benefits interruption if a replacement system is not identified and procured prior to the expiration of existing vendor support in 2022.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$6,631,605**	**$0**	**$6,631,605**	**3**	**2.25**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Since 2019, OEBB and PEBB have completed planning for a replacement Benefits Management System (BMS), selected a vendor to provide a solution, and begun implementation of that solution. The planning was done as a result of a technical assessment of the current BMS systems used by OEBB and PEBB, and as a result of Senate Bill 1067 (2017 Regular Session) to align operational and administrative activities of the two systems. The planning included requirements gathering, alternative analyses, development of a Request for Proposal (RFP), evaluation and scoring of RFP responses, vendor selection, and contract execution with the selected vendor. The replacement BMS is part of the goal to align the state's operational and support processes to provide demonstrably improved services with increased efficiency and sustainable effectiveness, and a fundamental step to activate that lever is alignment across OEBB and PEBB. Replacing the antiquated and independent operating systems for benefit management in the two programs with a single, modernized and efficient system is a necessary step toward integration and alignment of benefits.

The current benefit management systems used by OEBB and PEBB (MyOEBB and pebb.benefits respectively) no longer support all current business needs since their respective introduction in 2008 and 2003. These needs include the ability of OEBB and PEBB subscribers in securely accessing and changing their personal account information; updating family member eligibility with legal documentation, which may include personally identifiable information (PII) data; modernized, secured communications between subscribers and OEBB/PEBB support staff, and enhanced remote

capabilities for school district/university/state benefits administrators to properly manage accounts for their organizations and employees.

OEBB and PEBB, along with the OEBB and PEBB boards, are seeking to integrate the administrative and support of the two systems, with improved user experience and customer care, into a single platform to meet the legislative direction provided under SB 1067. Section 25 of the bill specifies the need for increased efficiency, reduction of duplication and merging of the two separate PEBB and OEBB oversight boards into one function as essential to driving cost reductions and driving operational improvements consistent with applicable law and administrative rule.

Both systems were built on, and still maintained with antiquated legacy technologies utilizing extensive custom code using development languages, tools and infrastructure which are past the end of their product lifecycle. Turnover of the current support staff further increases the urgency of this project as replacement staff require increasing amounts of time to become familiar with the old architecture before reaching a level of sufficient competency to address issues.

In addition, the continued operations and maintenance of an aging, complex and highly customized system (by essentially the same vendor under different names) has led to an increased dependency on this single vendor. The current contract ends June 30, 2025.

Finally, OHA’s 2015 Benefit Management System Technical Assessment Report noted that both systems are at the end of their lifecycles and continue to be supported with obsolete technologies. The report recommended implementing system upgrades in the short term and replacing the entire system as quickly as feasible to allow OEBB and PEBB to meet their statutory responsibilities.

2. What would this policy package buy and how and when would it be implemented?

OEBB and PEBB are in the initial stages of the replacement BMS implementation. This policy package funds the remaining implementation activities including additional project staffing, vendor implementation costs, hosting and licensing fees, oversight fees for quality assurance, and contingency allowances. The implementation plan outlined by the selected vendor, LifeWorks, has a go live date in the first quarter of 2025.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

PEBB and OEBB goals are the same – provide a modernized, centralized, standardized, supportable, and scalable solution to replace both OEBB's and PEBB's benefit management systems for public employees, with the ability to accommodate the administrative and organizational changes while implementing and maintaining more rigorous security best practices.

The new BMS would allow members to access anytime anywhere from multiple devices, including mobile devices. Mobile access is a significant benefit for members, including underserved communities who rely on them to easily enroll in benefits and use tools available to make informed benefit choices. The new BMS would also facilitate the potential collection of REALD & SOGI data for analyses of benefit disparities.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

REALD & SOGI Implementation

- The replacement BMS would facilitate the potential collection of REALD & SOGI data.
- As part of House Bill 3159, insurance carriers and providers are required to collect SOGI and REALD data from participants and report to OHA once per year effective July 1, 2022. OHA intends to build a data repository to store the data which is slated to be piloted in 2024.
- The potential for REALD & SOGI data to be stored in the BMS if not available elsewhere would allow for analyses of potential disparities related to access to benefit information, access to benefits, and utilization of benefits among various populations.

Broader access to enrollment and benefit tools

- The new BMS would allow members to access anytime anywhere from multiple devices, including mobile devices. Most website visits are from mobile devices.
- Mobile access is a significant benefit for members. Studies show that underserved populations are more likely to access health information on smartphones. A well-designed mobile app would provide more access for underserved populations and assist them to easily enroll in benefits, use tools available to understand their benefits and costs, and make informed benefit choices.
- OEBB-PEBB would look at the expandability of the mobile app to include wellness content, and incorporate plan partner programs so more members, including underserved populations, can easily understand and access.

Alignment with the ODHS / OHA Strategic Technology Plan (STP) Initiatives includes:
Business Automation
While the current Benefit Management System (BMS) solutions have provided significant efficiency gains, the multitude of options now available provide greater functionality and capability to further

automate and streamline essential business processes, including support of dependent eligibility verification.

Dynamic Needs Supported by Seamless Technology Services

OEBB and PEBB's existing systems have been continuously enhanced to meet the needs of the member populations served, and the program staff responsible for overseeing benefits administration; replacement solutions provide for additional capabilities including modularity, agility, reusability, and incorporation of best practices in benefit administration.

Enables Connectivity Anytime, Anywhere, in Multiple Ways

The current solutions provide connection capability via multiple interfaces, but alternative solutions offer expanded capabilities to better meet member, staff, and partner needs through inclusion of mobile devices.

Trusted Source for Health & Human Service Data

The member information collected in the existing systems is organized in such a way as to allow searching and reporting capabilities, but lacks the ability to provide predictive analytics, which may be available with more modern solutions. The proper use of predictive analytics would allow for a strong improvement of customer service and support, reduce unnecessary insurance risks based on more reliable interpretation of provider data, assist in detecting possible fraud, enable better marketing and facilitation of currently available options as well as new, innovative wellness and healthcare options, all while helping strengthen accessibility to improved healthcare and meet the insurance expectations of a highly diverse population of clients and their families.

Quantifying results

4. What are the long-term desired outcomes?

A new combined Benefit Management System (BMS) would allow OEBB and PEBB to modernize its members' and administrators' user experience. Among the top modernization goals:

- Alignment with state information technology strategic plan.
- Ability to implement and maintain latest security best practices.
- Mobile app compatibility.
- More integrated benefit education tools to allow informed benefit choices.
- Compatibility with commonly used browsers, operating systems and devices.
- Flexibility to make changes to accommodate business partners and customers.
- Expanded automated error checking and data validation.
- Availability of on-demand enrollment, and training tools for members and administrators.
- Self-service tools and features for members and administrators.
- Automated dependent eligibility verification among, and between OEBB and PEBB member groups.
- Integrated financial module to improve invoice and payment processing, reconciliation, and ensuring enrollment and financial payment accuracy.
- Remove reliance on single vendor to maintain custom coded system.
- Reduce ongoing operations and maintenance costs for the OEBB and PEBB Benefits Management System.
- Reduce manual and duplicative processes.
- Improved and enhanced reporting module for participating employers.

5. How will OHA measure the impacts on health inequities of this policy package?

Surveys and the availability of data would allow the opportunity to evaluate access and usage of benefit enrollment tools available in the new BMS. More information would lead to more targeted improvements in the application and better-informed choices by the members.
In addition to measuring impacts on health inequities, success of this policy package would be validated by the following outcomes being met:

- Business process improvements and cost containment/recovery upon system implementation shall be quantitatively and measurably improved relative to their respective initial baseline measurement.
- System performance and reliability shall be measurably improved relative to their initial baseline measurement.
- Data integrity and security shall fully meet all state and federal Health Insurance Portability and Accountability Act (HIPAA), Producer Price Index (PPI) and Personally Identifiable Information (PII) security standards.
- Reports and notifications to both internal and external partners and customers shall be complete, correct, and verifiable against currently held account and personal information to ensure correctness and timeliness of distribution.
- Security access shall be verifiably controlled (by role access) and limited to the appropriate agency representatives.
- Disaster recover stand-up and on-line accessibility shall meet or exceed their currently observed level with 99.5 percent reliability and database management redundancy

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

PEBB and OEBB have sought advice from technical experts within the Oregon Office of Information Services (OIS) and Oregon Office of the State Chief Information Officer /Enterprise Information Services OSCIO/EIS. OEBB and PEBB have continued to contract, with little negotiating leverage due to the antiquated technologies involved, for maintenance and operations support to maintain basic system functions. OEBB and PEBB staff must either rule out or be very selective about enhancements to the systems as new functionality adds to the custom-made complexity of each system and could introduce new security risks.

In 2015, PEBB and OEBB contracted to have an in-depth security penetration test and an overall technical assessment conducted to identify and help in addressing any discovered risks and issues. Recommendations proposed by the 2015 Benefit Management System Technical Assessment Report were followed, including implementing hardware and software system upgrades to remedy issues identified in the report, and to allow OEBB and PEBB to continue meeting their statutory responsibilities until the replacement solution could be implemented.

7. What alternatives were considered and what were the reasons for rejecting them?

Status quo

The current OEBB and PEBB benefit management systems were built on antiquated legacy technology. OEBB-PEBB recently had an independent security assessment conducted. Future security assessments and remediation would be conducted biannually but the risk of a browser-based penetration attack is increased with the older technology.

Because of the custom nature of the systems, transition time related to contractor staff turnover puts programs more at risk as it takes new staff a much longer period of time to understand the systems well enough to address identified issues. The continued contractual relationship with the same vendor

from the initial build to current maintenance and operations has resulted in an increased dependency on a handful of key knowledgeable individuals employed by the contractor due to the age, customization and complexity of the systems. Transitioning to a new vendor could be both cumbersome and costly in terms of maintenance and operations. In addition, the architecture of the systems, implemented over a decade ago, relies on server side, data base driven procedures and modernization of current systems to accommodate newer technology and program goals would be costly.

Workday
Incorporation of BMS reporting and management into the current WorkDay Human Resource Management platform was reviewed including software demonstrations by Workday. The Workday solution did not meet enough of the requirements for the combined BMS for OEBB-PEBB, particularly the financial services section and the uniqueness of the OEBB program and the participating school districts, community colleges, special districts, other local governments.

Internal custom development and support of a state-funded, self-maintained software package and hardware platform (an “in-house” product).
OIS resources not readily available for a customized in-house product. Another custom solution does not meet the strategic goal outlined by the Enterprise Information Services Office.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

OEBB and PEBB have received endorsements from both boards. The Office of Information Services (OIS), Legislative Fiscal Office (LFO), EIS, Oregon State Treasury, Oregon Department of Justice, Cyber Security Services, and DAS Procurement have all assisted in aspects of the RFP

development, evaluation, and contracting process. Other agencies, programs, and stakeholders would be involved with any implementation of a new system.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No additional statutes or changes to existing statutes.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    All the benefit and payroll processes of state agencies, universities, school districts, education service districts and community colleges would be impacted: either by benefiting from a new benefit management system or adversely impacted if the benefit systems were not maintained, maintenance costs increased substantially due to the reliance on a single vendor, or if the systems became no longer viable.

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): January 2025 for the implementation phase

12. What assumptions affect the pricing of this policy package?

- Estimated staff time allocated to the project and dedicated to the project
- Costs in contract for Internal Quality Management Services (iQMS) vendor (NTT Data)
- Implementation and Operations and Maintenance costs in contract with solution provider vendor (LifeWorks)
- Ten percent contingency

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Although there are technical advisors from OIS on the project, there are no new responsibilities identified.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

None.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

OEBB and PEBB would need four new limited duration positions for the implementation of the project. One of these positions will be to coordinate OEBB and PEBB User Acceptance Testing. Three positions would be used to assist and backup current staff who would be more involved in the implementation. These positions would be used to ease workload in the current legacy system and to assist in testing of the new software.

16. What are the start-up and one-time costs?

This policy package is comprised entirely of one-time costs. It includes $4.6 million to complete the implementation of the new BMS and $2.0 million for operations & maintenance of the current BMS system through June 2025.

17. What are the ongoing costs?

While this policy package does not have any ongoing costs, there would be ongoing operations & maintenance costs that would be paid for from PEBB/OEBB's existing operations budgets. After implementation, per contract, **annual** ongoing operations & maintenance costs for the new system are as follows:

Operations and Maintenance Support	$1,350,000
Third Party Software Licensing	$ 84,000
Hosting and Services	$ 566,000
Total	**$2,000,000**

Annual cost for O&M is in contract for five full years after 'go live'.

18. What are the potential savings?

After implementation, OEBB and PEBB expect savings in operations and maintenance (O&M) costs of at least $1 million annually initially. This is based on the O&M costs in the new vendor (LifeWorks) contract and the current (2022) O&M costs for the legacy system. The O&M costs for LifeWorks are

set for five years without an increase; the O&M costs for the legacy system vendor increase annually so savings in O&M likely exceed $1 million annually.

Additional research and ongoing measurements are needed to quantify savings by implementing a more modern system applying best practices regarding security, deduplication of processes, removal of one-off systems or the need to contract for additional enrollment.

19. What are the sources of funding and the funding split for each one?

Funding sources are Other Funds revenue from administrative fees assessed on PEBB and OEBB Core Benefits. The administrative fee is paid by members and state agencies through an assessment added to medical and insurance premiums and premium equivalents. A greater percentage is allocated to PEBB as PEBB would acquire two limited duration positions and OEBB would acquire one limited duration position.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$425,427		$425,427	3	2.25
Services & Supplies		$6,206,178		$6,206,178		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$6,631,605**	**$0**	**$6,631,605**	**3**	**2.25**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Center for Public Health Practice
Policy package title:	Newborn Bloodspot Screening Program Fee Ratification
Policy package number:	437
Related legislation:	Senate Bill 5526 (2023) fee ratification bill

Summary statement:

Oregon newborn bloodspot screening (NBS), which is statutorily mandated for the Oregon Health Authority (OHA), is conducted by the Northwest Regional Newborn Bloodspot Screening (NBS) Program at the Oregon State Public Health Laboratory (OSPHL). The requested fee increase would allow the NBS Program to eliminate the gap between revenue and expenses once sufficient fees are collected. Additionally, because of the evolving landscape for newborn screening, the fee increase would allow the program to be self-sufficient in future years and remain agile, with ability to respond to the needs of Oregon families and comply with federal law and guidelines.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$1,900,000**	**$0**	**$1,900,000**	**2**	**1.50**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. **Why does OHA propose this policy package and what problem is OHA trying to fix or solve?**

   Oregon newborn bloodspot screening (NBS) is statutorily mandated for the Oregon Health Authority (OHA) and is conducted by the Northwest Regional Newborn Bloodspot Screening (NBS) Program (NBS Program) at the Oregon State Public Health Laboratory (OSPHL).

   The NBS program is projecting a budgetary biennial shortfall approaching $4 million. Several factors lead to this deficit, including increased costs for staffing, reagents, and instruments; an expanding panel of diseases; heightened national standards set by Health Resources and Services Administration (HRSA); and a loss of other state partners.

   The requested fee increase would allow the NBS program to close the gap between revenue and expenses. Additionally, because of the evolving landscape for newborn screening, the fee increase would allow the program to be self-sufficient in future years during long-term program funding planning. In addition, the fee would support the program remaining agile to align with the increasing number and complexity of disorders screened. The fee change would further provide the program with the ability to respond to the needs of Oregon families and comply with federal law and guidelines.

2. **What would this policy package buy and how and when would it be implemented?**

   The fee increase would be used to back-fill the projected budgetary shortfall for the NBS program. In addition, the fee would be used for the following activities and program modernization to align with national best practices:

- Addition of new disorders to the Oregon NBS panel.
    - X-linked adrenoleukodystrophy (X-ALD) and Spinal Muscular Atrophy (SMA) have already been added by HRSA to the national recommended uniform screening panel (RUSP) and were recommended for inclusion to the Oregon panel by the NBS Program Advisory Board. Both of these diseases will be added to the Oregon panel by January 2023. The fee would cover the additional costs to screen newborns for these diseases.
    - Each year, at least 1–2 diseases are being considered for inclusion to the newborn screening panels within our state and nationally. The fee would give the program the ability to remain agile for the near future to align with national standards and provide the best care for Oregon families.

- Improve timeliness by providing courier service or expedited shipping.
    - Newborn bloodspot screening must be completed quickly after an infant's birth; approximately 38 newborn bloodspot screening programs provide a courier service or expedited shipping in their states. HRSA recommends all newborn bloodspot screening programs receive specimens in their laboratory within 24 hours of specimen collection.
    - The fee would allow the program to implement statewide specimen transport services during the 2023-25 biennium.

- Modernize equipment to meet industry standards.
    - Instrumentation within the laboratory needs to be maintained and updated to ensure accurate and timely newborn bloodspot screening results are provided.
    - Changing methodologies from biochemical to molecular tests requires new instrumentation and technical expertise to support more accurate and modern technologies.

- Modernize data exchange to ensure timely receipt of laboratory test results by providers.
    - Currently, most newborn bloodspot screening results are delivered via US mail. Moving toward electronic data exchange for orders and results will provide enhanced specimen tracking and improved result delivery.
    - The fee will support staffing to modernize laboratory data systems to improve methods and timeliness of result delivery.

- Appropriately address complex medical disorders.
    - The number and complexity of disorders for which the program screens continues to increase and involve advanced testing methods. In addition, these disorders require more complex follow-up care than previous disorders.
    - As part of newborn bloodspot screening, newborns who have a positive screening result are referred to specialty centers for diagnostic testing, evaluation, and/or treatment. The NBS program provides financial resources to these specialty clinics. The partnership between medical clinics and the NBS program is essential to appropriately support newborns and their families.

- Modernize payment mechanisms by adding the option to pay by credit card for Oregon birth centers/hospitals and state partners.
    - Currently, only check or electronic payments are accepted.
    - The program expects this option will be implemented by the end of the 2021-23 biennium.

- Enhance the equity of screening services, detailed below.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

The newborn bloodspot screening program is a statutorily mandated program requiring that all newborns receive testing, regardless of their ability to pay for this service. Oregon's screening rate is estimated at greater than 95 percent of all births. The additional fees would support heath equity by providing the funds needed to:

- **Enhance culturally and linguistically responsive outreach services.** Enhancements will include identifying populations who do not get screened, understand the barriers to screening, and explore opportunities for program education and community partnerships.

- **Monitor timely access** to diagnostic testing, medical evaluation, and treatment.

- **Enhance the process for addition of new conditions to the screening panel to include populations of color and opportunity for family input.**
    - As the NBS Advisory Board considers new disorders for Oregon panel, analysis of affected populations, location of available treatment and specialty providers, and any health equity concerns are assessed and addressed.
    - The NWRNBS Program is exploring options for affected families to provide more input on program services.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

- **Provide universally offered specimen transportation services to the laboratory.** Currently, providers in many rural and frontier counties experience challenges achieving national timeliness goals. Providing courier or shipping services will help ensure that specimens from infants born in Oregon reach the laboratory in a timely manner.
- **Modernize laboratory instruments and methods, resulting in more accurate screening results.** While some false positive and negative results are expected in screening, reducing the number of false positive cases reduces the burden on the medical community (e.g., follow-up care and additional testing, clinic visits) and minimizes the stress or anxiety placed on families. Reduction of false negative cases will provide the opportunity for all Oregon babies to receive early treatment and improve health outcomes.

While further health equity can be achieved through the state goals above, we recognize that the increased fee may create an obstacle to screening. A small percentage of families pay for newborn bloodspot screening out of pocket. The program offers a fee waiver for qualifying families, but the increased fee could result in families opting out of screening if families do not qualify for the waiver. The NWRNBS Advisory Board has expressed interest in evaluating the qualifying criteria for fee waivers.

Quantifying results

4. What are the long-term desired outcomes?

The NWRNBS Program aims to:

- Ensure all infants babies have access to newborn bloodspot screening.

- Meet federal guidelines for specimen collection timing, specimen transport and laboratory testing such that medical providers are notified of abnormal results within the first 5 to 7 days of life.
- Meet federal guidelines for the recommended diseases on the Oregon screening panel.
- Comply with federal laws related to patient access to laboratory test results.

5. How will OHA measure the impacts on health inequities of this policy package?

The NWRNBS Program plans to measure impacts to health equity by:

- Collaborating with the Center for Health Statistics to identify the community populations who are not receiving newborn bloodspot screening.
- Monitor and track families requesting fee waivers for newborn bloodspot screening.
- Monitor regions of the state experiencing challenges with specimen transport, therefore resulting in potentially delayed screening results.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

To promote sustainability, the NBS Program participated in a touch-time study to determine opportunities for program efficiencies. This study assessed all program costs, including staff time spent on specific programmatic activities.

To reduce costs, the NBS Program optimized staffing, reduced equipment, and consumables, implemented an inventory system to reduce wasted reagents and emergency supply orders, and changed testing algorithms and workflows to be more efficient.

Additionally, the NBS Program Advisory Board is forming a subcommittee to explore long-term funding options outside of fees for future programmatic support. The NBS Program will be working with the advisory board on this topic.

7. What alternatives were considered and what were the reasons for rejecting them?

The NWRNBS Program currently provides newborn bloodspot screening for infants born in Oregon, New Mexico, parts of the Navajo Nation, and other contracted international clients. The Program considered only providing screening services for infants born in Oregon. However, this was determined to not be a feasible option. The NWRNBS Program is staffed at a minimal level and incurs high fixed costs for test kits, supplies and equipment. Reducing the number of specimens tested would result in lower revenue and increase cost per test due to the economies of scale offered by larger volume testing. This option would require an even higher fee increase for Oregon than is currently requested.

The NWRNBS program currently requires screening of each infant twice, once at 24–48 hours of life and again at approximately two weeks of life. The program considered providing only one screen instead of two. While this action would likely decrease costs, some diseases are best detected on the second screen, due to infant developmental relationships with disease detection. This action would result in fewer diseases being identified, negatively affecting health outcomes, reducing the potential for early detection and treatment, and increasing long-term health care costs.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

The NWRNBS program has engaged key partners regarding this change, as part of the rulemaking and Senate Bill 333 processes.

Internal partners

- Public Health Division: Maternal and Child Health
- OHA Health Systems Division
- Oregon Department of Consumer and Business Services

External partners

- **The NBS Advisory Board**: Comprised of representatives from different specialties and perspectives related to the newborn bloodspot screening system including family members, birthing hospitals, advocacy groups, professional associations of midwifery and pediatricians and medical experts. The board discussed the fee increase on February 23, 2022 and provided feedback on how to engage with their respective areas. Board members served on the Rules Advisory Committee (RAC) on April 27, 2022.

- **Oregon providers and submitters**:
    - The NWRNBS Program engaged with a group of contracted specialty medical consultants in January and February 2022 to provide feedback and input on additional community engagement.
    - Various provider communities are represented on the NBS Advisory Board and their input was recorded and is described above.
    - The NWRNBS Program received feedback from the Oregon Association of Hospitals and Health Systems in April 2022.
    - Additional Oregon health care providers representing pediatrics and family practice were invited to serve on the RAC. These invitees did not attend but were otherwise represented by the NBS Advisory Board membership.
    - Oregon health care providers (i.e., hospitals, midwives, pediatricians) will have an opportunity to provide feedback through the rulemaking process, including a public hearing and public comment period.

- **Tribal partners**: A Dear Tribal Leader Letter was sent through the Tribal Affairs Office in April 2022. Within the letter, Tribal partners were invited to self-select to participate on the RAC.
- **Community Partners and Parent Groups**: The NWRNBS Program reached out to five community-based organizations and parent groups to discuss the program's interaction with the organizations and invite them to provide feedback on the fee change.
- **Insurance Industry**: The NWRNBS Program invited four individuals representing the insurance industry to participate on the RAC; one invitee attended.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

No significant impact anticipated to the OHA Health Systems Division (HSD) based on this rule change. The reimbursement rates paid by HSD and CCOs are defined in HSD rulemaking processes. The cost of NBS is a component of the total cost of labor and delivery.

A small impact could be anticipated on units of local government or Tribal agencies. Most babies who are seen at local health department clinics for the first well-baby check undergo collection of the second screen using the collection kit that has already been purchased by the birth facility or parent. However, units of local government or Tribal agencies caring for infants at the first well-baby check may need to purchase a small number of single-specimen collection kits when the second part of the kit is not available.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

The program generally assumes that current operational conditions will continue, including staffing levels, clientele, lab facility costs, and vendor contracts. The current Oregon birth rate is projected to hold steady. Personal services projections assume that all positions are filled.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No new responsibilities are anticipated, other than the typical needs associated with two new positions. The program plans to start work on a large-scale software package replacement in the 2023-25 biennium, but it is not anticipated to move from the planning stage to the implementation stage (which will likely require expanded OIS involvement) until a future biennium.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This package includes position authority for one Principal Executive Manager E (PEM-E) and one Operations and Policy Analyst 3 (OPA3) to support the enhancements planned and described in this narrative. Both positions are budgeted as management service (not represented by a union). The program does not anticipate a need to modify existing positions.

16. What are the start-up and one-time costs?

In the short term, startup costs funded by this policy package are limited due to other funding sources available to the program, including General Fund for Spinal Muscular Atrophy testing provided in House Bill 3107 (2021) and modernization funding available to the Public Health Lab in the 2021-23 biennium. There are more startup/one-time costs anticipated over the next few years; notably, there are $500,000 in consulting costs related to planning for the anticipated Laboratory Information Management System (LIMS). There is also $120,000 budgeted to reconfigure the room where tandem mass-spectrometry is performed due to changing requirements for updated instruments and another $100,000 to develop a robust continuity of operation plan to ensure that testing can continue even if the Lab is affected by supply chain issues or other externalities.

17. What are the ongoing costs?

The revenue generated by the policy package would allow the program to continue providing expanded services that they have recently implemented or will soon be implementing as part of improved screening practices and/or Modernization initiatives. These new services are intended to enhance health outcomes and include screening for new disorders, courier specimen transport, and

outreach to community-based organizations that can help educate parents and health care staff about disorders that may predominantly affect a particular race such as sickle cell disease.

18. What are the potential savings?

None.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent Other Funds, as the program is fee-based.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$389,688		$389,688	2	1.50
Services & Supplies		$1,510,312		$1,510,312		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$1,900,000**	**$0**	**$1,900,000**	**2**	**1.50**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Center for Health Protection
Policy package title:	Oregon Psilocybin Services: The Nation's First Regulatory Framework for Psilocybin
Policy package number:	449
Related legislation:	Ballot Measure 109

Summary statement:

This policy package provides Other Funds limitation for implementation of the Oregon Psilocybin Services Act by the Oregon Psilocybin Services (OPS) section at the Oregon Health Authority. In accordance with ORS 475A, OPS began accepting license applications on January 2, 2023 and will review applications, conduct site inspections, and issue licenses for applicants that meet requirements. Because it will take some time for applicants to submit applications for OPS review, OPS does not expect that licensing fee revenue will cover costs for the 2023-25 biennium. As the first state in the nation to implement a regulatory framework for the provision of psilocybin services, it is critical for OPS to create a safe, equitable, and accessible program for Oregonians while setting a precedent for the nation.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$6,587,395**	**$0**	**$6,587,395**	**22**	**22.00**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Oregon Psilocybin Services (OPS) received General Fund for start-up costs and staff positions for the 2021-23 biennium to begin implementation of Ballot Measure 109 (M109), the Oregon Psilocybin Services Act, which was passed in 2020 and is now codified in ORS 475A. OPS will begin receiving Other Funds revenue from licensing fees after January 2, 2023, when OHA begins accepting applications to license psilocybin manufacturers, psilocybin testing labs, psilocybin service centers, and psilocybin facilitators. It may take many months into the 2023-25 biennium for OPS to begin receiving enough revenue from license fees to cover the costs of the section's work.

For the psilocybin framework created by M109 to roll out successfully in Oregon, OPS must have the ability to fully support equity goals by centering equity and community throughout the process. Under ORS 475A, a client 21 years of age or older may access psilocybin services. While no prescription or referral from a medical or clinical provider is necessary, a client will be required to complete a preparation session with a licensed facilitator before participating in an administration session. The client will only access psilocybin at a licensed service center during an administration session in the presence of a trained, licensed facilitator. Optional integration sessions will be made available to each client after an administration session, which will provide additional safety and support planning for clients as they are supported in the integration process, as well as referrals to peer support networks and community resources.

Although OPS has worked to prevent delays to begin accepting license applications by January 2, 2023 for licensure of manufacturers, testing labs, service centers, and facilitators, there are many factors that are outside of OPS' control. For example, psilocybin facilitator training programs may be subject to Higher Education Coordinating Commission (HECC) career training school licensure, which could cause delays for psilocybin facilitator training programs admitting students and training them in time for the January 2, 2023 date. In addition, local governments may adopt ordinances to prohibit licensed manufacturers and service centers from operating in their local jurisdictions, which may cause further delays as those interested in setting up service centers or manufacturer sites navigate these ordinances, as well as possible land use and zoning changes, before investing in property and setting up businesses. For these reasons, OPS does not expect to have enough licensure fee revenue to cover the costs of the section's work until the end of the first year of the 2023-25 biennium. OPS will need any carryover funds from the 2021-23 biennium to help support the section's work.

2. What would this policy package buy and how and when would it be implemented?

This policy package provides Other Funds limitation for implementation of the Oregon Psilocybin Services Act by the Oregon Psilocybin Services (OPS) section at the Oregon Health Authority.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

Psilocybin has been used for centuries by various indigenous and Tribal communities for spiritual, ceremonial, healing, and other purposes throughout the world. Ensuring that OPS has the capacity to continue working with community partners, listening to community-based solutions, honoring indigenous and traditional knowledge, and working collaboratively to apply an equity lens in implementation will be critical to meeting the needs of communities across the state.
Research suggests that psilocybin can help address mental and behavioral health issues, including trauma, anxiety, depression, and addiction. The State Health Improvement Plan (SHIP), *Healthier Together Oregon 2020-2024*, identifies adversity, trauma and toxic stress, behavioral health, behavioral health, economic drivers of health, and access to equitable preventive health care as top priorities. Oregon Psilocybin Services has been working to implement ORS 475A by addressing the top priorities identified by community organizations in Healthier Together Oregon and also with OHA's strategic plan goal of eliminating health inequities by ensuring that psilocybin services become and remain a safe, equitable, and accessible option for achieving optimal health.

Because people of color can experience adversity, toxic stress, anxiety, and trauma due to racism, creating access to psilocybin services could have particular benefit for these communities, especially

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

when licensed facilitators are able to deliver psilocybin services in culturally responsive ways. To that end, facilitators will be required to complete training in health equity, history of indigenous use, cultural equity, racial justice, intergenerational trauma, and implicit bias. These training requirements are designed to ensure that culturally appropriate psilocybin facilitation is available to people of color in Oregon. OPS will provide appropriate technical assistance to training programs and our regulated community to maximize positive health impacts, particularly among Black, Indigenous, people of color, and Tribal members.

OPS has engaged with priority communities identified in the SHIP throughout the development period. OPS has incorporated meaningful ways for community members to share feedback and suggestions, with an emphasis on engaging with historically under-represented communities. Part of this work includes re-building trust with communities that have not always been well-served by government systems.
Oregon Psilocybin Services also creates new economic and business opportunities in Oregon. Successful implementation will help to decrease barriers for license applicants, especially for those in communities that are disproportionality affected by health inequities. This includes creating pathways for practitioners of diverse backgrounds who can support the health of their communities through facilitating psilocybin services in culturally grounded ways. This part of the work connects to the SHIP priority of addressing economic drivers of health.

Quantifying results

4. What are the long-term desired outcomes?

OPS is committed to creating safe, effective, and equitable psilocybin services in Oregon. OPS is also committed to centering equity and working toward the agency's strategic plan goal of eliminating health inequities by 2030. To do this, OPS will work closely with internal and external partners to ensure that psilocybin services become and remain a safe and accessible option for healing and wellness.

Research suggests that psilocybin may help reduce depression, anxiety (including end of life anxiety), problematic alcohol and tobacco use, and trauma-related disorders (including PTSD and race-based trauma). Across studies, psilocybin has been found to increase spiritual well-being. Making psilocybin services available as an option to address these behavioral health challenges has the potential to have a long-lasting positive impact on the health of Oregonians. The Oregon Psilocybin Advisory Board Rapid Evidence Review and Recommendations[2], or Revisión rápida de evidencia y recomendaciones del Consejo Consultor sobre la Psilocibina de Oregon, findings show that psilocybin, the active ingredient in psychedelic mushrooms, holds promise as an option to address mental health issues, and may be efficacious in reducing problematic alcohol and tobacco use.

To provide safe, effective psilocybin services to those who are 21 years or older who may be interested and seeking relief from anxiety, trauma, depression, addiction, or other issues, OPS must

[2]https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/Documents/Psilocybin%20evidence%20report%20to%20OHA%206-30-21_Submitted.pdf?utm_medium=email&utm_source=govdelivery

respond to licensees in a timely manner and have the funding to conduct the section's work appropriately. In addition, many priority populations outlined in Healthier Together Oregon have interest in applying for licensure, so it is important that OPS is effective in development and efficient and responsive to our regulated community. For these and many other reasons, implementing a sustainable framework is a priority for OPS.

5. How will OHA measure the impacts on health inequities of this policy package?

In January 2022, OPS conducted a community interest survey to better understand interest in accessing psilocybin services, in licensure, and in training program approval. The survey was open for one month and made available in Spanish, Russian, Vietnamese, Simple Chinese/Mandarin, and Somali. There were over 4,400 survey respondents indicating a high level of interest in seeking services and licensure. OPS used an adapted version of REAL-D in consultation with staff at the Equity and Inclusion Division and published a summary of findings in February 2022. OPS expects to conduct other community interest surveys in the future and will continue to include demographic data that can help measure how well we are engaging with different communities across Oregon.

OPS is in the beginning stages of developing a section-wide evaluation plan and equity plan. Both plans will help to chart the course for how we measure impacts and may include qualitative feedback from our community partners, community listening sessions, focus groups, interviews, and surveys.

OPS will continue to apply a health equity lens as programs are implemented, being mindful to balance program sustainability with the need for equitable access to services. Each program will

start with and focus on health equity, including outreach to communities and providing clear, timely, and accessible information. As a new section and first in the nation to implement psilocybin services, the OPS team will be continuously learning in response to feedback and stories from the community.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

As discussed above, for the psilocybin framework created by M109 to roll out successfully in Oregon, OPS must have the ability to fully support equity goals by centering equity and community throughout the process.

In the fall of 2021, OPS recognized there were several risks for licensure delays if OPS was not ready to license each of the four license types on January 2, 2023 and prioritized several implementation actions. OPS worked with the Oregon Psilocybin Advisory Board, community members, and partners to ensure that board recommendations and public feedback were provided in time to draft rules for rulemaking early in 2022.

- To ensure that trained psilocybin facilitators would be ready to apply for licensure by January 2, 2023, psilocybin facilitator training programs would need OHA curriculum approval before admitting students, and students would need to complete training by the end of 2022. OPS expedited the training program rules to ensure that rules were adopted by May 20, 2022 to give training programs the ability to move forward.

- Similarly, to ensure that testing labs would be ready to apply for licensure by January 2, 2023, the Oregon Environmental Laboratory Accreditation Program (ORELAP) would have to adopt rules for accreditation and begin accepting applications to accredit testing labs by the fall of 2022. Again, OPS expedited a subset of the products and testing rules to ensure that rules were adopted by May 20, 2022 to give ORELAP the ability to move forward.

Although OPS has worked to prevent delays for the licensure of manufacturers, testing labs, service centers, and facilitators there are many factors that are outside of OPS's control. For example, psilocybin facilitator training programs may be subject to Higher Education Coordinating Commission (HECC) career training school licensure, which could cause delays for psilocybin facilitator training programs admitting students and training them in time for the January 2, 2023 date. In addition, local governments may adopt ordinances to prohibit licensed manufacturers and service centers from operating in their local jurisdictions, which may cause further delays as those interested in setting up service centers or manufacturer sites navigate these ordinances, as well as possible land use and zoning changes, before investing in property and setting up businesses. For these reasons, OPS does not expect to have enough revenue from licensure fee revenue to cover the costs of the section's work by the end of the first year of the 23-25 biennium. OPS will need any carryover funds from the 2021-23 biennium to help support the section's work.

7. What alternatives were considered and what were the reasons for rejecting them?

There were no other alternatives as M109 (ORS 475A) requires that OHA adopt rules by December 31, 2022 and begin accepting applications for licensure on January 2, 2023. OPS received General

Fund for 21-22 and 22-23, and while OPS has no control over the risk of delays that may affect licensure but are not related to the section's work, the section is working with partners to identify possible ways to overcome them.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   OPS is engaging with many community members and partners on the implementation of M109 (ORS 475A), including the Oregon Department of Justice, Oregon Department of Revenue, Oregon Department of Agriculture, Oregon Liquor and Cannabis Commission, Oregon State Treasury, Higher Education Coordinating Commission, Oregon Department of Administrative Services, Oregon Department of Education, Secretary of State Office of Small Business Development, Business Oregon, Oregon Health Authority inter-agency partners, Oregon's 9 Federally Recognized Tribes, Oregon's Professional Licensing Boards, Local Governments, Local Public Health Authorities, Law Enforcement, Advocacy Organizations, Academic Institutions, Professional Associations, Psilocybin and Psychedelic Partners, Other states, Community Based Organizations, the Oregon Psilocybin Advisory Board and subcommittees, and members of the public.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

There would be an impact to Oregon Department of Revenue (DOR) if Oregon Psilocybin Services experienced a budget shortfall and did not have the capacity to license service centers. DOR will be collecting a 15 percent tax on the sale of psilocybin products to clients by licensed service centers and have spent time preparing staff and processes for the collection of this tax.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): June 30, 2024

12. What assumptions affect the pricing of this policy package?

Assumptions include that the legislature doesn't significantly amend Measure 109 (ORS Ch. 475A) in the 2023 session in a manner that affects OPS's ability to accept and assess application fees to cover program expenditures.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There would be no new responsibilities.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

If OPS experiences a budget shortfall and is unable to implement ORS 475A, there are many communities and members of the public that will not have access to psilocybin services. According to the results of the OPS Community Interest Survey Findings, out of **4,421** respondents, **94 percent** were interested in accessing services. In addition, **660** respondents were interested in applying for training program approval, **1,613** were interested in facilitator licensure, **982** were interested in manufacturer licensure, **903** were interested in service center licensure, and **226** were interested in testing lab licensure.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

There would be no new positions needed to implement this package.

16. What are the start-up and one-time costs?

OHA will continue to monitor expenses and expects costs will be covered by 100 percent Other Funds fee revenue toward the end of the 2023-25 biennium.

17. What are the ongoing costs?

OPS has been working to better understand the number of licensees it should expect to license and regulate beginning January 2, 2023 through the OPS Community Interest Survey, as well as working with partners. Because rules were adopted by the end of the development period in December of 2022, future regulated community members may not be ready to establish their businesses and apply for licensure until late in 2023 or early 2024. OPS does not expect to have enough licensure fee revenue to cover the costs of the section's work until the end of the first year of the 2023-25 biennium. OPS will need any carryover funds from the 2021-23 biennium to help support the section's work.

18. What are the potential savings?

These are unknown at this time, although OPS expects that the health impacts of psilocybin services in Oregon may have reductions in health care costs over time.

19. What are the sources of funding and the funding split for each one?

This policy package includes 100 percent Other Funds limitation for the first year of the 2023-25 biennium.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$4,699,781		$4,699,781	22	22.00

Services & Supplies		$1,887,614		$1,887,614		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$6,587,395**	**$0**	**$6,587,395**	**22**	**22.00**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Systems Division
Program:	Medicaid
Policy package title:	Medicaid Waiver Placeholder
Policy package number:	201
Related legislation:	Legislative concept #475

Summary statement:

This policy package would enable the Oregon Health Authority (OHA) to execute and implement the policy and program changes outlined in 1115 Medicaid demonstration waiver and approved by the Centers for Medicare & Medicaid Services (CMS).

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
ODHS	**$4,479,037**	**$0**	**$6,810,361**	**$11,289,398**	**55**	**34.65**
OHA	**$128,791,740**	**$2,640,614**	**$847,138,412**	**$978,570,766**	**131**	**104.68**
Policy package pricing:	**$133,270,777**	**$2,640,614**	**$853,948,773**	**$989,860,164**	**186**	**139.33**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs. Generally, section 1115 demonstrations are approved for an initial five-year period and can be extended for up to an additional 3 to 5 years, depending on the populations served. Oregon's Medicaid program has operated on an 1115 waiver since 1994. The 1115 waiver has been renewed many times since then with components designed to advance Oregon's health system transformation goals and improve the health of communities and populations served through the demonstration.

Oregon recently received Centers for Medicare and Medicaid Services (CMS) approval for the 2022-2027 1115 Medicaid Demonstration Waiver. Activated on October 1, 2022 and set to expire September 30, 2027, the approved waiver provides an opportunity for the Oregon Health Authority (OHA) to build on a strong foundation of successful innovation as well as address system vulnerabilities and health inequities underscored and exacerbated by the COVID-19 pandemic. Through the demonstration, Oregon will address many of the complex challenges facing many of Oregon's underserved residents, including individuals experiencing major life transitions such as youth aging out of foster care, youth with complex medical and behavioral health needs approaching adulthood, individuals experiencing or at risk of homelessness, individuals of all ages involved with the justice system, individuals at risk for climate-related events, and adults transitioning to dual Medicaid-Medicare enrollment. Under the demonstration, CMS approved initiatives related to continuous eligibility, coverage expansion, and health-related social needs (HRSN) with an emphasis on improving the health and well-being of Oregon's children and youth.

Oregon Health Plan (OHP) members and community partners have consistently reported the need for OHA to address health inequities both in the health system and in the communities where members live and work. Eliminating health inequities by 2030 is OHA's strategic goal. Oregon's 2022-2027 1115 Medicaid Demonstration Waiver focuses on these main goals aimed at eliminating health inequities by 2030:

- Continuous enrollment to increase access to care and to promote better health
- Coverage of new health-related social needs benefits (housing and nutrition supports, and supports for extreme climate events) for certain members facing complex challenges
- Enhanced coverage of and access to services for youth with complex medical and behavioral health needs
- Additional federal support for these initiatives through Designated State Health Programs.

The approved 1115 waiver demonstration and associated policy package will allow the state to meaningfully improve health outcomes in communities who face historic and contemporary injustices.

2. What would this policy package buy and how and when would it be implemented?

The demonstration renewal will continue covering the 1.4 million people in Oregon currently receiving benefits through the Oregon Health Plan (OHP). This proposed demonstration was developed in direct response to the community feedback collected through strategic planning processes and waiver engagement and continues building on the existing foundation of OHP to address health equity more intentionally.

Focusing this waiver renewal application on meaningful progress toward health equity, along with clear alignment with other health policy initiatives in Oregon, allows OHA to improve health outcomes in communities most harmed by social injustices. To carry out this vision OHA is seeking to:

- Maximize continuous and equitable access to coverage
- Expand Medicaid eligibility and benefits for "youth with special health care needs" (YSHCN) up to age 26 with income levels up to 300 percent of the federal poverty level (FPL).
- Streamline transitions between systems and improve health equity through defined benefit packages of health related social needs services for certain members facing complex challenges

The approved waiver provisions require a significant legislative concept and policy package in alignment with the policy and program changes outlined in the waiver, as well as operational resources, including appropriate number of staff, necessary to design and implement the transformational provisions authorized in the demonstration. Per the waiver approval, OHA has ten months after approval to complete implementation planning though some changes may go into effect sooner. Any resulting changes to coordinated care organization (CCO) contracts will occur through regular annual reinstatement or at 5-year contract procurement, as appropriate. This policy package would enable the OHA to execute and implement the policy and program changes outlined in 1115 Medicaid demonstration waiver and approved by the CMS.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

A 2018 independent evaluation of CCOs under Oregon's 1115(a) demonstration found that under CCOs, patient-reported health status improved, quality had improved where CCOs were paid for performance, cost growth was slowed, and access and patient satisfaction were maintained.

[1] Evaluation of Oregon's 2012-2017 Medicaid Waiver; OHSU Center for Health Systems Effectiveness, Dec. 29, 2017.

However, the data also show there is more work to do. Specifically, Oregon must better address the health inequities disproportionately impacting communities of color. The facts and need are stark. In Oregon:

- American Indians and Alaska Natives and non-Latino/a/x African Americans are more than twice as likely to die from diabetes as non-Latino/a/x whites.[2]
- Latino/a/x Oregonians comprise only 12% of the population but represent more than 18% of COVID-19 cases, and Black Oregonians are 3.1 times more likely to have a COVID-19 associated hospitalization than their white counterparts.[3]
- Non-Latino/a/x African Americans have nearly twice the rate of avoidable deaths from heart disease, stroke, and high blood pressure as non-Latino/a/x whites.[1]
- American Indians and Alaska Natives have a much higher death rate from chronic liver disease than any other group.[1]

OHP members and community partners have regularly voiced the need for OHA to address health inequities both in the health system and in the communities where members live and work. The COVID-19 pandemic brought this need into sharp relief as communities most harmed by social injustices were, and still are, disproportionately harmed by the disease. These communities consistently report that lack of access to care and health resources was and is at the center of their struggle to stay safe and healthy.

[2] Oregon's State Health Assessment, 2018: https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf
[3] OHA COVID-19 Weekly Report, Sep. 29, 2021. https://www.oregon.gov/oha/covid19/Documents/DataReports/Weekly-Data-COVID-19-Report.pdf

OHA has established a strategic goal to eliminate health inequities by 2030. Given the facts cited above, along with myriad other examples of health inequities permeating the health care system, Oregon's 1115 demonstration waiver renewal is focused on pushing Oregon's Medicaid system to address health equity directly and systematically.

OHA's renewed 1115 waiver renewal will provide:

- **Continuous Coverage:** With this approval, the state can provide continuous eligibility for children from the time of initial eligibility determination until they reach age six. The state may also provide continuous two-year eligibility for children and adults ages six and older, regardless of changes in circumstances that would otherwise cause a loss of eligibility. This continuous eligibility supports consistent coverage and continuity of care by keeping beneficiaries enrolled for 24 months or longer, regardless of income fluctuations or other changes that otherwise would affect eligibility (except for death or ceasing to be a resident of the state). Continuous eligibility policy is likely to minimize coverage gaps and to help maintain continuity of access to care. Continuous coverage is also an important aspect of reducing the rate of uninsured and underinsured individuals.

- **Expanded Medicaid Eligibility for Youth with Special Health Care Needs:** This demonstration allows Oregon to expand Medicaid eligibility and benefits for "youth with special health care needs" (YSHCN) up to the age of 26 with income levels up to 300 percent of the federal poverty level (FPL). This approval will provide these youth and young adults with time to better navigate transitions to Oregon's adult benefit package with fewer disruptions in coverage, while maintaining access to Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefits, increasing the likelihood that these youth will maintain access to the care they need as they enter adulthood.

- **Coverage of new health-related social needs benefits (housing and nutrition supports, and supports for extreme climate events) for certain members facing complex challenges and major life transitions**
  Data show members of high-risk populations often lose coverage and access to care during life transitions and in transitions between systems such as incarceration or admittance to the state hospital. These disruptions come at great cost to the individual and to the system.

  Health-related Social Needs: Oregon's waiver allows the state to provide or increase coverage of certain services that address certain health-related social needs (HRSN). CMS authorized increased coverage of certain services that address HRSN, as evidence indicates that these HRSN are a critical driver of an individual's access to health services that help to keep them well. These services include critical nutritional services and nutrition education, as well as transitional housing supports. This is ground-breaking authority and the first time HRSN have been approved as a Medicaid benefit. In Oregon, HRSN services will be provided for individuals experiencing life transitions, including individuals who are homeless or at risk of homelessness, individuals transitioning from Medicaid-only coverage to dual Medicaid-Medicare coverage, youth with special health care needs transitioning to adulthood, youth who are involved with the child welfare system, adults and youth released from incarceration or discharged from an Institution for Mental Diseases (IMD).

  The HRSN services approved for Oregon's demonstration include short-term post-transition housing for up to six months, housing supports, nutrition education, and medically-tailored food assistance. Providing these services is likely to directly improve health outcomes as well as improve use of other clinical services. For example, individuals with poor health who also experience housing insecurity are likely to frequently use the emergency department for their care. By providing defined benefit packages to members in transition, OHA can ensure these

Oregonians stay covered, have important social determinants of health needs met and maintain access to care and medicine, which ultimately improves health outcomes.
Coverage of HRSN during climate emergencies: The demonstration also allows for coverage of devices to maintain healthy temperatures and clean air during climate emergencies. Individuals with a high-risk clinical need who reside in a region that is experiencing extreme weather events that place the health and safety of residents in jeopardy as declared by the federal government or the Governor of Oregon will be eligible for these supports.

Additional Federal Funding through DSHP With this OHP demonstration, CMS has approved authority for Designated State Health Programs (DSHP – pronounced “DISH- PEA”) to enable the state to implement new innovative initiatives. CMS approved $268 million DSHP federal buy out for the five years of the demonstration. The buy-out allows federal matching funds for a state-funded Designated State Health Program that “free up” state funding to support new Medicaid coverage and HRSN services and related infrastructure investments. The “freed up” state funding will result in $1.2 billion across the demonstration, which includes a state contribution of $88 million during the last year of the demonstration. Therefore, the total in new federal funds are $1.1 billion for the demonstration.

These policy changes will deliver changes to OHP that address the same goals as the original 1994 waiver and subsequent renewals. Oregon is responding to and addressing the lessons learned over the past 10 years — particularly those raised directly by community partners, OHP members and Tribal partners — and those highlighted by the disparate impacts of COVID-19.

Quantifying results

4. What are the long-term desired outcomes?

The long-term desired outcome is to improve health outcomes in communities most harmed by social injustices in alignment with achieving OHA's goal of eliminating health inequities by 2030. The key goals to address drivers of health inequities include:

- Maximize continuous and equitable access to coverage
- Streamline transitions between systems and improve health equity through defined benefit packages of health-related social needs services for certain members facing complex challenges
- Expand Medicaid eligibility and benefits for "youth with special health care needs" (YSHCN) up to the age of 26 with income levels up to 300 percent of the federal poverty level (FPL).

OHA heard from community that if those goals are achieved the system will look like:

Maximizing continuous and equitable access to coverage	Enrolling a higher percentage of folks who are eligible
	Reducing churn and providing better continuity of coverage
	Reducing/eliminating the inequity in the uninsured rate
Improving health outcomes by streamlining life and coverage transitions	No language, cultural, or economic barriers to care
	Enrollment is preserved in OHP as patients transition between systems
	People experience streamlined, coordinated, and integrated care across health and social systems
	Easier to access and have Medicaid cover housing supports, social supports, and pre-treatment services

Expand Medicaid eligibility and benefits for "youth with special health care needs"	Maintain access to the care they need as they enter adulthood up to the age of 26
	Retain access to the care they need up to 300 percent of the federal poverty level (FPL).
	Reducing churn and providing better continuity of coverage
	Youth with special health care needs experience streamlined, coordinated, and integrated care across health and social systems

5. How will OHA measure the impacts on health inequities of this policy package?

As required by CMS, once the waiver renewal is in place, OHA will conduct a formal evaluation of the 1115 waiver's impacts and progress toward meeting goals and milestones. The evaluation will focus on two of the main components of the demonstration waiver:

1. Continuous eligibility, which is a proposal to reduce the unnecessary cycling of members on and off Medicaid by extending continuous eligibility (CE) to any child on Medicaid up to age 6, and CE for two years to any person aged 6 and older. This evaluation will focus on the costs and outcomes of this policy change, and will use existing qualitative data, as well as collect quantitative data among members affected by the change.
2. Health Related social needs services, which are packages of services that will be available to people transitioning out of certain populations or settings (justice-involved, Youth with Special Health Care Needs, psychiatric residential mental health facilities), and to people who are homeless or at-risk, who are dually eligible, who are vulnerable to extreme climate events, or who are child welfare involved. This formal evaluation focuses on outcome measures (for example,

impact to Medicaid members), and process measures (for example, improvements in system efficiency).

Reporting metrics will be developed that cover beneficiaries' enrollment and renewal, access to providers, utilization of services, and quality of care and health outcomes. These metrics must be reported for all populations and must also be stratified by key demographic subpopulations, including sex, race, ethnicity, age, primary language, disability status, and geography.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Many of the policy proposals in the 1115 waiver have been of interest to OHA, Tribal partners, and community members for years. However, OHA and partners analyzed the options proposed and determined that action could not be taken without an 1115 waiver, which allows for the waiver of certain federal regulations. The 1115 waiver is only renewed and negotiated every 5 years, and amendments are difficult. As such, action through the 1115 waiver was determined necessary to pursue these changes.

OHA was successful in gaining additional Federal Funding through Designated State Health Programs (DSHP) with this demonstration. CMS has approved authority for (DSHP) to enable the state to implement new innovative initiatives. CMS approved $268 million DSHP federal buy out for the five years of the demonstration. The buy-out allows federal matching funds for a state-funded Designated State Health Program that "free up" state funding to support new Medicaid coverage and HRSN services and related infrastructure investments. The "freed up" state funding will result in $1.2 billion across the demonstration, which includes a state contribution of $88 million during the last

year of the demonstration. Therefore, the total in new federal funds are $1.1 billion for the demonstration.

7. What alternatives were considered and what were the reasons for rejecting them?

Not leveraging this opportunity provided through the 1115 waiver would significantly impede advancement towards achieving OHA's 2030 goal of eliminating health inequities, and current inequities would continue unresolved. Furthermore, not moving forward with the policy package could greatly hinder OHA's ability to successfully implement provisions of the waiver, as well as cause compliance issues that could result in:

- CMS either withholding funding or requiring payback of previously provided funding
- Legal challenges from various populations not being served as federally required
- Political issues and loss of community trust if OHA receives federal DSHP funds to support specific new policies and programs and does not make corresponding system changes to operationalize those programs

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

The renewed waiver responds to the community feedback OHA has received over the past five years and builds on the existing foundation of OHP to address health equity more intentionally, while aligning with the priorities of Oregon's nine Federally Recognized Tribes[4] and the Urban Indian Health Program[5].

[4] https://www.oregon.gov/lcd/Commission/Documents/2021-09_Item-2_Directors-Report_Attachment-A_DEI-Action-Plan.pdf
[5] https://www.ihs.gov/urban/

In addition to extensive public and community input, staff reviewed the following existing strategic plans during the waiver development process:

- 2020 OHA Ombuds Program Report
- CCO 2.0 Community Engagement Report
- Oregon Health Policy Board (OHPB) 2021 Health Equity Recommendations
- OHA 2019 Strategic Plan for Community Engagement
- OHA 2019 Tribal Strategic Plan for Community Engagement
- State Health Improvement Plan
- COVID-19 Listening Sessions materials

Community partnerships

OHA held multiple information sessions in English and Spanish through the Community Partner Outreach Program (CPOP), OHPB, the Medicaid Advisory Committee (MAC), and the Health Equity Committee (HEC). All these forums welcomed public comments on the waiver. Further, the state held its official public comment period from December 7, 2021 to January 7, 2022. This included seven public meetings with opportunity for public comment, and people could also submit comment via survey, mail, or email. During state public comment, OHA heard from nearly 200 unique commenters on a variety of policy topics, and the following policy changes were made to the waiver application because of these comments:

- The waiver of the Early and Periodic Diagnostic and Treatment (EPSDT) benefit for children was removed from the application.[6]
- The waiver of retroactive eligibility was removed from the application.

[6] The Governor's Budget funds this policy change in policy package #414.

- OHA clarified the request for House Bill 3353 (2021) expenditures to count as medical for purposes of rate setting. This request in the application was previously combined with other health-related services requests for rates and was separated out onto its own line for clarity.
- OHA added broadband services to transitions related to extreme climate events.
- OHA changed the number of upstream metrics proposed for its Quality Incentive Program from 3–5 to up to 6.

Partnership with the nine federally recognized Tribes and UIHP

In accordance with CMS requirements and OHA's Tribal Consultation and Urban Indian Health Program (UIHP) Confer Policy, OHA distributed a Dear Tribal Leader Letter, which included an invitation for consultation, on November 29, 2021, to each of Oregon's nine federally recognized Tribes and the UIHP. The 1115 Medicaid Waiver Tribal Consultation occurred via videoconference on December 14, 2021, which was no fewer than sixty days before submission of the final Waiver language to CMS on February 15, 2022.

In addition to meeting the requirements for Tribal Consultation, OHA partnered with the Nine Federally Recognized Tribes so that they were involved in and informed of the ongoing development of the state's 2022-2027 1115 Waiver Application. This included regular updates at Tribal Monthly Meetings and Senate Bill 770 (2001) Health and Human Services Cluster Meetings, drafting a Tribal Concept Paper based on known concerns raised previously by the Nine Federally Recognized Tribes, and working with the Nine Federally Recognized Tribes to develop this concept paper before inclusion in the application. Further, OHA met with the Nine Federally Recognized Tribes in a series of meetings to further develop the policies proposed in the Tribal Concept Paper after waiver submission in preparation for conversations with CMS, to ensure all materials and responses reflected the intent of the nine federally recognized Tribes. OHA continues to update the Nine Federally Recognized Tribes and UIHP about the 1115 waiver at Tribal Monthly Meetings, Senate

Bill 770 HHS Cluster Meetings, and via email as appropriate. OHA staff are working to ensure that appropriate consultation happens with the Nine Federally Recognized Tribes and UIHP as policies move toward implementation.

Coordinated care organizations (CCOs)

In addition to receiving public comment from CCOs at public meetings and through state and federal comment, OHA has provided regular waiver updates to CCOs at the OHA CCO Leadership Policy and Strategy and CCO Operations meetings. Additionally, OHA has regularly met with a subset of CCO CEOs to provide waiver negotiation updates and receive feedback. OHA has had additional meetings at the request of CCOs or those who represent them, including Coalition for a Healthy Oregon (COHO) and CCO Oregon. OHA also has met with Health Share of Oregon, whose pilot program around housing has informed Oregon's SDOH transitions support work.

Regional health equity coalitions (RHECs)

The proposal for Community Investment Collaboratives (CICs) was co-created with Oregon Regional Health Equity Coalitions (RHECs) through a unique community-driven process. In 2021, RHECs came to OHA with a proposal for the 1115(a) demonstration waiver renewal and worked closely with the Legislature to inform the design of House Bill 3353. Subsequently, OHA and RHEC leadership worked together to build out the intent of House Bill 3353 and increase accountability to community by emphasizing communities' role in identifying inequities and making investment decisions to address inequities. The OHA/RHEC workgroup met 12 times between May and July 2021 to develop strategies to develop a model for shifting power and resources to community. Recognizing that the process can be as important as the outcome, the work involved relationship and trust building, particularly to build increased trust between community organizations and government, naming some of the values held in conducting work together through developing group agreements, sharing needs

to successfully accomplish the work together, clarifying roles and scope of work, and agreeing on guiding principles to ensure the model was designed to achieve health equity goals, including investment in racial, cultural, and underserved communities. The OHA/RHEC workgroup has continued to meet through 2021 and 2022 to continue development of this proposal through negotiations with CMS.

Partnerships with other state agencies

OHA has worked with several other state agencies to ensure success of the 1115 waiver demonstration, including the Oregon Department of Human Services (ODHS), Oregon Department of Corrections (ODOC), and Oregon Housing and Community Services (OHCS). ODHS has been involved in informing the work for youth with special health care needs and the SDOH transition supports, as well as informing any needed changes to the ONE system. OHCS has been consulted on housing policy. ODOC has been consulted on providing eligibility and benefits for those in state prisons.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

OHA submitted a legislative concept placeholder (LC 44300-010), because the precise outcomes of the negotiations with CMS are uncertain. Currently, the placeholder includes:

- Consistent with OHA's health equity goal and the policy concept outlined in the waiver application, language is needed to revamp the CCO Quality Incentive Program to equitably redistribute power. A new Health Equity Quality Metrics Committee (HEQMC) — composed of Oregon Health Plan (OHP) members, community members from diverse communities, individuals with lived experience of health inequities, health equity professionals and

researchers, and a representative of the Behavioral Health Committee — will lead the CCO Quality Incentive Program.
    - ORS 413.017
- Under its 1115 demonstration, Oregon is proposing to use funds freed up through designated state health programs (DSHPs) to fund bundles of services addressing social determinants of health (SDOH) for populations undergoing a transition (for example, a transition between systems or a life transition). Funds for SDOH service packages would flow through CCOs via a non-risk contract in the first three years of implementation and would be incorporated into CCO capitation in later years. OHA requires statutory authority/allowances for OHA to issue non-risk payments.
    - ORS 414.570 and potentially 414.025 (Definitions for ORS chapters 411, 413 and 414).

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The HRSN services package mentioned above would impact counties and their jails, because as part of the 1115 demonstration renewal request, Oregon is seeking to cover adults and youth transitioning out of the criminal justice system. This would include adults in custody (pre- and post-adjudication) of county jails or local correction facilities – this is still under negotiation with CMS.

<u>The Nine Federally-Recognized Tribes</u>
Formal consultation and ongoing engagement with the nine federally recognized Tribes and UIHP is explained above. The proposed policies in the Tribal Concept Paper are based on requests of the Nine Federally Recognized Tribes and would have significant impact in reducing health inequities for Tribal members and is still under negotiations with CMS .

See question #8 for more details on the impacts to state agencies.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): October 1, 2022

End date (if applicable): September 30,2027

12. What assumptions affect the pricing of this policy package?

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Oregon received new authorities never approved by CMS and not granted to other states. There is significant work to develop the provider capacity to deliver these new services involving significant work for the Health Systems Division responsible for administering the state's Medicaid program.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

To be determined..

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Positions needed are based on what CMS has approved. OHA currently roughly anticipates needing 131 new full-time positions to implement waiver policies currently in negotiation with CMS.

16. What are the start-up and one-time costs?

To be determined based on the outcomes of negotiations with CMS.

17. What are the ongoing costs?

Component	Budget Area	GF	OF	FF	TF	POS	FTE
Ages 6+ two-year continuous enrollment	Program	$ 25,497,129	$ 2,567,406	$ 171,057,337	$ 199,121,872		
Up to age 6 continuous enrollment	Program	$ 39,481,464	$ -	$ 72,096,000	$ 111,577,464		
ACA 2.6% FMAP Adjustment	Program	$ 34,350,913	$ -	$ (34,350,913)	$ -		
Tribal	Program	$ 725,695		$ 23,178,725	$ 23,904,420		
Justice Involved	Program	$ 10,440,103	$ -	$ 45,253,050	$ 55,693,153		
DSHP	Program	$ -	$ -	$ 547,000,000	$ 547,000,000		
Position and Operations Cost	Admin	$ 12,650,613	$ 73,208	$ 12,221,411	$ 24,945,232	109	87.14
Information Systems	Admin	$ 5,645,823	$ -	$ 10,682,802	$ 16,328,625	22	17.54

18. What are the potential savings?

- The HRSN services approved in the waiver can be expected to help stabilize the housing and nutritional circumstances of certain Medicaid enrollees and thus ensure that they will keep receiving and benefiting from physical, oral and behavioral health services. This leads to better care, improved health, and lower costs overall.
- HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional

medical services. For example, individuals with poor health who also experience housing insecurity are likely to frequently use the emergency department for their care. By providing the short-term services needed to stabilize their housing, this demonstration will test whether the individual's health outcomes and their utilization of appropriate care will improve.

- The continuous eligibility policy is likely to assist in promoting the objectives of Medicaid as it is expected to minimize coverage gaps and to help maintain continuity of access to program benefits for the populations of focus, and thereby help improve health outcomes of beneficiaries.
- Hiring agency staff as a strategy to achieve the resources needed to complete waiver implementation work will result in overall savings; an alternative is to utilize contractors, which would result in higher costs to complete necessary work.

OHA may realize long-term savings in OHP expenditures due to more cost-effective, high-quality care being delivered to OHP members. To the extent savings occur, they will be reflected in subsequent years' CCO rates, which are based on past expenditures, and incorporated into OHA's budget as part of the capitation rates for CCO-enrolled OHP members.

19. What are the sources of funding and the funding split for each one?

Direct Service Payments:

- Funded with Medicaid matched with State Funds
- Funded with DHSP

Positions:

- Most of the positions will be funded with an allocation of state funds and Medicaid and CHIP Federal Funds.
- Positions not eligible for Federal Funds will be paid entirely with state funds.
- Support staff will be allocated over multiple funding sources through cost allocation.

Contracts:

- Most of the contracts will be funded with state funds matched with Medicaid Federal Funds.
- Contracts not eligible for Federal Funds with be paid entirely with state funds.

Total OHA funding for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$11,446,196	$66,305	$12,479,821	$23,992,322		
Services & Supplies	$6,850,240	$6,903	$10,424,392	$17,281,535		
Capital Outlay						
Special Payments	$110,495,304	$2,567,406	$824,234,199	$937,296,909		
Other						
Total	**$128,791,740**	**$2,640,614**	**$847,138,412**	**$978,570,766**	**131**	**104.68**

Oregon Health Authority
2023-25 Policy Package

Division(s):	Health Policy & Analytics
Program(s):	Health Insurance Marketplace
Policy package title:	Basic Health Program
Policy package number:	202
Related legislation:	House Bill 4035 (2022)

Summary statement:

During the pandemic, federal rules led to hundreds of thousands of additional Oregonians receiving health care through the Oregon Health Plan (OHP). In 2022, the Legislature passed House Bill 4035 to fund the federally mandated redetermination process. HB 4035 authorized Oregon to temporarily expand Medicaid up to 200% of the federal poverty level (FPL) while the state develops a permanent coverage solution in the form of a Basic Health Program (BHP) for adults with income 138-200% FPL.

This policy package continues funding for policy development work related to the design of the BHP. It does not continue the funding initially provided in HB 4035 to support the redeterminations process set to begin April 1, 2023, or to temporarily expand Medicaid during redeterminations. It also does not provide the resources necessary to implement the BHP.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$3,000,000**	**$0**	**$0**	**$3,000,000**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

About one in three people in Oregon rely on the Oregon Health Plan (OHP) for their health care coverage. People with coverage are more likely to receive preventive care and to seek care quickly when they are sick, both of which help avoid or minimize many serious health conditions. Losing that coverage contributes to poorer health and health inequities, from short-term acute health problems as well as long-term chronic ones, and to higher expenses for the individual and the entire health care system.

During the COVID-19 public health emergency (PHE), the federal government directed states not to terminate Medicaid members' coverage for the duration of the PHE. Largely as a result, OHP enrollment rose from about 1 million members to about 1.4 million. Oregon's overall uninsured rate fell from 6.0 percent to 4.6 percent, with the largest improvements among African Americans and other populations who have long experienced health inequities.

Congress passed an omnibus funding package in December 2022 that signaled the end of the continuous coverage requirements of the PHE. Starting April 1 2023, states are required to assess whether every individual enrolled in Medicaid is eligible, a process known as "redetermination." Current estimates are that anywhere from 90,000 to 300,000 current OHP members will be ineligible once the redeterminations process begins. This would erase the significant gains in coverage achieved during the PHE. Preventing the loss of health care access for many thousands of people in Oregon is a major priority for the Legislature and OHA.

Separately, before the pandemic, there was another challenging problem related to OHP enrollment that OHA had been working to address, known as “churn.” Churn is when a member cycles on and off OHP coverage due to short-term changes in their income, changing family circumstances, or the challenges of navigating the procedures for maintaining coverage. In 2019, one-third of “new” OHP members were returning after less than 12 months, and one-quarter after less than six months. This churn breaks the connections between the patient, their primary care provider, and other providers and community services assisting the patient, which disrupts or delays medical care—again contributing to poorer health and health inequities.

Churn also adds an expensive administrative burden on the state as people are enrolled, disenrolled, and enrolled again. For example, a 2015 cost analysis of national data (2005-2010) estimated that disenrolling and reenrolling one person in coverage within a year incurs administrative costs between $400 and $600, an amount which would likely be higher today.

One more related problem is the difficulty in accessing health care faced by people who earn a bit too much to qualify for OHP but not enough to afford quality private coverage. This population includes the “churn” population during those times when their income fluctuates above the OHP threshold. It is the population least likely to have employer-provided coverage. The Affordable Care Act (ACA) provides tax credits to help people with lower incomes purchase coverage through the Health Insurance Marketplace. However, this assistance does not cover the full cost for most people and is based on the price of a silver plan (the second-lowest level, below platinum and gold). Many people either end up with the lowest level of coverage (that is, bronze), which typically has the highest co-pays and deductibles and covers the fewest services, or they remain uninsured. Once again, poor or non-existent coverage contributes to poorer health and health inequities.

The Legislature has already taken initiative to address these interwoven challenges. House Bill 4035, passed in 2022, created a task force to develop a program to "provide affordable health insurance coverage and improve the continuity of coverage for individuals who regularly enroll and disenroll in the medical assistance program or other health care coverage due to frequent fluctuations in income." House Bill 4035 funded the initial costs for the redetermination work in the 2021-23 biennium, including planning and preparatory work needed before the PHE ends. It also funded temporary expansion of OHP for those found ineligible who cannot afford other coverage, to avoid them instantly losing coverage, and the development of a plan for a sustainable long-term solution to ensure lower income people in Oregon can access health care coverage, in the form of a Basic Health Program (BHP).

This policy package continues some of the work begun in House Bill 4035. It would allow for the agency to continue developing a Basic Health Program that will serve as a permanent coverage solution for adults 138-200% FPL. Additional funding will still be needed to support the redetermination process itself, and to temporarily expand OHP up to 200% FPL during that process.

The Legislature recognized that the end of the PHE brings with it much more than merely an obligation to conduct an enormous administrative redetermination process. It also brings a tremendous opportunity to maintain the gains in health care coverage, ensure coverage for even more people in Oregon, improve health outcomes, reduce health inequities, and save money in our health care system. Instead of falling back to pre-COVID levels of health care coverage, Oregon can increase the health and economic benefits associated with having stable access to health care.

2. What would this policy package buy and how and when would it be implemented

To partially realize the goal of the Legislature expressed in House Bill 4035, to develop a new health coverage option for adults with income from 138-200 percent of the Federal Poverty Level. This policy package funds policy development work in HPA to obtain federal approval for a Basic Health Program.

This policy package would enable OHA to fund policy and actuarial analysis required to inform the build of the BHP, make final determinations of caseloads and service levels, and identify and address potential impacts on the Health Insurance Marketplace. Current estimates are that about 102,000 people will ultimately enroll in the program, which will help Oregon retain coverage gains experienced during the PHE that have lowered the state's uninsured rate to an all-time low.

BHP implementation is planned for two phases. The first phase is for people currently on OHP who, through the redetermination process required when the PHE expires, are found not to be eligible to remain on OHP. The second phase is for people not currently in OHP, who are, at best, struggling to afford coverage on the Marketplace, and, at worst, simply uninsured. The first phase of implementation assumes that Oregon will implement a temporary Medicaid eligibility category to keep people in the 138-200 percent FPL range covered by OHP during the development of the BHP. However, this policy package does not include funding for this temporary Medicaid coverage.

As with OHP, the BHP would be provided through coordinated care organizations (CCOs), taking advantage of Oregon's experience with this innovative approach to Medicaid. Also, this way, if a person's income fluctuates around 138 percent of FPL, the CCO can administratively transition that person between OHP and BHP, while their actual health care remains seamless, maintaining

continuity of coverage and access to their health care network. As part of the BHP implementation, Oregon is seeking a waiver to expand Medicaid eligibility so that American Indian / Alaska Native (AI/AN) individuals in the BHP income range would be able to retain the ability to choose fee-for-service (Open Card) coverage instead of enrolling in a CCO.

This policy package does not include funding for implementation of a BHP itself. However, when the BHP is implemented it will not require significant, ongoing state funds. This is because federal funding is available for the BHP without state match requirements. Section 1331 of the ACA allows states to cover people with income under 200 percent FPL who would otherwise qualify for federal tax credits toward the purchase of private coverage through the Health Insurance Marketplace. To do this, states can receive a lump sum amount based on the tax credits enrollees in the state would have received and use those funds to provide health care coverage directly for those people. This approach allows states to design a more comprehensive and coordinated system for its residents, reduces costs, and avoids many difficulties associated with buying in the Marketplace. With the BHP, Oregon would be the third state to take advantage of this extraordinary opportunity to increase and improve health care coverage for its residents. The BHP is being designed to operate within the federal funding constraints so that, once implemented, it is nearly entirely supported by federal funds and requires only limited ongoing state funds.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

The populations who most often experience health inequities are the same populations who most often lack health care coverage. For example, the groups of people in Oregon who saw the greatest increase in coverage during the COVID-19 pandemic were, by race, African Americans and, by income, those between 138 percent and 200 percent of FPL. These same populations are most at risk of losing their coverage through redeterminations. Maintaining coverage would improve health equity in every aspect of their lives that can be positively affected through health care services, from preventive care to long-term chronic care to critical care that many people delay due to cost.

This policy package will put OHA in position to implement a BHP, if additional funding is secured, and build upon recent coverage gains and equity investments. However this policy package alone will not improve health equity because it does not provide resources to prevent coverage loss during redeterminations or to implement a BHP.

Quantifying results

4. What are the long-term desired outcomes?

The desired outcome of the BHP is that a higher percentage of people in Oregon have health care coverage, which in turn helps improve and eliminate inequities in health care access and health outcomes. Coverage should be more stable, with less “churn.” As a result, people should experience better health because they receive the care they need when they need it, and overall costs to individuals and the health care system should be lower than otherwise.

Because the BHP would be administered like OHP, the same or similar measures, such as CCO metrics, would be broadly applicable to track these outcomes. Thus, overall, a larger percentage of

Oregon's population should meet improved health metrics and outcomes as measured through CCO metrics.

5. How will OHA measure the impacts on health inequities of this policy package?

Because the BHP would align with OHP administration and benefits, impacts on health inequities regarding BHP members would be measurable in the same or similar ways as is done with OHP. The same improvements in collecting and analyzing REALD & SOGI data currently underway in the health care system would be broadly applicable to the program without creating new mechanisms.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

The pandemic and the impact it had on OHP enrollment have led to unprecedented circumstances. There simply is no prior experience with such a situation. Without a determined effort, increased health care coverage rates during the pandemic will be squandered, and the opportunity to increase coverage rates further will be lost.

In addition to this policy package, OHA is pursuing a new continuous coverage policy via the 1115 OHP Medicaid demonstration waiver renewal. This continuous coverage policy would allow OHP enrollees aged 0–6 to stay enrolled for 5 years at a time without needing to submit for redetermination and would allow for 2 years of continuous coverage for enrollees age 6 and older. As described earlier, many individuals churn on and off OHP due to income fluctuations and an administrative burden. The 1115 waiver continuous coverage policy addresses the administrative

burden element, but in addition, this policy package is needed to address the churn associated with fluctuations in income.

In passing House Bill 4035, the Legislature recognized the challenge and opportunity facing our state and directed OHA to develop a Basic Health Program. While this policy package would not enable OHA to implement a BHP in the 2023-25 biennium, it will enable further policy development towards the creation of a BHP when additional funding allows.

7. What alternatives were considered and what were the reasons for rejecting them?

The main alternative is to do nothing. After the federally mandated redetermination process ends, people whose income is between 138-200 percent FPL would be able to seek heath insurance coverage through the Health Insurance Marketplace. Based on pre-PHE experiences, a significant number of these individuals will not actually enroll in Marketplace coverage, but will instead end up uninsured and once again struggle to access affordable health care. The gains in health and health equity will fade away.

For those who do enroll in Marketplace coverage, federally-funded cost sharing reductions and tax credits will make this coverage free or close to free. However, for others, there will still be costs; these costs, though relatively low, may present a barrier to care, leading individuals to refrain from obtaining needed medication or care and ultimately leading to worse health outcomes and higher costs than under a BHP. Additionally, the provider networks used by commercial health plans do not mirror those used by OHP, which means that many people obtaining private coverage will not be able to continue to see their existing providers. Continuity of care will be disrupted, and some individuals may even stop seeking care without access to trusted providers, resulting in churn and correspondingly higher administrative costs for the state. Finally, families that obtain individual

commercial coverage may be faced with a situation that requires some individuals to obtain OHP and others to obtain health insurance. This may present logistical hurdles that are difficult for some to navigate, also resulting in a disruption of care and coverage.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   Development of the BHP is being informed by CMS and the task force established by House Bill 4035, which included leadership from OHA, the Division of Financial Regulation and the Oregon Department of Human Services. OHA has been meeting with CMS regularly since March 2022 to identify the best path forward for covering people in Oregon whose income hovers above Medicaid eligibility. The next steps involve the submission of a BHP blueprint, which will reflect the opinions and priorities identified by the task force.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   House Bill 4035 created a task force to “develop a proposal for a bridge program to provide affordable health insurance coverage and improve the continuity of coverage for individuals who regularly enroll and disenroll in the medical assistance program or other health care coverage due to frequent fluctuations in income.” OHA will work with the Legislature if statue changes are necessary to implement task force recommendations.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The Oregon Department of Human Services (ODHS) will be affected by the restarting of the annual redetermination process as a partner in the ONE system and call center. However, this policy package DOES NOT include funding for these elements as they relate to either the redeterminations process or the BHP, separate from any packages submitted by ODHS on other matters related to the ONE system and call center.

Although OHA is pursuing federal approval to use Medicaid to cover Tribal members who would be eligible for coverage under the BHP so as to enable a choice between fee-for-service through open card or CCOs, this policy package does not include funding for this coverage.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): July 1, 2024

12. What assumptions affect the pricing of this policy package?

The pricing of this policy package is based on current staffing and consultant agreements for the ongoing development of a Basic Health Program in Oregon. This policy package does not enable

OHA to launch a BHP in the 2023-25 biennium nor does it include funding for a temporary Medicaid expansion that is designed to keep members who will be covered by a Basic Health Program enrolled in OHP until the program is launched.

13. **Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.**

    As written this policy package does not create new responsibilities for OHA and/or Shared Services.

14. **Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.**

    This policy package does not fund increased caseload from the temporary Medicaid expansion nor does it enable the actual implementation of the BHP, therefore, there is no impact on caseload.

15. **Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.**

    This policy package includes funding for positions in HPA but does not include the position authority.

16. **What are the start-up and one-time costs?**

    This policy package is entirely one-time costs to support policy and programmatic development of the BHP.

17. **What are the ongoing costs?**

    This policy package does not provide ongoing costs to operate a Basic Health Program, nor does it fund ongoing costs associated with the redeterminations process.

18. What are the potential savings?

Because the policy package does not enable the implementation of a BHP, there are no potential savings.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies	$3,000,000			$3,000,000		
Capital Outlay						
Special Payments						
Other						
Total	**$3,000,000**	**$0**	**$0**	**$3,000,000**	**0**	**0.00**

Oregon Health Authority & Oregon Department of Human Services
2023-25 Policy Package

Division:	ODHS, OHA Health Systems Division
Program:	ODHS Oregon Eligibility Partnership, OHA HSD Business Information Systems
Policy package title:	Mainframe Migration Provider & Client Payment Systems
Policy package #:	203
Related legislation:	None

Summary statement:

Everyone deserves uninterrupted access to needed supports and to the income they earn at work. More than one million Oregonians count on the state's current mainframe platform to receive their benefit and provider payments. The COBOL programming code on the mainframe system dates to the 1970s and is increasingly unsupported. Mainframe-proficient staff are shrinking in number and hard to replace, resulting in service and payment bottlenecks. There is increasing risk the agency will be unable to make timely payments to Oregonians, potentially for an extended period. ODHS and OHA are therefore jointly requesting resources to upgrade the mainframe platform and ensure continuity of payments and benefits. It is critical to migrate all current mainframe functions to more modern, ideally cloud-based, solutions. Doing so will help avoid the risk of service breakdowns, bring ODHS│OHA technology into alignment with peer agencies, improve flow across information systems, and allow Oregon to fully benefit from its investments in the ONE eligibility system. This package proposes a strategy to plan for and pilot new payment/financial modules, develop a plan to move remaining benefits on the mainframe to other applications, and decommission/archive remaining mainframe programs and data.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
ODHS	$2,958,688	$880,474	$1,991,333	$5,830,495	10	7.14

OHA	$1,985,589	$4,229,090	$1,088,537	$7,303,216	21	14.50
Policy package pricing:	**$4,944,277**	**$5,109,564**	**$3,079,870**	**$13,133,711**	**31**	**21.64**

Purpose

1. Why does OHA/ODHS propose this policy package and what problem is OHA/ODHS trying to fix or solve?

The agency's mainframe system dates from the 1960s. It has become a critical risk to delivering services to Oregonians and is limiting the agency's ability to respond quickly to changing needs. Over one million Oregonians receive benefits or provider payments via the mainframe. Mainframe systems are also used for provider authorization for over 40,000 care providers, and to determine eligibility for benefits to more than 11,000 Oregonians. The current payment system was designed by a single agency employee decades ago and is highly customized and unique to Oregon. This staff member is the only individual with comprehensive knowledge of the functions within that system. If they retire or otherwise become unavailable, there is significant risk that processing for benefits recipients and providers could be impacted.

More widely, the mainframe represents an anachronism at a time when the IT industry has shifted almost entirely to modern cloud platforms. It has become extremely difficult to replace staff as they retire from the mainframe team, and expanding the team is effectively impossible. 30 percent of the mainframe team's 42 total positions are unfilled, and 50 percent of the current staff are already eligible for retirement or will be within five years. Almost no technology vendors still offer mainframe consulting, software, or services.

The lack of staff to work on the mainframe has resulted in an increasingly visible bottleneck. The OregonSaves retirement plan was delayed for some home care and personal care workers, in large part because of limited mainframe team capacity and a lack of modern development tools and practices. A lack of training environments on the mainframe have made it more difficult to train new and existing staff to support Oregonians.

2. What would this policy package buy and how and when would it be implemented?

This project supports the planning and initial execution of steps necessary to migrate the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) off the mainframe computing platform maintained and supported by their shared Office of Information Services (OIS). An investment in this work would constitute a multi-biennia effort. Limited mainframe team capacity has been a long-running concern for the agency and has impacted numerous key initiatives including ONE, Provider Time Capture (PTC), the transfer of the Employee Related Daycare (ERDC) program to the Department of Learning and Care (DELC), and OregonSaves. This solution offers a new take on that challenge by focusing on addressing the fundamental, long-term issues rather than attempting to simply add more resources.

The project approach has two strategic goals and phases:

1. Conduct requirements analysis and market analysis for new payments/financial modules, identification, and acquisition
    - High-level requirements and business processes are defined
    - Market analysis of leading solutions is conducted
    - Pilot program/process/area is identified

2. Create a plan to move all remaining benefits processing, eligibility, provider authorization, and other functions off the mainframe and create a decommissioning/archiving plan is defined for migrated mainframe programs and data. Migrate to another system, migrate to the cloud, replace or decommission all remaining mainframe programs. Evaluation and establishment of “Tolerate, Invest, Migrate, Eliminate” (TIME) posture toward remaining mainframe programs and data. This

includes identifying data that has strategic value and determining a suitable archiving or warehousing location for it.

1. All mainframe programs and data that still have business value are identified
2. A future direction is defined for each item (for example, Gartner TIME model)

This project proposes to mitigate the risks identified above, and leverage the opportunities presented by conducting business on modern, well-supported platforms through investment in planning and execution efforts necessary to migrate off the mainframe.

	6 months	**12 months**	**18 months**	**24 months**
Payment/Financial modules	Establish governance; assemble team	Define scope; identify vendors	Procure solution	Pilot solution
Plan for benefit migration and decommissioning	Establish governance; assemble team	Define scope	Define requirements	Define implementation plan

Funds for this solution would be used to:

- Procure specialized financial consulting support needed to identify suitable public sector payments/financial modules
- Hire financial analysts with experience in modern payment-processing standards, systems, and practices
- Procure and pilot the new payments/financial modules
- Pay for technical consulting to assist with planning analysis to move remaining benefits to other systems (including ONE) and decommissioning remaining items on the mainframe. Procure

training and modern software tools for our current mainframe team, to help them transition to current technologies and archive or migrate valuable data from the mainframe

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's and/or ODHS's mission and align with its strategic plan?**

   Migration and modernization of the mainframe environment would support an increase in benefit visibility to clients, and likely increase uptake of benefits, due to their integration into the ONE platform alongside other benefits. Additionally, clients would require less time to apply for all benefits, because the ONE platform facilitates a 'one stop shop' experience for an increased number of benefits. This proposal also reduces the risk of interrupting payments to members of all Oregon communities and of delaying provider services to communities facing inequities. It would improve the agency's ability to respond to the changing needs of those communities. It would also make it easier to collect, store, analyze and use data to provide visibility of equity issues and improve service delivery to these communities. Finally, by increasing capacity it would help to avoid situations where the agency must prioritize one community's needs over another because it isn't possible to advance multiple efforts in parallel.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Quantifying results

4. What are the long-term desired outcomes?

This solution would make the agency more flexible and responsive to changing circumstances including federal regulations and policies, which increases trust, compliance and public confidence. When completed, this project would reduce the risk of interrupting payments to members of all Oregonian communities. It would reduce the risk of delaying provider services to communities facing inequities and improves the agency's ability to respond to those communities who are in the most need.

Creating a plan to move the remaining mainframe-based benefits determination processes to a modern, well-supported system would make it easier and faster to implement changes whether mandated at the agency, state, or federal level.

Adopting modern systems to replace the current mainframe environment would produce significant secondary benefits which align with Strategy 8 of the Diversity, Equity and Inclusion Action Plan: Diversifying the Workforce and Creating an Inclusive Workplace. This impact is expected because modern systems rely on programming languages, and technological concepts for which there are broader and more diverse hiring pools. This is expected to open doors to applicants with skillsets in those areas.

5. How will OHA/ODHS measure the impacts on health inequities of this policy package? How will ODHS measure the impact on system and access inequities and/or impact disproportionality in accessibility and services in ODHS programs through this policy package?

Anticipated outcomes from this solution would include:

- The agency can more easily find resources to work on more modern systems, and find them from multiple sources (vendors, consultants, open recruitment)
- Benefits are more visible to the community, and there is increased uptake of them, due to their integration into the ONE platform alongside other benefits
- Clients require less time to apply for all their benefits, because the ONE platform facilitates a 'one stop shop' experience for an increased number of benefits

Quantifiable outputs from this solution would include:

- New, payments/financial modules have been procured and piloted
- A plan has been developed to move the remaining benefits to other systems and a decommission plan for the mainframe has been initiated.

Data on the success of this solution would be gathered from multiple sources:

- Project management and quality assurance metrics on implementation progress
- Internal recruitment and project staffing metrics
- Results of the payments/financial modules pilot have been accessed

Table –Benefit and Measurement

Benefit	Measurement
Reduce the risk of not being able to make payments to benefits recipients and care providers	New payments/financial modules are in pilot
Fill open positions more easily, bringing more resources to bear on agency needs	Recruitment time is decreased for positions that are currently in the mainframe space
Improve flexibility and responsiveness to changing business needs	The volume of work pending in the mainframe is reduced. New requests are implemented more quickly
Align technology with statewide modernization and cloud forward initiatives	Mainframe solutions are replaced with cloud-based solutions, whether form vendors or internally developed

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Previous efforts to address the problem focused on adding more mainframe staff, procuring contractors, and utilizing system integrators rather than shifting to newer technologies. Those efforts have not been fully successful, as the IT industry has moved almost entirely away from the mainframe: there are simply not enough resources available in the market to meet the agency's needs. Experienced mainframe staff command very high wages, and the state's compensation is not competitive with other public and private sector IT employers.

Given the lack of overall capacity, the agency has had to prioritize the limited capacity that is available, resulting in suboptimal outcomes. As noted above, OregonSaves was delayed for many care workers. And the agency is currently out of compliance with several federal reporting requirements. The mainframe staff's work is prioritized through IT governance groups comprised of business and IT executives.

Two policy packages (POP 203 Critical Systems and POP 204 Modernization: Financial Payment Systems) were included in the 2021-23 Agency Request Budget to start the work of planning in this critical area. Neither package was funded.

7. What alternatives were considered and what were the reasons for rejecting them?

Status Quo

Previous efforts to address the staffing problems focused on short-term, less costly solutions such as adding more mainframe staff, rather than shifting to newer technologies. Those efforts have not been successful, as the IT industry has moved almost entirely away from the mainframe. There are simply not enough resources available in the market to meet the agency's needs, address federal regulations, and new policies. Experienced mainframe staff command very high wages, and the state's compensation is not competitive with other public and private sector IT employers. There were two POPs (POP 203 Critical Systems and POP 204 Modernization: Financial Payment Systems) in the 2021-23 Agency Request Budget to start the work of planning in this critical area and both were denied.

Continuing the status quo operation of mainframe systems will retain the risks identified above and over time will increase the risks accumulated with an aging and understaffed workforce. The risks of relying on antiquated, COBOL-based systems became highly visible nationally and in Oregon during

the first year of the COVID-19 pandemic; states were not able to rapidly make emergency payments, change benefits rules, and make other adjustments in payments processing. Another large Oregon agency struggled to issue pandemic-related assistance and was unable to scale up its systems to handle a large increase in claimants. The impacts of those issues caused by aging IT systems fell disproportionately on disadvantaged populations.

Failure to fund this investment will cause OHA, ODHS and OIS to pay increased costs for hardware maintenance. In 2022, Enterprise Information Services (EIS) State Data Center informed its customers that it would no longer be able to operate mainframe hardware due to staffing issues. Instead, EIS is preparing to outsource hardware operation and maintenance to a managed service provider.

If the project was not funded, the largest risk to Oregonians is around benefit and provider payments. We would defer the lower priority items to a later policy package, while continuously seeking opportunities to find funding from other sources for the overall solution.

The risk profile for maintaining a status quo disposition toward mainframe programs was identified as ‘not viable.’

- This alternative would not alleviate or mitigate risks identified in staffing, program specialization, system stability and agility and will most certainly result in increasingly disproportionate burden on Oregonian’s that have been economically and socially marginalized.
- The high risk of failure to make accurate and timely payments will continue to grow, due to personnel/resource issues.

- As mainframe skills, resources and partners become less and less available, we will have more and more risks, delays, and constraints with mainframe-based solutions.

Do the minimum amount possible

There are a few identified approaches that incrementally address a better future than the “do nothing” or current state, but minimally:

A. Reduce personnel risks by adding more positions to the team
    - Currently the mainframe team has 42 positions, of which 13 (30 percent) are unfilled. Recruitments routinely fail multiple times, and candidates do not possess the level of skills we need. The State Data Center is preparing to outsource its mainframe operations to an external partner because they cannot fill internal positions.

B. Lift and shift (translate) mainframe code to another platform
    - OIS engaged a partner to evaluate the feasibility of migrating the mainframe code to another platform (Microsoft’s Azure cloud platform)
    - Technically, a migration is feasible however it would have significant risks and limitations

C. The largest risk to Oregonians is around benefit and provider payments. We would defer the lower priority items to a later funding request and future biennium, while continuously seeking opportunities to find funding from other sources for the overall solution.

This alternative is not viable. “Lift and shift” just moves the problem and doesn't fix the core issues:

- A direct migration to Azure doesn’t address the issue that the financial system has been developed in-house and there is no wider expertise or other source of skills available.
- A direct migration doesn’t provide any new or improved capabilities; the functionality remains the same.

- The cloud environment is new to the state; we haven't attempted anything close to the scale and complexity of running the current mainframe workloads on Azure. There would be a very high risk of technical and process failures due to our lack of cloud maturity.
- Adding positions does not address the current inability to competitively pay, attract and hire mainframe skilled staff.

Migrate Mainframe Programs [desired solution]

This solution will require investment for the following:

- Procure and pilot the new payments/financial modules
- Pay for technical consulting to assist with planning analysis to move remaining benefits to other systems (including ONE) and decommissioning remaining items on the mainframe
- To procure training and modern software tools for our current mainframe team, to help them transition to current technologies

This project promotes shared, reusable solutions that can be adopted by multiple service areas. Although not in the scope of this effort, a new payments/financial solution could become the default for other new initiatives. Having a robust, well supported, industry-standard solution available means the agency can avoid developing individual solutions for different service areas.

From the IT perspective, adopting more modern and standard solutions expands the range of resources that can be applied to projects and other initiatives. Work that can only be done by the mainframe team today will be easier to assign to other technical specialists in the future.

This solution is the most viable and sustainable of those considered.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   OIS, ODHS, and the Office of Financial Services (OFS). The agency has also engaged with the State CIO's office, including the State Chief Technology Officer and Data Center Services (DCS). DCS operates the mainframe hardware in the State Data Center for those agencies that still use it.

   The ODHS CIO along with the state CTO is forming a workgroup with other agencies still on the mainframe to coordinate and ensure we provide the state an overall approach to moving off the mainframe.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    The mainframe is not directly visible to Tribes or other community members, and as such we have not solicited Tribal or community input on what they believe would be suitable technologies to replace it.

    The Service Employees International Union (SEIU) has expressed concerns in the past about initiatives like OregonSaves that have been delayed and had an impact on their members. The union has sought assurances from the agency that ODHS│OHA will take steps to ensure the agencies can meet commitments to its members within agreed timeframes. This solution recognizes those

concerns and aims to address them by shifting to more modern technical platforms where the agencies can add resources more easily and respond more quickly to changing needs.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): TBD, this will be a multi biennia effort

12. What assumptions affect the pricing of this policy package?

- The elements of the policy package are somewhat independent of each other, and work can proceed on them independently. However, resources are a constraint in all areas and may limit flexibility.
- This investment includes vendor and consulting resources and new positions that would reduce the impact of implementation work on active, ongoing mainframe projects and priorities. However, even with those resources it is possible that there would be conflicting demands for current mainframe team resources; the agencies will monitor the capacity and priorities of the team and resolve any issues appropriately and in a timely manner.
- Microsoft's Azure cloud is the target platform for migrating mainframe programs and data.
- The current mainframe team does not have the capacity and modern technology skills to execute a migration to more modern platforms, therefore additional resources will be required.

- Cost of professional services is assumed to be in alignment with other comparable efforts.
- Resources (both internal to the agency and externally/vendors) with the necessary skills will be available
- This solution anticipates demographic and retirement trends in the aging mainframe team.

13. Will there be new responsibilities for OHA, ODHS, and/or Shared Services? Specify which programs and describe their new responsibilities.

ODHS would lead the migration project, including overseeing of contractors, procurement and implementation of new software solutions with support from OIS. OHA, ODHS and OFS Shared Services staff would participate in business requirements gathering and supporting the migration to ensure ongoing services are not disrupted.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

It is not anticipated that this project would affect client caseloads.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

The Office of Information Services requests a total of 19 new positions to support planning and implementation. These positions include Information System Specialists, Operations & Policy Analysts, a Project Manager, a Fiscal Analyst, and a Principal Executive Manager and Administration Specialist.

ODHS is requesting at total of 10 new positions. These positions include Operations & Policy Analysts to support requirements gathering and testing requirements, as well as an Accountant, Project Managers and a Training & Development Specialist to support migration.

Two OPA3 staff would support OHA's Health Systems Division in the planning and requirements to a new solution as it relates to integrating with MMIS and other existing OHA systems.

16. What are the start-up and one-time costs?

None. All costs are ongoing.

17. What are the ongoing costs?

All costs are ongoing.

18. What are the potential savings?

Once the mainframe has been completely migrated to new environments, the agencies expect to save on staff and technology costs related to current operations and maintenance of the legacy mainframe system. This is an expected savings of approximately $6.15 million per year.

19. What are the sources of funding and the funding split for each one?

Please see the table in question #17 for a breakdown of state General Fund and Federal Funds sources and split by agency. The source of ODHS Other Funds are Waiver-Case Management. The source of OHA Other Funds is a mix of General Fund and Federal Funds — this is the accounting method to track OIS costs.

OHA, OIS, SAEC total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$181,316	$3,621,912	$285,981	$4,089,209	21	14.50
Services & Supplies	$1,804,273	$607,178	$802,556	$3,214,007		
Special Payments	$0	$0	$0	$0		
Total	**$1,985,589**	**$4,229,090**	**$1,088,537**	**$7,303,216**	**21**	**14.50**

ODHS (OFS, SAEC, ONE,) total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$334,398	$705,961	$501,588	$1,541,947	10	7.14
Services & Supplies	$60,828	$42,309	$71,414	$174,551		
Special Payments	$2,563,462	$132,204	$1,418,331	$4,113,997		
Total	**$2,958,688**	**$880,474**	**$1,991,333**	**$5,830,495**	**10**	**7.14**

Oregon Health Authority
2023-25 Policy Package

Division:	Central Services
Program:	Equity and Inclusion Division, External Relations/Community Partner Outreach Program, Strategic Action Team, Chief Financial Office, Chief Operating Officer
Policy package title:	Eliminating Health Inequities
Policy package number:	401
Related legislation:	None

Summary statement:

The Oregon Health Authority and its Equity and Inclusion Division are leading the state's effort to accomplish the largest and most ambitious transformation in health care and health delivery in the nation. The equity work charged to and led by the OHA Equity and Inclusion Division has agency-wide, state and national scope and impact. All divisions of the agency must be prepared and equipped to support equity and inclusion at every level of their work as well. It is critical to the success of this work that the agency hire additional subject matter expertise in the discipline of equity and inclusion and anti-racism. The work requires practitioners with career and lived experience, well versed in the research, theory and practical application of equity and inclusion. This policy package represents the next phase of assets necessary to achieve the state's and agency's imperative for health systems transformation and close the gap on health inequities that prevent the opportunity for all people in Oregon to attain optimal health, per a gap analysis related to additional capacity necessary to achieve the strategic goal of eliminating health inequities in Oregon by 2030.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$5,000,000**	**$437,610**	**$812,656**	**$6,250,266**	**31**	**22.03**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

The Oregon Health Authority (OHA) has worked to center health equity in all its work and programs and still has more to accomplish in this realm to meet the health goals for Oregon and the strategic goal of the agency to eliminate health inequities in Oregon by 2030. In reviewing current assets and work, looking toward the goal of the agency and state, members of the OHA Leadership Team and key personnel determined what more the agency requires after the Legislature's most recent investment in the agency's equity and inclusion work.

The policy package that OHA submitted represented a comprehensive next phase of assets necessary to achieve Oregon's and agency's imperative for health systems transformation and close the gap on health inequities that prevent the opportunity for all people in Oregon to achieve optimal health as represented in the agency's health equity definition:

> "Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
>
> Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
>
> > The equitable distribution or redistribution of resources and power; and
> > Recognizing, reconciling, and rectifying historical and contemporary injustices."

The funding level supports the initial priorities necessary to effectuate a tiered approach to its strategic goal of eliminating health inequities in Oregon to include:

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility (DITCR)
This initiative seeks to bridge OHA's current work to maintain compliance and expand to meet OHA's strategic goal to eliminate health inequities in Oregon by 2030. This work can be imagined as a house, where OHA is moving forward from a foundation of anti-racism. OHA's current compliance work is responsive to federal and state statutory and regulatory requirements (for example, ADA, WCAG 2.1, Rehab Act, Title VII, Affirmative Action, EEOC, ORS 659A) which can be imagined as the floor of the home. The proposed work is the home's structure from the floor to the ceiling— OHA seeks to not only have a safe floor for people to exist, it seeks a sound structure in which all people can flourish.

Currently, OHA's dedicated resources responsible for addressing potential civil rights, inclusion and access issues are maxed out due to the perfect storm of COVID-19, Medicaid expansion, and long-standing and current social and racial injustices and social turmoil. Now, more people need more support which requires more resources, like engineers, architects, masons, contractors, and building supplies to maintain the floor's structural integrity and prevent people from falling through. Here, the home is Oregon. Here the resources needed are trained equity and inclusion professionals who can respond to potential civil rights issues, train a workforce to practice equity and anti-racism in how they do their jobs, create processes and systems that are accessible, helpful, usable, and relevant to the people of Oregon, whomever they are, wherever they live, however they communicate and whatever they know. OHA needs more resources to maintain the floor. Importantly, OHA seeks to do more than maintain a floor. OHA seeks to eliminate health disparities in Oregon by 2030, creating a sound and healthy home for all people in Oregon.

Phase 1 DITCR Investments includes 15 positions to support increased capacity and specialized expertise to respond to increasing internal and public civil rights issues; increased capacity and specialized expertise to develop and sustain strategic training initiatives and training programs related to integrating and operationalizing health equity by OHA's workforce; dedicated subject matter expertise in disability access including digital accessibility, workplace accessibility, and public accessibility; dedicated subject matter expertise in language access to align with current and anticipated state and federal laws and regulations.

Health Equity and Health Emergency Response

This policy package includes two positions in the OHA External Relations Division to advance OHA's commitment to eliminating health inequities and advance co-creation with community and individuals in Oregon through coordination and collaboration as accomplished by the Community Partner Outreach Program (CPOP).

CPOP works within OHA and externally with individuals and partners in a way that centers equity and elevates the voices and experiences of those served by OHA in all programs, operations, and initiatives.

This includes a broad range of activities including the development of culturally and linguistically responsive community-centered outreach and community engagement strategies, overseeing emergency response communications, integrating equity-centered feedback received across teams to agency decisions, and developing partnerships and resources for research and paid media.

Strategic Action Team (SAT)

This policy package includes 10 positions as part of a Strategic Action Team, including project management and change management expertise, to create systems and processes that add capacity and enhance work on key initiatives across the agency that get us closer to our strategic goal to eliminate health in equities in Oregon by 2030. The team would amplify and support the work that has been led and is underway via the Equity and Inclusion Division, Tribal Affairs, the Community Partner Outreach Program, broadening the agencies capacity across all divisions to achieve our strategic goal, providing an array of operational supports and resources to strengthen OHA's ability to apply health equity and anti-racism principles and practices in our everyday work. The work of the Strategic Action Team would be informed and driven by communities that have experienced disproportionate health inequities and Oregon's nine federally recognized Tribes.

The Strategic Action Team would:

- Provide coaching and change management support to ensure it has been designed or adapted with health equity and anti-racism principles and practices at the forefront.
- Assist with scoping, planning, mapping out and communicating an implementation plan that is centered in health equity and anti-racism.
- Ensure that initiatives follow OHA's Tribal Consultation and Urban Indian Program Confer Policy in coordination with OHA's Office of Tribal Affairs and divisional Tribal liaisons.
- Elevate and synthesize applicable best practices, policies, or processes for the program team that redistribute power and resources, centers community in achieving change, and disrupts white supremacy culture practices.
- Document and provide project metrics and a project dashboard or scorecard for a variety of views throughout the organization.
- Support cross-divisional program teams in addressing resistance to anti-racism and change.

- Identify and share when policy, practice, decisions, outputs and documentation is in tension with our strategic goal, indicating the potential need for work to pause.

In addition to the support provided on key agency initiatives or programs, the Strategic Action Team would provide broader agency supports while following the lead and subject matter expertise already established in OHA, including agency-wide supports such as providing:

- Project management tools and templates to assist OHA teams in centering health equity in their work, including forms and templates to facilitate the development of project estimates, project plans, project schedules, issues management, change management and project reporting.
- Project tracking tools and example project metrics and dashboards.
- Coaching resources to support divisions and program staff to create, adapt and manage initiatives with health equity at the core of change management and project management.

Fiscal Equity

As part of OHA's implementation of the definition of health equity and its work to eliminate health inequities by 2030, this initiative provides the OHA's Fiscal Division with one new position to better understand, analyze and break down structurally racist financial infrastructures and budgets to better achieve agency goals.

Equity and Inclusion Business and Programmatic Support

This policy package includes two positions to establish a centralized business and enhanced programmatic structure for Equity and Inclusion both within the division and across the agency, to ensure effective and high-quality programmatic operational processes to support the exponential

growth of the division's staffing, managers, teams and programs, many of which are legislatively mandated initiatives.

Among the current 72 positions and additional pending, there is not adequate centralized operations and programmatic resources to develop and implement business processes and workforce development strategies or to organize, monitor and control information and resources related to state and agency policies and division-level and agency level processes, records and programs. If not addressed, this problem undermines OHA's ability to implement legislatively mandated work, and it does not position the division's expanding programs to effectively lead the work within the division and across the agency that it is required to do, to eliminate health inequities in Oregon by 2030.

If this problem remains unaddressed, it will result in increased loss of life and health inequities among the people of Oregon, particularly with OHA's priority populations. The COVID-19 pandemic has underscored systemic racism and health inequities faced by Tribal communities, communities of color, and additional communities in Oregon and across the country most harmed by health inequities. This reality shows it is vital to OHA's mission to redistribute resources to fully support the Equity and Inclusion Division, which has been integral in centering equity and anti-racism in OHA's and Oregon's pandemic response, contracts with and requirements of coordinated care organizations and providers, the development of the equity-centered 1115 waiver, the incentivized health equity metric, language and universal access and a multitude of other initiatives.

Additionally, the ongoing growth of Oregon's statutorily mandated Health Care Interpreter (HCI) Program has caused the program needs to outgrow its current resourcing. That the HCI program fills a critical healthcare gap – communication for people who speak little or no English – underscores the need to allocate additional resources to sustain the program.

Organizational Resilience and Healing (ORHP)

OHA is committed to developing a resilient and healing workplace culture that is responsive to the impact of racism and trauma on staff. The Governor's Budget includes one position to support this effort. As part of ongoing commitment to supportive workplaces, OHA is sponsoring a workgroup to develop an internal policy related to organizational resilience and healing. This work is being done in alignment with the OHA strategic goal of eliminating health inequities in Oregon by 2030, including commitment to anti-racism and healing.

OHA has created an operational policy to shift organizational culture to one that promotes resilience and healing in the workplace. The approach in this policy outlines how managers and staff can work together to put the policy into practice through a strategic implementation plan.

Leading with race in this work is key because structural and institutional racism have long histories and pervasive presence which have shaped our structures, systems and institutions. Because of this, racism in all its forms create harm and trauma across all systems and sectors, as well as impacting us at the personal, interpersonal and cultural levels. By focusing on racism where harm and trauma most deeply and consistently show up, it makes it possible to address the dynamics that shape marginalization addressing oppression in all its forms. This work is critical to understanding how true, sustainable resilience and healing can be achieved through the centering of anti-racism. The combination of addressing harm and trauma at the root, while uplifting strengths where they exist, can create a work environment where all people can be healthy and well, and therefore serve the people of Oregon to the best of their abilities.

2. What would this policy package buy and how and when would it be implemented?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility

This initiative supports bringing on additional experienced and knowledgeable equity and inclusion professionals who are subject matter experts in stewarding supportive, respectful, and healthful work cultures for OHA staff, including disciplines such as training/adult learning, civil rights, disability access, language access and equity and inclusion generally. By providing proactive, restorative and cost-effective resources necessary to support the growing and ever-diverse OHA workforce and the varied needs of the people who live and work in Oregon.

One example based on a painful lesson learned from Oregon's COVID-19 response: many people who live and work in Oregon communicate in a language other than English. To provide information that is useful to people, we must invest in resources to produce and deliver information in languages other than English. It takes expertise to know how to do that effectively and efficiently. A second lesson learned is that not everyone can access and use information that is produced and delivered on a website. Even assuming you had a device and internet access, if you are blind you need the information on the website to be formatted so that your screen reader can read the information to you. That planning and doing does not happen automatically. This proposal buys justice, liberty and life for the people of Oregon, especially the people who have been most harmed by injustice and health inequities, experiencing the most of the worst than, including racism, disenfranchisement and marginalization.

This investment represents OHA's commitment to not only ensure compliance with statutory and regulatory requirements. It is a sound investment enabling the agency to develop internal capacity support a thriving workforce who are key to eliminating health inequities for the people of Oregon.

Health Equity and Health Emergency Response

This proposal allows CPOP to expand the scope of their external reach to populations most harmed by health inequities, lead OHA overall around community-centered outreach, engagement, and co-creation within all programs, amplify the work of the OHA Equity and Inclusion Division and bring this feedback and community voice to inform, shape and influence OHA programs, policies and practices.

Strategic Action Team (SAT)

This initiative would fund positions as part of a Strategic Action Team, including project management and change management expertise, to create systems and processes that add capacity and enhance work on key initiatives across the agency that get us closer to our strategic goal to eliminate health in equities in Oregon by 2030. This team would amplify and support the work that has been led and is underway via the Equity and Inclusion Division, Tribal Affairs, the Community Partner Outreach Program, and broaden the agencies capacity across all divisions to achieve our strategic goal.

The Strategic Action Team would provide an array of operational supports and resources to strengthen the ability of our agency to apply health equity and anti-racism principles and practices in our everyday work.

For key initiatives in the agency, the Strategic Action Team would:

- Provide coaching and change management support to ensure it has been designed or adapted with health equity and anti-racism principles and practices at the forefront.
- Assist with scoping, planning, mapping out and communicating an implementation plan that is centered in health equity and anti-racism.

- Ensure that initiatives follow OHA's Tribal Consultation and Urban Indian Program Confer Policy in coordination with OHA's Office of Tribal Affairs and divisional tribal liaisons.
- Elevate and synthesize applicable best practices, policies, or processes for the program team that redistribute power and resources, centers community in achieving change, and disrupts white supremacy culture practices
- Document and
- Provide project metrics and a project dashboard or scorecard for a variety of views throughout the organization.
- Support cross-divisional program teams in addressing resistance to anti-racism and change.
- Identify and share when policy, practice, decisions, outputs, and documentation is in tension with our strategic goal, indicating the potential need for work to pause.

In addition to the support provided on key agency initiatives or programs, the Strategic Action Team would provide broader agency supports while following the lead and subject matter expertise already established in OHA, including agency-wide supports such as providing:

- Project management tools and templates to assist OHA teams in centering health equity in their work, including forms and templates to facilitate the development of project estimates, project plans, project schedules, issues management, change management and project reporting
- Project tracking tools and example project metrics and dashboards
- Coaching resources to support divisions and program staff to create, adapt and manage initiatives with health equity at the core of change management and project management

Fiscal Equity

This portion of the policy package would establish a new position, i.e., the start of a team, in OHA's fiscal division who would be fully dedicated to analyzing the agency's investment in health equity and anti-racism, including return on investment in health equity spending at OHA and in OHA-funded programs. This position would work with OHA subject matter experts and community partners to analyze the fiscal impact of OHA-funded health equity work and how those investments are contributing to OHA's strategic goal to eliminate health inequities. This highly-skilled and experienced professional would be better able to analyze, understand and quantify the costs of institutional racism within OHA programs and the effects of OHA's and the state's investments to address those institutional costs(harms). This position would make evidenced-based recommendations for future budget structure and budgetary levels needed for the elimination of health inequities.

The position would work closely with the Equity and Inclusion Division and Tribal Affairs to ensure that their work is inclusive, collaborative, and in alignment with the direction of agency initiatives.

Equity and Inclusion Business and Programmatic Support

This policy package further develops an infrastructure necessary to support equity and inclusion initiatives within the Equity and Inclusion Division and across the agency. It buys one position to provide essential administrative support to build the infrastructure necessary to support the physical and programmatic expansion of the Equity and Inclusion Division, and a second position to administer and lead strategic alignment of the expanding and statutorily mandated health care interpreter (HCI) program.

Organizational Resilience and Healing (ORHP)

This policy package includes one full-time Operations & Policy Analyst 4 position to work with OHA leadership and employees to develop project management plans, assess policy impacts, and make recommendations for resources needed to fully implement the Organizational Healing and Resilience Policy (ORHP). This position will also conduct an environmental scan to create a compendium of culturally appropriate staff resources and conduct a gaps analysis to assess what supports are still needed. This effort will also make recommendations to support implementation, including staffing supports and training.

Meaningfully impacting these workforce inequities requires fiscal investment. Specific benefits of these resources include:

- Increased morale, a sense of belonging, general wellness and an overall quality of workplace interactions for OHA staff.
- Decreased staff turnover
- Increased staff retention which can especially contribute to fostering a more diverse workforce
- Allows employees the level of autonomy needed to improve equity in meaningful and appropriate ways that ensures anti-racist priorities are not compromised.
- Continues to grow the necessary capacity of OHA to address equity issues in culturally specific and effective ways.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility

See answer to #2. The proposal seeks to resource the part of OHA that is mainly responsible for leading, training and modeling how to practice health equity and anti-racist principles in concert with OHA's mission and strategic plan. It recognizes the growing need to support with resources and programming to inculcate equity and anti-racism sustainably and consistently as it relates to OHA's workforce and the employment experience to enable the same sustained and consistent service provision and policy development for OHA's service recipients and the people who live and work in Oregon.

Health Equity and Health Emergency Response

As essential to OHA's commitment to eliminating health inequities and co-creating with community, it is essential for OHA to understand individual and community concerns and ensure the workforce is leading with cultural humility and in a linguistically and culturally responsive manner.

CPOP leads and models this externally for OHA as a whole and prioritizes bringing information back internally from community. The CPOP team have an essential role in elevating the voices and experiences of the people in Oregon to participate with OHA and help OHA act upon that community feedback.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Strategic Action Team (SAT)

This policy package would directly enhance the opportunity for OHA to expand its capacity, including skills, experience, and staffing, that help the agency eliminate health inequities during the planning, implementation and communications pertaining to key OHA programs, policies, and initiatives across all divisions of the agency.

Recruitment for the positions on this team would prioritize the following skills, knowledge, and experience to achieve the goals sought by this policy package:

- Lived and professional experience leading organizational transformation and community initiatives to achieve anti-racism, racial equity, decolonization, accessibility processes and outcomes.
- Knowledge, skills, and certifications related to anti-racism, racial equity, diversity and inclusion, decolonization, equity-informed project management and change management principles.
- Proficient bilingual skills, preferably Spanish.
- Commitment to ongoing personal development on the topics of anti-racism, elimination of health inequities, culturally and linguistically appropriate practices, trauma, healing and resiliency-informed practices, social determinants of health and equity, universal accessibility, and development of diverse and inclusive work environments.
- Experience and skills in trauma, healing and resiliency-informed practices and cross-cultural communication.
- Experience building and stewarding relationships with Tribes and community groups most harmed by historical and current social and health inequities (Tribes, Tribal communities, communities of color, immigrant groups, the disability community).
- Possess interpersonal and professional skills that:
  - Prioritize and center impact versus intent.

- Understand and work within complexity and multiculturalism.
- Demonstrate authenticity, humility, and personal accountability in daily interactions. Demonstrate creative and innovative thinking that de-centers white supremacy and dominant culture thinking and approaches. Recognize how current systems and structures limit and obstruct possibilities for equitable outcomes.
- Prioritizes the relational aspects of work.

Fiscal Equity

This initiative seeks to provide better financial data and analysis so that OHA can meet its 2030 goal to eliminate health inequities. This staff person would be 100 percent dedicated to reviewing and implementing modern fiscal tracking technologies and strategies to better quantify what the agency is spending on health equity and anti-racism, and conduct tangible analysis related to the return on investment for equity work. This position is necessary to modernize and expand the discipline of budget and finance to center equity and the costs of racism. One aspect of the health equity definition revolves around equitable distribution or redistribution of resources and power. The person in this position would work closely with communities most harmed by racial injustices and align fiscal practices with health equity. The person in this position would not only work within the confines of the budget system but develop a more responsive, community-centered budget build process within OHA.

Equity and Inclusion Business and Programmatic Support

This package supports the resilience and health of OHA's priority populations — communities most harmed by health inequities — because it provides centralized business support resources to the Equity and Inclusion Division's programs and additional programmatic support across the agency. With the assistance of this package, the division's programs would have centralized business

resources and supports so they are equipped to do the work they were hired to do: lead nationally-recognized health equity initiatives, including the HCI program.

This package furthers the agency's mission and aligns with its 2030 health equity goal, and particularly with the OHA definition for health equity. Compared to many other divisions and departments, the Equity and Inclusion Division has historically not benefitted from equitable resources to develop a centralized operations and business structure. If implemented, this package would be the initial step in modelling the health equity definition and further right-size the division's resources, to establish internal capacity for managing a growing volume of business operations within the division and equity-related activities across the agency. This investment would recognize and reconcile at least one injustice the division has experienced historically.

Organizational Resilience and Healing (ORHP)

The package recognizes the growing need to support OHA staff with resources and programming to inculcate equity and anti-racism sustainably and consistently within the employment experience to enable the same sustained and consistent service provision and policy development for OHA's service recipients and the people who live and work in Oregon. A thriving OHA workforce translates into optimum service to all Oregonians.

Quantifying results

4. What are the long-term desired outcomes?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
Long-term outcomes include greater workforce satisfaction, productivity and engagement, which makes for better outcomes in the communities that OHA serves. Ultimately there is also a cost reduction related to less turnover, fewer conflicts, fewer investigations and fewer lawsuits.

Health Equity and Health Emergency Response
Further investment would better allow for the integration of community feedback internally to the agency. It would also better elevate and integrate the feedback and experience of communities and individuals throughout Oregon into OHA's work, prioritizing and rectifying historical injustices by ensuring populations most harmed by health inequities, especially OHA priority populations, are embraced and their recommendations acted upon.

Related to external engagement, OHA can better become a trusted messenger for and partner with all people in Oregon, particularly individuals and communities who experience historical and contemporary injustices and are most harmed by health inequities.

Strategic Action Team (SAT)
The SAT would measure impact through:

- Elimination of health inequities by 2030
- De-centering of white dominant culture thinking and practice across the agency
- Consistent adherence to OHA's Tribal Consultation and Urban Indian Program Confer Policy in coordination with OHA's Office of Tribal Affairs and divisional Tribal liaisons

- Incorporation of health equity and anti-racist principles, tools and practices across core initiatives and agency-wide programs
- Increased workforce supports for healing and resiliency

Fiscal Equity

Long term desired outcomes include creating a new, more equity-focused budget build process within OHA with recommendations to DAS and LFO for how to change the entire process to be more equitable. The budget process currently strengthens the structures that disenfranchise and discount resources for Tribal communities and communities of color, in particular. The system is built on white dominance and white privilege. Dismantling this structurally racist system will mean that all people in Oregon have the opportunity to thrive. Pricing out the impact of racism on the health and welfare of Tribal communities and communities of color in Oregon will yield a better and more equitable future system. This position would help quantify the impact of OHA's focus on health equity, anti-racism, and health inequities.

Equity and Inclusion Business and Programmatic Support

This program would measure impact through an effective operations and program (i.e., HCI Program) structure in the division and across the agency so that the OHA workforce and programs can lead OHA and the state to eliminate health inequities in Oregon.

Organizational Resilience and Healing (ORHP)

While communities of color experience avoidable inequities due to structural racism (Agénor, et. al, 2017), there remains great strength, resilience, and wisdom which should inform efforts to ultimately address health equity issues. Many over the years have discussed the power of culture in healing the traumas resulting from racism, discrimination and inequities, and the need for community wisdom

to develop creative, long-term solutions to health barriers at the policy, system, and environment change (PSE) level.

Employees have the expertise based in lived experience to identify most critical equity issues, while crafting PSE solutions. This means that employees most harmed by inequities are leading identification of the “right issues” (those most urgent or impactful issues in their workplace) and develop more effective solutions with less unintended consequences.

Meaningfully impacting these workforce inequities requires fiscal investment. Specific benefits of these resources include:

- Increased morale, a sense of belonging, general wellness and an overall quality of workplace interactions for OHA staff.
- Decreased staff turnover
- Increased staff retention which can especially contribute to fostering a more diverse workforce
- Allows employees the level of autonomy needed to improve equity in meaningful and appropriate ways that ensures anti-racist priorities are not compromised.
- Continues to grow the necessary capacity of OHA to address equity issues in culturally specific and effective ways.

5. How will OHA measure the impacts on health inequities of this policy package?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility

Impacts would be measured through employee engagement and cultural climate assessments as well as the quantification and decrease of investigations, turn-over (data disaggregated by race,

ethnicity, language, disability, sexual orientation, gender identity and gender expression) and lawsuits.

Health Equity and Health Emergency Response

Impacts would be measured in the CPOP program by the

- Number and reach of Community Partner network particularly to Limited Engligh Proficient (LEP) populations and other OHA priority populations.
- The negative impact of not-funding: Inadequate staffing for OHA to co-create with community and operationalize health equity values.

Strategic Action Team (SAT)

Outcome and process measures for each agency initiative would be deployed using data disaggregated by race, ethnicity, language, disability, sexual orientation, gender identity and gender expression to measure the impact of this initiative.

Fiscal Equity

This position would build the financial models and work with staff across the agency to better understand the fiscal impact of its work with a focus on the impacts of health inequities. Currently, this work is not funded and staff doing health equity do not have a financial or economic background to fully price out the impact of the work. The person in this position would integrate fiscal equity in the established processes and make recommendations on how to change these processes to better incorporate health equity spending and dismantle structural racism in the budget. This work will require resourcefulness, creativity, finesse, and resilience.

Equity and Inclusion Business and Programmatic Support

There are many metrics that can be used to measure impacts of this initiative, that would assist in the division meeting its legislatively mandated requirements and ensure it has the resources to lead OHA in meeting its goal to eliminate health inequities in Oregon by 2030.

Contracts, procurement, and grant management:

- Contract and grant agreement turnaround time
- Request for proposal (RFP) turnaround time
- Grant application process turnaround time

Program staffing and workforce strategy:

- Hiring turnaround time
- New hire onboarding / network access turnaround time
- Performance appraisal turnaround time
- Retention rates
- Employee satisfaction rate
- Workforce equity metrics

Administrative support:

- Customer Satisfaction
- Committee Attendance

Facilities support:

- Office space acquisition
- Ergo Assessments

Accounting:

- Invoice turnaround time
- Payment rework

Organizational Resilience and Healing (ORHP)

The OPA4 will be responsible for developing plans to measure the impact of this investment and will project potential future impacts related to additional investments of resources.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility

The unit has worked diligently to ensure civil rights, anduniversal accessibility for the OHA workforce and for the public; however, personnel are crushed by the workload. For example, each of the three investigators on staff currently have a case count of fifteen at any given time, which is well beyond industry standards. There are no further actions short of additional team members that will alleviate this issue.

The addition of dedicated staff well-experienced in particular fields of practice (language access, digital access, ADA access) and public civil rights will mean more timely and responsive support for OHA employees and the public whom OHA serves.

Health Equity and Health Emergency Response

Culturally and linguistically nimble staffing across teams to elevate community input and experience would allow help to shift power imbalances that have led to a lack of representation of people and

ideas across race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, geographies, or intersections among these communities or identities in the decision-making, design, and evaluation of OHA policies and programs.

Adequate staffing is needed to ensure that the people of Oregon have the opportunity to meaningfully engage and participate in OHA activities and services regardless of disability status, language, or access to technology.

Strategic Action Team (SAT)

The agency has made progress in the following areas:

- Agency-wide performance measurement system
- Agency strategic goal development and commitment
- Agency-wide anti-racism training
- Agency policy development
- Investments in OHA's Equity and Inclusion Division, Office of Tribal Affairs, Community Partner Outreach Program

Yet the need for project and change management spanning across the agency became apparent through the gap analysis process. The large, diverse, dynamic and sprawling nature of OHA with eight divisions and nearly 5,000 employees necessitated this proposal for the SAT.

Fiscal Equity

OHA is working under a new definition for health equity and has a goal to eliminate health inequities in Oregon. OHA has asked for and received resources focused on improving data collection for REALD/SOGI data in all OHA systems, bolstered training in anti-racism for the OHA workforce,

increased the workforce focused on health equity, and funded community partners to work on the ground to eliminate health inequities.

All these prior investments did not focus on building up financial and budgetary analysis capacity to better understand and analyze the fiscal structures, systems, and investments in health equity.

Equity and Inclusion Business and Programmatic Support

As a result of the 2021-23 investments, the division added several new positions that lead or support operations, many of which are intended to support each unit in the division. These are critical positions to begin building a foundation for ensuring effective business operations in the division. However, since there has been exponential growth in staffing and programs with additional positions pending, the division needs to right-size the number of centralized operations roles

Additionally, the division's Equity Unit is in need of a manager position to effectively lead the ever-expanding and statutorily mandated Health Care Interpreter program.

Organizational Resilience and Healing (ORHP)

The co-leaders of this effort reached out to Oregon Department of Human Services (ODHS) to have conversations about the possibility of developing a joint policy. ODHS has their own trauma informed workplace policy which was established in 2019, and the possibility of aligning policies and sharing resources was thoughtfully discussed and considered over several months. In January 2022, both groups decided that having aligned, separate policies made the most sense due to the unique nature of the agencies' work.

Workgroup members participated in anti-racism training with Engage to Change facilitators, Rakeem Washington and Kasia Rutledge, to establish an anti-racist foundation from which to do this work.

Additionally, the workgroup received training from Anti-Racist Trauma Informed Care (AR-TIC) to help prepare and support members in this important work. These trainings were critical to understand how, through the centering of anti-racism, that true, sustainable resilience and healing can be achieved. Partners from ODHS also joined the OHA workgroup in participating in these trainings while continuing to discuss the possibility of a joint policy.

The OHA version of a draft policy has been established and was reviewed by the Equity Advancement Leadership Team (EALT), Employee Resource Groups (ERGs), executive sponsors, and the ORHP Workgroup to finalize this policy. The draft policy has been through several iterations, and feedback from engaged parties was integrated, including a plain language review. This policy was approved in November of 2022.

Currently the ORHP workgroup is developing the strategic implementation plan. This includes continuing to engage the ERGs to collect input about how to put this policy into practice in the most meaningful way possible.

Additionally, the ORHP co-leads have presented to OHA executive leadership team to provide background on the policy and work to date, as well as to request resources that will be required for implementation and to assist with addressing immediate needs of employees most harmed by racism and discrimination. This includes dedicated staff for implementation rollout; training, facilitation, and technical assistance; and establishing a bias incident response team who can support staff who have experienced harm related to bias.

7. What alternatives were considered and what were the reasons for rejecting them?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility

The unit has worked diligently to ensure civil rights and universal accessibility for the OHA workforce and for the public; however, personnel are crushed by the workload. For example, each of the current investigators have a case count of fifteen at any given time, which is well beyond industry standards. Additionally, currently one position is responsible for the agency's public civil rights, public ADA matters, and language access programs. There are no further actions short of additional team members that will alleviate this issue.

Health Equity and Health Emergency Response

CPOP will not be able to truly elevate and integrate co-creation and true partnership with the community without adequate staffing.

Strategic Action Team (SAT)

Alternatives considered included additional investments in specific programs or other divisions, contracted support or no additional investments. The reason for proposed approach relates to the need for accountability and direction at agency Director-level in support of the agency's strategic goal and expectations for cross-agency key initiatives, plus agency-wide implementation of anti-racist and equity principles.

Fiscal Equity

OHA did evaluate whether current personnel could build onto their current workload, but based on workload within the Fiscal Division and the specialized nature of the desired work there are no resources available to complete this important work. If this position is not funded, this work will not get done.

Equity and Inclusion Business and Programmatic Support

Upon being hired, the Director of Operations built relationships with the division's executive support staff to foster communication and coordination, with the intention of building a system whereby executive support and administrative staff dedicate a percentage of their time to do division-wide operations work and agency-wide programmatic work. While this has been possible to a small degree, it has not resulted adequate capacity required for developing a centralized operations foundation for the division and cross divisional programmatic collaboration. The approval of one administrative support person is a necessary first step to establishing sustainable operations within the division.

Additionally, as to the HCI program. The division has leveraged all existing resources to their limits to provide essential services. As stated above, the exponential growth of the statutorily mandated HCI program coupled with the critical function that this program provides to ensure accurate and meaningful healthcare for limited English and non-English communicating patients, necessitates further investments. Current resources are insufficient to maintain increased programmatic requirements.

Organizational Resilience and Healing (ORHP)

OHA explored whether this work could be accomplished with existing staff. There is consensus that the complexity and workload associated with implementing the ORHP policy requires dedicated staff for meaningful impact. Therefore, OHA proposes creating bias incident response teams to help employees navigate services and resources, plus staff to examine existing resources and identify gaps and potential future partners. This policy package funds one new position for this work.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
Human Resources, Office of Information Services, Budget and Finance, Community Partners Outreach Program

Health Equity and Health Emergency Response
OHA's Equity and Inclusion Division and Tribal Affairs

Strategic Action Team (SAT)
Director's Office, Equity and Inclusion Division, Office of Tribal Affairs, External Relations Division, OHA Leadership Team

Fiscal Equity
OHA would work with other budget offices and budget staff in the agency and work with OHA-ODHS Shared Services Budget Unit (SSBU) to discuss how this could be rolled out. In addition, OHA would work with budget and equity counterparts in the Oregon Department of Human Services (ODHS) to discuss the work of this group. OHA also wants to get feedback from the Department of Administrative Services (DAS) and potentially other agency fiscal representatives about how this fiscal equity team could work.

Equity and Inclusion Business and Programmatic Support
The OHA Director's Office.

Organizational Resilience and Healing (ORHP)
Currently there is a workgroup related to this body of work whose members developed the policy and are in the process of creating a strategic implementation plan that would be used as a starting place for the OPA4 included in this policy package.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
    None.

    Health Equity and Health Emergency Response
    The ERD intersects with local government agencies for all OHA-wide work as appropriate. Adequate equity-centered staffing within ERD, which includes CPOP, would allow OHA to lead in this work with working with other state, Tribal and/or local government agencies and other state agencies around OHA policies.

    Strategic Action Team (SAT)
    Not applicable.

Fiscal Equity
DAS and other state agencies will be impacted when OHA puts forward new recommendations for a more equitable, less structurally racist budget process. Currently, budgets are put together with limited community input. This team would work with community partners to build a new budget process that is community led and does not tokenize the needs of community.

Equity and Inclusion Business and Programmatic Support
None. However, by implementing this package, a centralized business operations structure would positively support the division to more effectively partner, collaborate and consult (i.e., developing MOUs) with other state, tribal and local government agencies on health equity initiatives including the HCI program.

Organizational Resilience and Healing (ORHP)
The impact is specific to OHA, and therefore will not affect other state, Tribal, and/or local government agencies.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No, with the exception of the following:

Organizational Resilience and Healing (ORHP)
Yes, this request is related to the implementation of recommendations from a 2020 Oregon Secretary of State audit (see recommendation #19).

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
Assumption that the OHA and state of Oregon seriously want to eliminate health inequities by 2030. Assumption that OHA will be able to timely recruit and hire for proposed positions at the appropriate classification in order to have qualified people on staff to do the work.

Health Equity and Health Emergency Response
Assumptions include that OHA will continue to prioritize and need dedicated multi-cultural, multi-lingual and equity professionals to ensure OHA moves towards eliminating health inequities and co-creation with community. Assumption that needs to ensure this is coordinated and acted up effectively across OHA for external engagement and ensuring internal understanding and implementation.

Strategic Action Team (SAT)
Positions would be funded beginning July 1, 2023.

Fiscal Equity
Position would be funded beginning July 1, 2024.

Equity and Inclusion Business and Programmatic Support
The position descriptions can be reviewed by OHA Human Resources and DAS and recruited for prior to December 1, 2023.

Organizational Resilience and Healing (ORHP)
The assumption that health equity and OHA's 2030 strategic goal to eliminate health inequities are indeed priorities for the agency and the state.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No with the exception of the following:

Organizational Resilience and Healing (ORHP)
Yes, OHA will need a dedicated staff to lead the effort of laying the groundwork for implementation of the ORHP policy.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Diversity, Inclusion, Training, Civil Rights,and Universal Accessibility
The unit would have the capacity to provide timely service and resolution to requests for accessibility from the public, timely resolution of civil rights complaints

Health Equity and Health Emergency Response
CPOP would have increased capacity to engage with individuals and communities who have critical needs and who have not had the opportunity to meaningfully and consistently partner with OHA.

Strategic Action Team (SAT)
No.

Fiscal Equity
No.

Equity and Inclusion Business and Programmatic Support
No.

Organizational Resilience and Healing (ORHP)
No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
This policy package establishes 15 new permanent full-time positions (7.90 FTE), priced between 9 and 18 months for the 2023-25 biennium.

The following are the amounts and classifications for the positions that would be established:

- One Electronic Publishing Design Specialist 3 position
- One Fiscal Analyst 2 position
- One Information Systems Specialist 8 position
- Three Diversity Equity and Inclusion Manager 2 positions
- Three Operations & Policy Analyst 4 positions
- One Training & Development Specialist 2 position

- One Administrative Specialist 2 position
- Four Operations & Policy Analyst 3 positions

Health Equity and Health Emergency Response
This policy package would establish 2 new permanent full-time positions, 1.26 FTE, 15 months for positions.

The following positions would be established:

- One Operations & Policy Analyst 3 position
- One Operations & Policy Analyst 2 position

Strategic Action Team (SAT)
This policy package establishes 10 new permanent full-time positions (10.00 FTE) priced at 24 months each for the 2023-25 biennium.

The following are the amounts and classifications for the positions that would be established:

- Three Operations & Policy Analyst 4 positions
- One Administrative Specialist 2 position
- Five Project Manager 3 positions
- One Business Operations Manager 3 position

Fiscal Equity
This establishes one new permanent full-time position (.50 FTE) priced at 12 months for the 2023-25 biennium:

- One Economist 3 position to research and analyze data for health equity spending in OHA and other public health and health. They would create reports on spending for health equity and anti-racism efforts for presentation by the Chief Financial Officer, Equity and Inclusion Division director and other OHA leaders. Work across OHA and other state agencies to understand trends for spending in equity and inclusion efforts.

Equity and Inclusion Business and Programmatic Support

This policy package establishes 2 new permanent full-time positions (1.54 FTE) priced between 18 and 19 months for the 2023-25 biennium:

- One Administrative Specialist 2 (AS2): Responsible for organizing, inventorying, monitoring, and controlling information and resources related to state and agency policies and division-level processes and records that relate to operations. Serves as the division's lead administrative position to coordinate division-wide purchasing and logistics processes. Collaborates with the division's Organizational Improvement Specialist, Operations Analysts, and administrative positions in each unit to organize, archive, monitor and communicate information related to fiscal, human resources, technology, hardware/software orders, inventory of supplies, purchase of office supplies, submission of invoices for payment, archiving information on established contracts, and maintaining informational resources/supports for division staff.
- One Diversity Equity and Inclusion Manager 1 (DEI Manager 1) for Health Care Interpreters (HCI).

Organizational Resilience and Healing (ORHP)

This OPA4 position is needed to work with OHA leadership and employees to develop project management plans, assess policy impacts, and make recommendations for resources needed to

fully implement the ORHP policy. This position will also conduct an environmental scan to create a compendium of culturally appropriate staff resources and conduct a gaps analysis to assess what supports are still needed.

16. What are the start-up and one-time costs?

Not applicable.

17. What are the ongoing costs?

The total for all ongoing costs for this policy package are $6.25 million in 2023-25.

Diversity, Inclusion, Training, Civil Rights,and Universal Accessibility
Fifteen new permanent full-time positions for $2.18 million in the 2023-25 biennium. It also includes other Services & Supplies (S&S) such as: language differential for specific positions, contracts, interpreter services, and consultants. Other S&S is $87,000 in 2023-25.

The total ongoing costs are $2.27 million.

Health Equity and Health Emergency Response
Budget for staff positions.

Strategic Action Team (SAT)
Ten new permanent full-time positions. $3.0 million in the 2023-25 biennium.

Fiscal Equity
All costs are ongoing. $139,000 in the 2023-25 biennium.

Equity and Inclusion Business and Programmatic Support
Two new permanent full-time positions (1.54 FTE).$350,000 in the 2023-25 biennium.

Organizational Resilience and Healing (ORHP)
The ongoing costs are estimated at $126,000 to support 1 position (0.42 FTE) to ensure dedicated support for implementation of OHA's ORHP policy. See below for further detail.

18. What are the potential savings?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
When working proactively on compliance matters liability is mitigated, therefore, there are potential savings as the work prevents lawsuits and rework when accessibility and compliance are well resourced. Training and workforce equity programs also mitigate lawsuits and rework as the workforce is well informed and supported on policy compliance and accountability.

Health Equity and Health Emergency Response
Streamlined agency work and responsiveness across our agency would lead to equity-centered approaches, enhanced communications, and reduces risks overall to the agency.

Strategic Action Team (SAT)
Short term savings relate to efficiencies added through project management and change management supports for the implementation of complex, priority projects including those that have been identified or supported as priorities by community partners as well as Oregon's nine-federally recognized Tribes. Long term savings expected through supports and additional capacity for staff retention, healing and resilience, plus the attainment of improved health outcomes and health equity for communities and individuals in Oregon.

Fiscal Equity
Redistribution of resources away from programs and activities that exacerbate health inequities and into programs that move to eliminate health inequities.

Equity and Inclusion Business and Programmatic Support
Savings would result by reducing and avoiding duplicative purchasing of goods and services because of having centralized division-wide operations processes. Savings would also occur as result of executive support and administrative staff not doing duplicative tasks and having more time to do specific support activities for each of the division's units.
Savings would be realized from efficiencies in HCI programmatic work, minimizing need for overtime and staff burnout.

Organizational Resilience and Healing
This funding is a nominal investment for substantial returns in terms of cost savings to impacted systems by way of improving inequities. Specifically, turnover would decrease and save resources related to outreach, recruitment, hiring, interviewing, training, and disruption of institutional knowledge. Without dedicated staff to support implementation, there would not be opportunities to meaningfully address racism and discrimination that employees face, and therefore these issues would not be as comprehensively addressed.

When employees are able to name the issues most impacting their health and wellness, and develop solutions to those challenges, it means there is less waste in addressing the wrong issues and pursuing ineffective efforts. These focused and intentional solutions not only save time and resources but move the state closer to health equity for both OHA employees and the people they serve.

19. What are the sources of funding and the funding split for each one?

Diversity, Inclusion, Training, Civil Rights, and Universal Accessibility
This work is on behalf of the entire agency and would use the agency-wide cost allocation pool to distribute costs to revenue sources. The estimated fund splits range between 80 percent General Fund to 100 percent General Fund, 0 to 11 percent Other Funds, and 0 to 11.5 percent Federal Funds.

Health Equity and Health Emergency Response
Community Partner Outreach Program utilizes the cabinet report cost allocation pool that distributes costs based on OHP clients by eligibility which is estimated at 50 percent General Fund and 50 percent Federal Funds.

Strategic Action Team (SAT)
This work is on behalf of the entire agency and would use the agency-wide cost allocation pool to distribute costs to revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds.

Fiscal Equity
This work is on behalf of the entire agency and would use the agency-wide cost allocation pool to distribute costs to revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds.

Equity and Inclusion Business and Programmatic Support
This work is on behalf of the entire agency and would use the agency-wide cost allocation pool to distribute costs to revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds.

Organizational Resilience and Healing
This work is on behalf of the entire agency and would use the agency-wide cost allocation pool to distribute costs to revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$4,494,813	$393,309	$730,412	$5,618,534	31	22.03
Services & Supplies	$505,187	$44,301	$82,244	$631,732		
Capital Outlay						
Special Payments						
Other						
Total	**$5,000,000**	**$437,610**	**$812,656**	**$6,250,266**	**31**	**22.03**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Systems Division
Program:	Behavioral Health
Policy package title:	988 & Behavioral Health Crisis System: 988 call center
Policy package number:	404
Related legislation:	House Bill 2417 (2021)

Summary statement:

House Bill 2417 (2021) directs the Oregon Health Authority to implement, expand and enhance Oregon's 988 & Behavioral Health Crisis System (988 & BHCS) and declared a state of emergency for Oregon's struggling behavioral health crisis system. The directive includes enhancement of existing services and expansion of the current system to provide a "no wrong door" approach to ensure people in crisis receive the appropriate level of care through three programs: a statewide 988 call center, expanding mobile crisis team outreach, creating crisis stabilization centers (CSCs) within each county, and developing a seamless continuity of care through follow-up service referral and tracking. This request for funding is specific to ensuring the sustainability and creating capacity necessary to continue meeting federal standards for 988 call centers. Oregon has received $5 million from House Bill 2417 for the 988 call centers. However, call volume increase in subsequent years will drive resource needs to approximately $21 million in ongoing costs. This is the front door of the continuum of crisis services with relatively less funding need and highest return on investment. In addition, over time, as 988 becomes more well-known and call volume rises, additional resources will be necessary to provide capacity coverage.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$18,367,309**	**$0**	**$2,866,574**	**$21,233,883**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

The Legislature directed the Oregon Health Authority (OHA) in House Bill 2417 (2021) to build upon and improve Oregon's coordinated crisis system. This policy package continues that effort by expanding 988 call center capacity.

House Bill 2417 directs OHA to enhance existing services and expand the current crisis system to provide a "no wrong door" approach to ensure individuals in crisis receive the appropriate level of care. This approach includes establishing a statewide 988 call center, expanding mobile crisis team outreach, creating crisis stabilization units within each county, and developing a seamless continuity of care through follow-up service referral and tracking.

An effective crisis response system includes someone to talk to (988 call center), someone to respond (mobile crisis response), and somewhere to go (CSCs). Due to gaps in the crisis services continuum, individuals in crisis may end up in the hospital or jail systems. This policy package aims to fill the following gap:

- 988 call centers lack sufficient capacity for call, text, and chat functions at a level that meets the projected need. Over the next five years, OHA anticipates call volume will increase gradually from 80,000 in year one (2022) to over 240,000 from year two (2023) and beyond.

House Bill 2417 provided funding to begin ensuring people in crisis have someone to talk to by appropriating $5 million for 988 call center capacity and workforce. In April 2022, OHA was awarded

$2.1 million through a federal grant for training support and workforce capacity at 988 call centers in year one (2022). Oregon's 988 call center projections for implementation are 80,000 calls in 2022, with a gradual increase to 240,750 annually after five years. Correspondingly, annual funding needs for the 988 call center for call, text, and chat functions will grow from $13 million in 2022 and to $21 million in 2023 and beyond.

2. What would this policy package buy and how and when would it be implemented?

This policy package funds additional capacity for 988 call centers to ensure all calls are answered timely as volume increases;

This policy package includes $18.4 million General Fund ($21.2 million Total Funds) for 988 call centers to hire and train crisis intervention specialists, clinical supervisors, and other relevant staff imperative to operating a crisis call center. The added capacity will ensure Oregon is able to answer at least 90 percent of in-state calls with no more than 20 seconds wait time for each call, which is the federal standard. This policy package funds 51 counselors, 10 supervisors, and 4 quality assurance staff. Implementing a chat and text function is projected to require additional 6 staff per year. 988 call centers are staffed with Qualified Mental Health Associates (QMHAs) and Qualified Mental health Professionals (QMHPs), and clinical supervisors trained specifically in crisis intervention and de-escalation for all ages. This is the front door of the continuum of crisis services with least resource need and highest return on investment.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

This policy package aligns with OHA's strategic goal of eliminating health inequities through the development of more equitable access to behavioral health crisis care for all Oregonians. Building a full continuum of crisis services promotes health equity and would support the diversion of individuals from the emergency department and jail and experiencing a behavioral health response to a behavioral health crisis. Further, this policy package would increase access to culturally, linguistically, and developmentally appropriate crisis services by increasing capacity of 988 call centers and therefore ensuring a larger more diverse workforce that reflects the population they serve. Crisis call centers such as 988 are especially impactful in providing behavioral health crisis intervention and de-escalation services to youth and young adults who are experiencing suicidal thoughts or BH crisis but are hesitant to reach out for clinical help Historically, communities of color have been disproportionately experienced adverse outcome such as jail or ED while seeking help for behavioral health crisis. OHA's 988 & BHCS, Equity and Community Partnership, and Recovery and Resilience teams continue to actively work with the Crisis System Advisory Workgroup (CSAW) and the CSAW Steering Committee to ensure the creation of the crisis system is community-led.

This policy package supports OHA's commitment to eliminate health disparities in Oregon by 2030, as communities of color and other communities that have been and are currently economically and socially marginalized are disproportionately impacted by the lack of comprehensive behavioral health services, especially during a behavioral health crisis. Communities who have historically had less

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

access to health care due to systemic discrimination and racism have a higher risk of encountering law enforcement and first responders and ending up in the emergency department or jail when in crisis.

An alternative number (988) to 911, is critical for individuals who are most disproportionately impacted by inappropriate law enforcement response to a behavioral health crisis. 988 is part of the prevention efforts to divert individuals away from emergency departments and jail by providing an alternative place to go. Individuals who are most likely to need that level of response disproportionately belong to communities of color, LGBTQIA2S+, and individuals with development disabilities (IDD).

Quantifying results

4. What are the long-term desired outcomes?

The development of the statewide coordinated crisis system is intended to increase access to behavioral health services across Oregon. OHA anticipates the following outcomes:

- Improved access to quality community behavioral health services prevents interactions with the criminal justice system and prevents hospitalizations.
- People can easily access behavioral health services at the appropriate level of care through visibility into bed capacity and a “no wrong door” approach to obtaining services.
- Seamless connections between 988 call centers and crisis response services.
- Prevent suicide deaths.

5. How will OHA measure the impacts on health inequities of this policy package?

OHA will use measures disaggregated by REALD and SOGI requirements. The list below captures an initial set of measures that would continue to be built on.

The contractor would use trauma informed, culturally and linguistically appropriate evidenced-based best practices for data collection and offer opportunities for individuals to engage and provide feedback and recommendations as an essential part of the equitable data collection process. The contractor would collect, analyze, and report granular data that aligns with REALD & SOGI requirements to combat service and systemic inequities inherent in aggregate data and to ensure data-informed decisions and resources are dedicated to mitigating the disproportionate impacts experienced in historically and currently marginalized communities. In addition, the contractor would assume responsibility for and accountability of the behavioral health crisis system data and ensure accuracy of the data collected. The contractor would be responsible for providing behavioral health crisis system data to OHA upon request.

Monthly reports from the contractor would include:

- Presenting problem/symptom/issues
- Total number of contacts received, broken down by call, text, or chat.
    - Answer rate
        - Goal: to meet or exceed 90 percent of total calls/texts/chats answered to reduce the amount going to the national back up centers by 10 percent or less
    - Call abandonment rates
        - Goal: of less than 10 percent of total calls
    - Average answer speed
        - Goal: of 90 percent answered in 20 seconds or less
    - Average call length

    - Contact Satisfaction Survey results
        - Goal: of 93 percent or above “favorable.”
- Total number of individuals who contacted 988 via call, text, or chat for themselves
- Total number of individuals who contacted 988 via call, text, or chat for someone else
- Number of contacts for youth and young adults
    - Number and percentage of youth contacts who are 0–17 years of age and callers who are 18–20 years of age
    - Number and ages of youth who contact 988 directly for themselves
    - Relationship to person of concern, if contacting on behalf of a child or young adult
- Total number of calls, texts, and chats transferred from or to the 988 line:
    - Behavioral Health Support Line
    - Alcohol and Drug Hotline
    - County crisis line
    - Race Equity Support Line
    - Senior Loneliness Line
    - Helpers Helping Helpers
    - Youthline
    - Veteran’s Crisis Line
    - 911 (includes rescue calls)
- Types of community-based resources that the individual or family was connected to
- Total number and percentage of contacts that were resolved by crisis call centers and did not require an in-person response
- Number and percentage of contacts for youth ages 20 and under that were resolved by 988 call center
- Number of contacts that led to request for Mobile Crisis or MRSS Teams dispatch. Of those contacts, Contractor must also document:

    - Whether contact was through call, text, or chat
    - Time of request for mobile crisis or mobile crisis teams dispatch
    - Name of entity to whom request for mobile crisis or mobile crisis teams dispatch was made
    - Outcome of mobile crisis or mobile crisis teams dispatch request.
- Average number of follow-up calls to individuals
    - Outcome of follow-up calls.
- Number of contacts requesting veterans' services
- Number of contacts coded as suicide in progress

Quarterly reports from the contractor would include:

- The types of contacts received (stated problems/needs).
- Warm transfer or connection to community-based services, including the type of service and location
- Follow-up utilization failure report identifying reasons individual, or family did not receive services in the community following the call to 988 (self-reported)

Annual reports from the contractor would include:

- Annual budget
- A Quality Improvement Plan focusing on policies, first contact, assessment, referral, and access to local care to ensure there is a comprehensive and coordinated response to individuals at imminent risk for suicide
- 988 call center workforce diversity including:
    - Aggregate data on REALD & SOGI for call center workforce
    - Language and interpretation services availability
- 988 call center training report including:

- Names of evidence-based trainings approved by OHA on culturally, linguistically, and developmentally appropriate services given to staff
- Frequency of each training
- Percentage of staff who have completed training and their designation.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

The Legislature appropriated $5 million in House Bill 2417 to fund both 988 call centers. OHA has applied and been awarded $2.1 million through a federal grant for training support and workforce capacity at 988 call centers in year one.

7. What alternatives were considered and what were the reasons for rejecting them?

An alternative that has been proposed in the past to establish a sustainable source of funding for 988 call centers is a 988 fee per phone line per household for telecommunication providers. 911 call centers are funded similarly and a few other states such as Nevada, Washington, and Utah have taken this approach to funding 988. However, this option was not approved or supported by legislators and telecommunication providers when it was being considered during the 2021 Legislative Session.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Collaboration on this policy package includes but is not limited to the nine-federally recognized tribes and Urban Indian Health Program, consumers, Medicaid providers, CCOs, peer-delivered services

community, local community mental health programs (CMHPs), Oregon Council Behavioral Health (OCBH), Crisis System Advisory Workgroup (CSAW), CSAW Steering Committee, Medicaid Advisory Committee (MAC), Oregon Consumer Advisory Council (OCAC), Health Policy Board, Alcohol Drug Policy Commission (ADPC), Addictions and Mental Health Planning and Advisory Council (AMPHAC), Oregon Association of Hospitals and Health Systems (OAHHS), NAMI, law enforcement, emergency medical services, 911 programs, and other first responders.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    This policy package will improve access to 988 & BHCS system services for the nine federally recognized Tribes and the Urban Indian Health Program, Oregon Health Plan members. Tribes have the option to work with OHA to implement 988 call centers

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023 for call centers

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

- OHA's third party consultant and HSD budget estimated a state share of cost based on population data and anticipated Medicaid match.
- There might not be a 988 tax or fee to support the 988 & BHCS system and related services.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Overall, the anticipation is that as 988 becomes more socialized, call volumes will exponentially increase: 80,000 in year one (2022) to over 240,000 from year two (2023). In addition, behavioral health crisis has had a significant increase in need across all populations over the last two years.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Currently, OHA does not have staff assigned to this work. Staff time from other programs will need to be reprioritized to execute the work.

16. What are the start-up and one-time costs?

The startup cost is $18.4 million to hire and train crisis intervention specialists, clinical supervisors, and other relevant staff imperative to operating a crisis call center. The startup cost will fund 51 counselors, 10 supervisors, and 4 quality assurance staff. Implementing a chat and text function is projected to require additional 6 staff.

17. What are the ongoing costs?

The startup cost is $21.2 million to continue maintaining capacity that is built up through startup cost and also fund additional capacity needed as call volume increases.

18. What are the potential savings?

Resourcing 988 call centers at the full capacity will have immediate and long-term savings on the following:

1. Mobile crisis services
2. Emergency department related service including ED boarding
3. Other acute care facilities for behavior health services
4. Residential services
5. Outpatient services

988 call centers are staffed with Qualified Mental Health Associates (QMHAs) and Qualified Mental Health Professionals (QMHPs), and clinical supervisors trained specifically in crisis intervention and de-escalation for all ages. This is the front door of the continuum of crisis services with least resource need and highest return on investment.

19. What are the sources of funding and the funding split for each one?

Much of this program is funded by state funds. The Federal Funds represent anticipated grant funds from Substance Abuse and Mental Health Systems Administration (SAMHSA).

Funding for program-related efforts is varied and used solely for program costs. No dedicated funds have been allocated to the necessary information systems and data needs to support the program efforts.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos	FTE
Personal Services					0	0.00
Services & Supplies						
Capital Outlay						
Special Payments						
Other						
Total	**$18,367,309**	**$0**	**$2,866,574**	**$21,233,883**	**0**	**0.00**

Oregon Health Authority
2023-25 Policy Package

Division:	Central Services
Program:	Equity and Inclusion Division
Policy package title:	Regional Health Equity Coalition Program Expansion
Policy package number:	410
Related legislation:	Senate Bill 70 Regional Health Equity Coalitions (2021); ORS 413.042; OAR 943-021-0001, 943-021-0005

Summary statement:

In alignment with OHA's 2030 strategic goal to eliminate health inequities, this is the second phase of expansion for the legislatively mandated Regional Health Equity Coalition (RHEC) program to move toward statewide representation to address health inequities more meaningfully, especially for communities of color. This policy package funds five new RHECs. This program provides necessary capacity and infrastructure building support for communities to identify the most pressing health equity issues in their region and create meaningful solutions at the policy, systems, and environment change level. The second phase of expansion requires sufficient staff capacity to support RHECs and internal operations related to the program.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$2,098,305**	**$40,801**	**$75,772**	**$2,214,876**	**3**	**2.25**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Regional Health Equity Coalitions (RHECs) are autonomous, community-driven, cross-sector groups whose backbone organizations are non-governmental in nature. The work of these coalitions, to identify and address health equity issues, covers a wide range of underserved communities, including communities of color, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, persons with disabilities and lesbian, gay, bisexual, transgender and questioning communities. Communities of color are the leading priority because communities of color often experience the greatest health inequities, both in Oregon and nationally. The work of the RHECs addresses social determinants of health that have persisted for generations in sectors such as health, education, housing, employment and transportation. Ultimately, the coalitions are working to improve the overall state of health equity in Oregon.

Senate Bill 70 (2021) defined RHECs and several other key terms[1], which described the key components of the RHEC model. It also required OHA to work with RHECs and "ensure that it has adequate staffing to support grantees through ongoing technical assistance, contract administration, program planning, and daily operations."

As defined in statute and rule regional health equity coalitions are:
"(a) Autonomous, community-led, cross-sector groups focused on addressing health inequities experienced by priority populations, at the policy, system, and environmental levels, with the leading priority being communities of color.

[1] Additional key terms defined in this statute included: communities of color, cross sector, priority populations, and community-led.

(b) Completely independent of coordinated care organizations and public bodies as defined in ORS 174.109.
(c) Supported by fiscal agents such as federally recognized tribes of Oregon and community-based nonprofit entities, including culturally specific organizations, social service providers, organizations that provide health care, organizations that conduct public health research, organizations that provide behavioral health treatment, private foundations, and faith-based organizations.
(d) Required to have decision-making bodies:
(A) Whose membership is at least 51 percent individuals who identify as members of communities of color who have experienced health inequities.
(B) That prioritize the recruitment of members who identify as members of communities of color or who work in roles that address health inequities and institutional racism.
(2) The regional health equity coalition model means an approach that:
(a) Recognizes the impact of structural, institutional and interpersonal racism on the health and well-being of communities of color and other priority populations;
(b) Meaningfully engages priority populations to lead efforts to address health inequities;
(c) Supports and strengthens leadership development for priority populations;
(d) Honors the wisdom of members of priority populations; and
(e) Ensures that policy solutions and system changes build upon the strengths of the priority populations."

2. What would this policy package buy and how and when would it be implemented?

The root causes of health inequities have persisted for centuries because systems and institutions have been created to benefit a select group of people over time. According to Agénor, et. al, "structural racism has had a substantial role in shaping the distribution of social determinants of health and the population health profile of the USA, including persistent health inequities." Meaningfully impacting health equity issues requires redistribution of resources, and in the context of

the RHEC program, sustained, long-term efforts with dedicated fiscal investment is critical for success.

Resources are included to support expansion of the RHEC program to add five more coalitions in additional regions across the state. The RHECs receive funding from several sources, but primary support comes from OHA. This foundational or base funding provides necessary nimble infrastructure support allowing the RHECs to focus their priorities on work that communities indicate are most important, rather than categorical funding which can be too narrowly focused on issues that may not be critical in some regions.

Capacity building grants are used to develop new RHECs by supporting coalitions to pilot the RHEC model with the health equity work they are doing and offers an opportunity to complete foundational RHEC activities. These activities include, but are not limited to: coalition building, developing and solidifying governance structures via charters, conducting community needs assessments, etc. After one biennium, the capacity building grantees are assessed for readiness to move into the implementation phase of their work, and whether the RHEC model aligns with the grantee's vision for their health equity work. Capacity building would take place from 2023 to 2025, with implementation anticipated in subsequent years.

There are several benefits to growing the RHEC model statewide through sustained and expanded funding, including:

- Increasing opportunities for coordinated care organizations (CCOs) to partner with RHECs, offer technical assistance and training to build CCO's capacity around health equity and the social determinants of health.
- Allowing coalitions the level of autonomy needed to improve health equity in meaningful and appropriate ways that ensures anti-racist priorities are not compromised.

- Continuing to grow the necessary capacity of Oregon to address health equity issues in culturally specific and effective ways.
- Creating additional opportunities to sustainably address issues related to avoidable policy and system barriers which may help lower costs to health and other related systems.

Lastly, three new positions (2.25 FTE) are being included to support this expansion and ensure adequate support to grantees through continued technical assistance, sufficient time for contract administration activities, daily operations, and future program planning. Positions include a Program Analyst 3 to support program coordination, planning, training, and technical assistance; a Research Analyst 3; and an Administrative Assistant 2.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[2] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

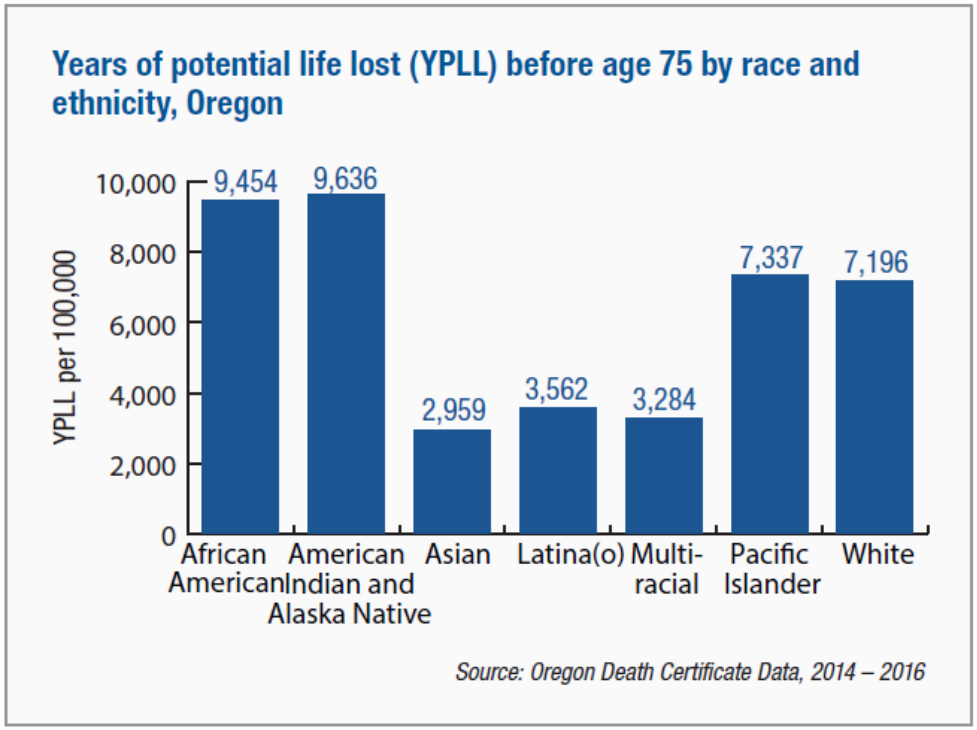
Health inequities continuing to persist is evidence that status quo efforts lead by dominant culture organizations, agencies, and institutions remain largely ineffective. This points to the need for innovative approaches with communities harmed by inequities leading and informing efforts to address structural racism. The RHECs have expertise based in lived experience to apply anti-racist frameworks with regard to policy and systems change efforts and to identify the most critical and regionally-specific health equity issues, while crafting policy, system and environmental solutions.

In Oregon, African Americans and American Indians and Alaska Natives experienced more years of potential life lost (YPLL) than any other race and ethnicity in the state. See Figure 1 (Oregon Death

[2] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Certificate Data, 2016). Chronic illness is also greater for many communities of color. For example, African Americans (38.9 percent), Pacific Islanders (36.1 percent), American Indians and Alaska Natives (33.4 percent), and Latinos (29.1 percent) are more likely to experience high blood pressure in this state.

Figure 1. Years of Potential Life Lost before age 75 by Race & Ethnicity in Oregon

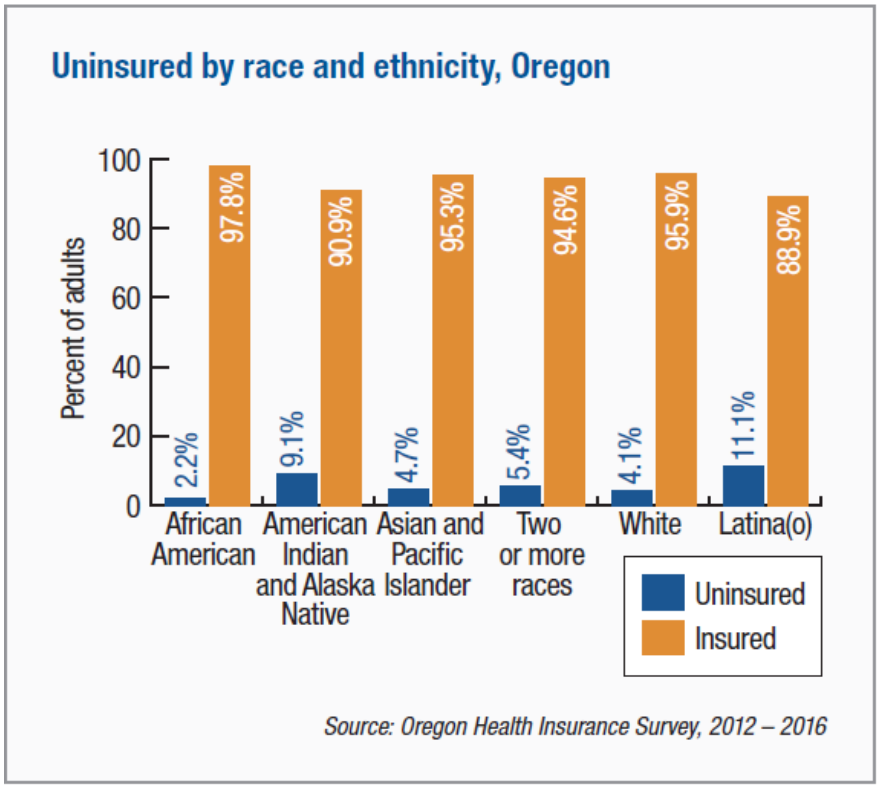


Furthermore, communities of color are also more likely to be uninsured. See Figure 2 (Oregon Health Insurance Survey, 2016).[3] Overall, 62 percent of those who are uninsured delayed or did not

[3] Oregon Health Insurance Survey. Available from: https://bit.ly/2NDqLbK.

get at least one type of care because of cost (as compared with 20.4 percent to 32.4 percent among those with insurance).[4] Being uninsured increases the chances that health care needs are unmet, which in turn leads to worse health outcomes.

Figure 2. Oregon Uninsured by Race & Ethnicity



[4] Oregon Health Authority, Oregon Health Insurance Survey: Cost Barriers to Care Fact Sheet (2015). https://www.oregon.gov/oha/HPA/ANALYTICS/InsuranceData/2015-OHIS-Cost-Barriers-to-Care-Fact-Sheet.pdf

Quantifying results

4. What are the long-term desired outcomes?

While communities of color experience avoidable inequities due to structural racism (Agénor, et. al, 2017), there remains great strength, resilience, and wisdom which should inform efforts to ultimately address health equity issues. Many over the years have discussed the power of culture in healing the traumas resulting from racism, discrimination and inequities, and the need for community wisdom to develop creative, long-term solutions to health barriers at the policy, system, and environment change (PSE) level.

The RHECs have the expertise based in lived experience to identify the most critical and regionally-specific health equity issues, while crafting PSE solutions. This means that communities most harmed by health inequities are leading the identification of the "right issues" (i.e., most urgent or impactful issues in their region), and develop more effective solutions with fewer unintended consequences. Coalition efforts also work to address root cause issues that perpetuate structural racism and result in continued health inequities, while working to develop solutions that build on existing strengths and foster health equity. Ultimately, the RHEC model addresses structural racism through policy and systems change to work toward the elimination of health inequities.

Meaningfully impacting these issues and health inequities in general requires sustained, long-term efforts with dedicated fiscal investment. Specific benefits of sustained and expanded funding include:

- Increased opportunities for CCOs to partner with RHECs, offer technical assistance and training to build CCOs' capacity around health equity and the social determinants of health.
- Allows coalitions the level of autonomy needed to improve health equity in meaningful and appropriate ways that ensures anti-racist priorities are not compromised.

- Continues to grow the necessary capacity of Oregon to address health equity issues in culturally specific and effective ways.
- Creates additional opportunities to sustainably address issues related to avoidable policy and system barriers which may help lower costs to health and other related systems.

5. How will OHA measure the impacts on health inequities of this policy package?

The new Research Analyst would be responsible for developing a robust, and culturally appropriate program evaluation to examine program impacts. Evaluation would likely happen through a combination of process measures and outcome measures that would be developed in partnership with RHECs. Methods would rely on documenting practice-based or community-based evidence, with a focus on community-engaged and community-led evaluation efforts, such as community-based participatory research (CBPR[5]), wherever possible.

Due to emerging research regarding place-based investment, the evaluation plan may rely on several methods to evaluate the collective impacts of the investments and associated benefits of the RHECs. The evaluation plan would likely utilize a collective impact framework (CIF[6]). This effort works to build on community strengths and assets and align existing resources toward a common

[5] CBPR involves researchers and community engaging as equal partners in all steps of the research process and can be a strategy to improve data collection and interpretation while also promoting community health and addressing health inequities as well as empowering communities with evaluation capacity.

[6] CIF informs how a network of community partners, organizations, and institutions can develop common objectives, learn, align, and integrate actions, and leverage a shared measurement strategy to promote systems-level change and achieve health equity priorities (Kania and Kramer, 2011).

goal. The CIF underscores the important role of community in decision making. This is consistent with guidance received from community partners over the years and OHA's commitment to shifting power and amplifying community voice in community engagement efforts.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In July 2011, the Equity and Inclusion Division developed the RHEC program to support local, community-led, culturally-specific activities to reduce inequities and address social determinants of health specifically among communities of color. A significant amount of the division's limited budget has been invested in RHECs over the years, often in lieu of basic infrastructure supports for the division. Because of the demonstrated successes of these coalitions and the urgency to address health inequities and ultimately the early deaths of so many, this strategic investment has continued over the years.

In the 2021 biennium, the division began the first phase of expansion for the RHEC program which included adding four new coalitions and additional staff to support the program. Since then, a request for grant proposal (RFGP) was issued and through competitive solicitation four new coalitions were awarded. The RHECs have expanded to add nine counties in addition to the existing 11 county region and including Confederated Tribes of Warm Springs.

Because of limited existing internal capacity to roll out an expansion of this magnitude, this expansion effort is using a phased approach. This policy package is the second phase and continuation of this expansion to work toward statewide representation. These coalitions have had

great success over the years, and there needs to be greater capacity to lead critical health equity efforts in regions across the state, especially because Oregon's population is diversifying.

7. What alternatives were considered and what were the reasons for rejecting them?

The OHA Equity and Inclusion Division looked at whether current RHECs could expand beyond their regions, but given existing capacity, workload, and partnerships with priority populations this was not possible. Additional resources are needed to support new coalitions in other parts of the state that do not currently have representation. Resources are needed for five additional coalitions.

Related to the division's staff capacity, existing staff could not support an expansion of this magnitude with their current workload and responsibilities and sufficient resources are not available to effectively carry out this important work and legislative mandates.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Regional Health Equity Coalitions

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Strengthening RHECs would enhance resources for Tribal Governments and boost opportunities for local and county governments to partner with RHECs and to receive technical assistance and training to build capacity around health equity and the social determinants of health. For example, a RHEC capacity building grant to Warm Springs Confederated Tribes has successfully shown that additional RHECs run by Tribal Governments can enhance equity work with Tribes.

Another example is when Mid-Columbia Health Equity Advocates (MCHEA) successfully advocated to County Commissioners for a county identification card for all community members regardless of barriers related to age, housing, transportation, immigration status, and cost. Having an official identification card improves access to basic services and helps make law enforcement interactions less frightening.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): N/A

12. What assumptions affect the pricing of this policy package?

The assumption that health equity and OHA's 2030 strategic goal to eliminate health inequities are indeed priorities for the agency and the state. The RHECs would receive grants in the amount of $150,000 per coalition every 12 months to support their efforts.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No, all aspects of this policy package fit within existing responsibilities of the agency including compliance with state and federal law, and OHA's 2030 strategic goal to eliminate health inequities.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Not applicable.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Three new permanent positions (2.25 FTE) are included to support this expansion and ensure adequate support to grantees through continued technical assistance, sufficient time for contract administration activities, daily operations, and future program planning. The positions are as follows:

Program Analyst 3
The purpose of this position is to build community and organizational capacity to address health equity through developing and coordinating funding partnerships between the OHA Equity and Inclusion Division and partner organizations. The Regional Health Equity Coalition (RHEC)

Coordinator's role is to coordinate all aspects of the RHEC program, providing communications and logistical support, training and technical assistance directly to RHECs, monitoring contract deliverables, assuring compliance with contracts and other support contracts, and conducting site visits where they would collect and review site visit data and write internal reports on progress and activities.

Research Analyst 3
This position would be dedicated to evaluation and research specific to the RHEC program. They would be responsible for the following:

- Planning and coordinating moderately complex research and evaluation projects
- Developing research methodology, procedures and forms for data collection
- Analyzing and interpreting information
- Reporting findings and recommendations in plain language

Administrative Analyst 2
This position would assist the RHEC program manager and team. They would perform administrative research, analysis, and/or evaluation in support of the RHEC program. The work performed by this employee requires a comprehensive knowledge of the RHEC program and foundational concepts related to health equity. This would include interpreting laws, rules, policies and procedures and supporting compliance for the RHEC program. They would also lead developing, processing, submitting and tracking grant/contract paperwork, and requests for disbursements to grantees.

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

The ongoing costs are estimated at $1.6 million to support the development of five new RHECs across the state; $0.5 million to increase staff support to three full-time, permanent positions to ensure adequate support to grantees through continued technical assistance, sufficient time for contract administration activities, daily operations, and future program planning, approximately $8,000 for bi-lingual differential for the PA3 position, $42,900 for other Services & Supplies (S&S), and $40,000 for training and supporting cross-learning opportunities among coalitions.

18. What are the potential savings?

This funding is a nominal investment for substantial returns in terms of cost savings to impacted systems by way of improving inequities. Sustaining and growing the Regional Health Equity Coalition program provides expertise and assistance to the state to demonstrate and carry out regionally appropriate, concerted efforts to address issues of inequity across Oregon.

Without RHECs, there would not be as many opportunities to address inequities across the social determinants of health and therefore these issues would not be as comprehensively addressed. The RHECs are working to address inequities at the PSE level and across many sectors including health, housing, corrections, behavioral health, education, transportation and beyond.

When community partners are able to name the issues most impacting their health and wellness, and develop solutions to those challenges, it means there is less waste from addressing the wrong issues and pursuing ineffective efforts. These focused and intentional solutions not only save time and resources but move the state closer to health equity.

OHA directly benefits from this partnership because of the expertise RHECs bring in guiding the agency’s health equity and PSE efforts toward being more appropriate and meaningful. For example,

the RHECs were one of the primary vehicles for establishing the OHA strategic goal through a comprehensive community engagement effort where networks within the RHECs were called upon to host and facilitate community feedback events. They provide direct connection to community partners and investing in this expansion means we improve reach across all of Oregon.

19. What are the sources of funding and the funding split for each one?

This work is on behalf of the entire agency and would use the agency-wide cost allocation pool to distribute costs to revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds for all costs except the grants to RHECs ($1.5 million) which are funded at 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$356,878	$31,227	$57,990	$446,095	3	2.25
Services & Supplies	$1,741,427	$9,574	$17,782	$1,768,781		
Capital Outlay						
Special Payments						
Other						
Total	**$2,098,305**	**$40,801**	**$75,772**	**$2,214,876**	**3**	**2.25**

Oregon Health Authority
2023-25 Policy Package

Division:	Oregon State Hospital
Program:	Salem Campus, Junction City Campus
Policy package title:	Sustainable Staffing
Policy package number:	411
Related legislation:	House Bill 5024 (2021) Budget Note, House Bill 5202 (2022)

Summary statement:

As directed within the Budget Note within House Bill 5024 (2021), the Oregon Health Authority was directed to:

> "submit a financially and programmatically sustainable plan to the Emergency Board or Interim Joint Committee on Ways and Means that provides solutions for maintaining appropriate daily staffing levels to ensure the safety of both patients and staff [at the Oregon State Hospital]."

House Bill 5202 (2022) granted a portion of that request. This policy package includes the remainder.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$34,465,572**	**$0**	**$0**	**$34,465,572**	**304**	**94.63**

Purpose

1. **Why does OHA propose this policy package and what problem is OHA trying to fix or solve?**

   The Oregon State Hospital (OSH) has been challenged over the years in maintaining the appropriate staffing levels to achieve a high level of quality care while ensuring patient and staff safety. This is primarily due to enhanced patient needs from a dramatic shift of the population OSH serves as well as a lack of budgeted position authority necessary to ensure adequate clinical and operational staffing levels resulting from the non-delivered staff for both scheduled and unscheduled leave. This instability negatively affects the consistency of service delivery, cohesion across care providers, and a sense of responsibility to the unit or program teams and to the overall hospital.

2. **What would this policy package buy and how and when would it be implemented?**

   This policy package represents an equalization of the staffing needs with budget authority. Simplified, this package provides additional positions and system resources to provide a consistent level of care for our patients, while maintaining a safe environment conducive to that care.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   This package directly contributes to health equity among disadvantaged populations with behavioral health symptoms and unable to receive alternative care. As such, it is critical infrastructure for a

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

portion of the population that otherwise lacks the capacity to receive care or administer to their own needs. In addition to traditional definitions of health equity, OSH patients are often without significant financial, personal, or infrastructure support, that would empower them to begin the treatment process.

Quantifying results

4. What are the long-term desired outcomes?

Long term outcomes are both patient and staff centered. Patients should experience a more personal level of care with staff who know their individual symptomology to assist in their recovery. Staff should experience a more consistent and stable work environment that limits the stress of the job to the treatment being provided, rather than being burdened with concern over adequate levels of day to day support or the reliance on agency staff that do not possess an established connection to the patient. Both patients and staff should see an environment that better promotes treatment goals, safety, and improved mental and physical health.

5. How will OHA measure the impacts on health inequities of this policy package?

Impacts of this policy package would be primarily measured through staffing levels. The goal of this package is to provide a level of consistent staffing, which should result in staffing levels being sustained, regardless of call-outs and a decreased reliance on contracted services and mandated overtime. This staffing would in turn impact health inequities within individual patients. Although not easily measured in any statistical category, they include: increased camaraderie between patients and staff and staff-to-staff; a better environment of care; fewer obstacles in individual recovery; and other such essential but immeasurable attributes.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

As the specific request is recent, the prior attempt was a presentation as directed by the Legislature in response to the budget note. In more general terms, the staffing issues have been an ongoing struggle for the hospital with a variety of actions resulting in increased scrutiny of call-outs, changes to unit staffing to promote team environments and individual responsibility, review of program structures to allow better staff utilization, and periodic review of staffing needs as a whole. These actions had only varying degrees of success. As a behavioral health facility, OSH will inherently experience instances of aggressive behavior during treatment. If there are no real or perceived additional resources for employees in terms of available staff or help on the horizon, this can result in loss of morale that leads to staffing issues regardless of how the current limited resources are shifted.

7. What alternatives were considered and what were the reasons for rejecting them?

This issue is a staffing need. OSH has tried various solutions to resolve the need within existing resources. But OSH simply cannot support a sustainable staffing plan — one that provides ongoing stability for both staff and patients — within its current budget and position authority as contracted staffing drives additional spending as does limited duration or non-budgeted positions, both of which the hospital has utilized. This package is intended to shift that recurring over-spend need to budgeted positions that can deliver the necessary care.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

This package has the support of Disability Rights Oregon, who recognize that more reliable staffing contributes directly to more reliable patient care. Both SEIU and AFSCME-Registered Nurses are in support.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No. This policy package does not require statutory updates; however, there are portions of the total staffing concept that may require such changes and be introduced as future policy packages.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Primary impact would be to communities at the front and back end of the individual patient recovery. It would first assist with providing a hospital-level of care to those individuals who truly need it; ultimately resulting in the placement of those individuals into community housing as patients no longer in need of hospital-level care. An increase of available community facilities is currently a recognized issue — both for those persons who need a hospital-level of care and a place to transition to, as well as the persons who do not need OSH care but could be treated in communities. OSH admits those who are determined to need hospital care, regardless of community of origin.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No. It is the result of a budget note to address a known issue within the behavioral health continuum of care.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

Pricing is impacted by the pilot and implementation of a more patient-centered staffing tool or “acuity tool”. This method is designed to rate the acuity of a particular unit of the hospital by patient acuity through a standardized measurement of the individual patients’ ability to meet certain clinical criteria. The overall acuity of the program on which the units reside results in the staffing needs for that day and may shift from day to day by patient population and treatment goals. Because this is in pilot, adjustments to quantities or classifications may occur.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There will be associated human resources and payroll needs for the increase in positions. Those position resources are part of this policy package.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No change.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This request is entirely related to additional staff.

Position pricing for 2023-25 includes a shift in classifications requested from the original request within the SPA. On the Salem campus, this is a net increase of 149 positions (72.88 FTE). The position total of 261, offset by 112 positions that will be re-purposed within 2023-25, but eventually phased out. The total Salem position request is estimated at $30.9 million for the 2023-25 biennium. On the Junction City campus, this is a request for 43 positions (21.75 FTE) estimated at $5.1 million.

For the 2023-25 biennium, this policy package includes 304 positions with 112 of that total phasing out at the end of the biennium, to net to 192 new positions. The total expenses for 2023-25 is estimated at $34.5 million.

16. What are the start-up and one-time costs?

There are no start-up costs.

17. What are the ongoing costs?

Expenses in the 2025-27 biennium will reflect the phase-out of the positions repurposed to meet the evolving OSH acuity need. The ongoing costs of the policy package are expected to be $79 million in

2025-27 for a total of 192 positions. Of those positions, 149 positions ($69.1 million) will be on the Salem campus and 49 positions ($9.9 million) will be on the Junction City campus.

18. What are the potential savings?

No budgetary savings are expected as a result of this package.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$31,675,890			$31,675,890	304	94.63
Services & Supplies	$2,789,682			$2,789,682		
Capital Outlay						
Special Payments						
Other						
Total	**$34,465,572**	**$0**	**$0**	**$34,465,572**	**304**	**94.63**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Policy and Analytics
Program:	Oregon Health Insurance Marketplace
Policy package title:	Marketplace Transition from SBM-FP to SBM
Policy package number:	416
Related legislation:	LC #471

Summary statement:

This policy package furthers OHA's mission of improving access to quality, affordable health care for Oregonians and its goal to eliminate health inequities by 2030. This policy package funds the initial stage of Oregon's transition away from the federally facilitated marketplace to a state-based eligibility and enrollment platform and call center for operation and administration of Oregon's health insurance exchange. Oregon is seeking a platform that:

- Interfaces with Oregon's Medicaid systems to keep people covered during transitions and address churn.
- Improves the qualified health plan shopping and customer services experience for Oregonians.
- Integrates input from Oregon's various and diverse communities into technology and call center implementation.
- Collects, analyzes, and stores enrollment data, including REALD & SOGI data to improve access to affordable coverage.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$0**	**$2,059,864**	**$0**	**$2,059,864**	**4**	**3.25**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

The purpose of this policy package is to end Oregon's reliance on the federal health insurance exchange eligibility and enrollment platform and the federal call center, and to fund the initial stage of its transition to a state-based marketplace platform and state-controlled call center.

In 2010, President Obama signed the Affordable Care Act (ACA) into law. Part of the intent of the ACA was to make individual health insurance more affordable so that more of the then-estimated 44 million uninsured Americans could obtain coverage. To reduce costs for individuals and families who do not receive health coverage through an employer or a government program, the ACA uses income-based tax credits that eligible consumers could choose to receive in advance (advanced premium tax credits, or APTC) and subsidies to reduce cost-sharing (cost-sharing reductions, or CSRs) such as co-insurance, co-payments, and deductibles. APTCs and CSRs are available only to consumers who purchase a qualified health plan (QHP) through a health insurance exchange. A health insurance exchange is a public or semi-public entity that administers the provisions of the ACA under state authority, including using technology to determine eligibility for APTCs, allowing consumers to shop for and choose health insurance plans, enrolling consumers in those plans, and storing consumer information. Under the ACA, if a state fails to administer its own exchange, the federal government will step in and do so.

The Oregon Health Insurance Marketplace (Marketplace) is an office of the Health Policy and Analytics (HPA) division of OHA. The Marketplace is Oregon's health insurance exchange, and its mission is to empower Oregonians to improve their lives through local support, education, and access to affordable, high-quality health coverage. The Marketplace administers Oregon's health insurance exchange in this state, through which Oregonians may purchase ACA-compliant individual

health insurance plans and receive tax credits and cost-saving reductions to make those plans more affordable.

States like Oregon, that retain direct authority over their exchanges but rely on the technology and call center provided by the federal Centers for Medicare and Medicaid Services (CMS), a division of Health and Human Services (HHS), for its APTC, CSR, and plan eligibility, shopping, and enrollment operations, are known as state-based marketplaces on the federal platform (SBM-FPs). Thus, because Oregon is an SBM-FP, Oregonians enroll in QHPs through HealthCare.gov, which is owned and managed by CMS. HealthCare.gov is the front end of the enrollment technology that is known as the federal platform or federally facilitated marketplace (FFM). Tied to the FFM is a telephone consumer assistance center staffed by customer service representatives – federal employees or contractors – who help people with APTC and CSR eligibility, plan enrollment and related support over the phone. Oregon health insurance companies selling plans through the Marketplace pay a fee for use of the federal technology. The fee has fluctuated over the years from zero to three percent of total premiums paid by Oregonians who purchase QHPs through the Marketplace.

Oregon and other states using the federal platform as SBM-FPs began doing so because a lack of alternative options available to them at the time. When the SBM-FP exchange classification was created, the federal government made the FFM and its call center services available without charge.

The agreement with CMS to use the federal platform does not have any guaranteed service levels. Instead, the agreement is focused on the requirements of the SBM-FP, and the conditions with which Oregon and the Marketplace must comply for use of the platform. This is one of the disadvantages of using the federal platform, which also includes the following:

- **Inflexibility of the FFM technology.** Because the HealthCare.gov is a one-size-fits-all solution, it is designed for use by many states and cannot be customized according to Oregon’s needs,

preferences, or requirements. In other words, what works for Oregon must also work for Alabama. For example, CMS cannot or will not operationalize the following:

- Increasing the length of open enrollment to accommodate the specific needs of Oregonians. So, while Oregon has the authority to increase the length of open enrollment (which may be important due to specific conditions in the state, such as unusually high COVID-19 infection or hospitalization rates), Oregonians cannot take advantage of the opportunity because the FFM cannot operationalize this change.
- Creating special enrollments to accommodate Oregon-specific circumstances. For example, Oregonians in need could not take advantage of a special enrollment created for victims of wildfires, flooding, or earthquakes unless the FFM deemed it necessary independently of what the state determines.
- Providing on-demand and real-time access to current or historical enrollment data and statistics, including race, ethnicity, and language, disability, sexual orientation, and gender identity data (REALD/SOGI).
- Coordinating with OHA's Medicaid program to eliminate gaps in coverage and care resulting from churn or to auto-enroll individuals who are redetermined ineligible for Medicaid after the end of the public health emergency.
- Establishing a basic health program to use federal funds to provide Medicaid-like coverage for individuals with incomes from 138 percent of the federal poverty level (FPL) to 200 percent FPL, including lawfully present immigrants who do not qualify for Medicaid due to limited in-country residency.
- Innovating and coordinating with other state agencies to, for example, create an easy Marketplace eligibility system for interested Oregonians that allows them to simply check a box on their tax returns authorizing the automatic transfer and analysis of income data to the Marketplace's system to determine APTC and CSR eligibility.

- **Lack of control over operations, customer service, and service levels.** Oregonians can face long wait and hold times when contacting the FFM's Customer Assistance Center (CAC), and when finally able to speak with a customer service representative, there is no guarantee that the information provided will be accurate. The latter is because the CAC serves many states, and its representatives are not all familiar with Oregon laws and requirements. This has resulted in some Oregonians needing to call the CAC repeatedly over periods extending into weeks or months to resolve complex case issues. While these issues would typically be addressed with the CAC vendor in a service level agreement (SLA) (assuming the state had access to performance metrics), CMS has not entered into an SLA with states for either the enrollment technology or the consumer assistance center, and Oregon does not have the leverage to insist that one be instituted. The agreement for use of the federal platform is presented by CMS to each state for acceptance or rejection. There is no negotiation, and all states receive the same terms. For a state to reject the agreement, it must be able to administer its own exchange and provide its own technology platform.
    - The FFM technology's provider search option is frequently out of date. When a consumer desires to select a plan based on its coverage of their doctors, the consumer cannot always trust that that the information displayed is correct. Incorrect provider directory information does not serve as a basis for a plan-selection "redo," meaning that a consumer will have to remain in a plan that doesn't cover their doctors until the next open enrollment (unless they cancel coverage or qualify for special enrollment for another reason).

- **Unpredictable and opaque charges.** The fee for using the FFM is paid directly to CMS by Oregon insurance companies and is passed on to consumers in the form of increased insurance premiums. In 2023, a family of five will pay an estimated $42.50 per month in premiums solely for the use of the FFM. The fee is established annually by CMS as part of a set of rules called the Notice of Benefit and Payment Parameters (NBPP). While initially free for SBM-FP states to use, starting in 2017, CMS began charging for use of the federal platform. In 2017, 2018, 2019, 2020,

2021, 2022, and 2023 the fees were 1.5 percent, 2 percent, 3 percent, 2.5 percent, 2.5 percent, 2.25 percent, and 2.25 percent respectively, of total premiums for plans purchased through HealthCare.gov.

- CMS claims its charges are based on the following “special benefits” provided to insurers that use the FFM: (1) provision of consumer assistance tools; (2) consumer outreach and education; (3) management of a Navigator program; (4) regulation of agents and brokers; (5) eligibility determinations; (6) enrollment processes; and (7) QHP certification processes. As an SBM-FP state, Oregon performs the majority of these functions yet CMS charges Oregon only half of one percent less than it charges states that rely on the FFM for all of these functions. Although, for the past several years Oregon has inquired about CMS’s charging calculous and its underlying rationale and have requested a state-specific break down of services used and charges imposed, CMS has refused to acknowledge Oregon’s requests. The state has questioned how a flat percentage fee on premiums could possibly apply across the board. Such a "flat tax" disadvantages smaller states, like Oregon, whose residents collectively use fewer federal resources - fewer people are using the call center, seeking eligibility determinations, using the federal platform, requesting special enrollments, asking shopping-related questions, receiving APTCs, etc.
- CMS's flat user fee does not give Oregon credit for the expense and success of state-specific programs. As an SBM-FP, Oregon funds its own navigator program and funds a very targeted outreach and education program. For the 2016 plan year, without federal navigator funding, Oregon increased its enrollment by 31 percent over the 2015 plan year, far exceeding any of the FFM states. This increase was second only to New Mexico, another SBM-FP state. For the 2017 plan year, when almost all FFM states lost enrollment, Oregon increased enrollment by 6 percent. In fact, six of the ten top performing states, including Oregon and Nevada, were state-based marketplaces. From the 2015 plan year, when Oregon became an SBM-FP, to the 2017 plan year, Oregon increased enrollment by a total of 39 percent, second only to Utah (at 40 percent), and far outperforming the vast

majority of FFM states. The Marketplace also pays for use of a shopping tool that allows Oregonians to compare plans based on medications taken, accurate provider searches, and more. It provides a superior shopping experience than HealthCare.gov.

- Although CMS has touted savings and cost-reductions at the federal level, it does not account for those savings when setting the user fee. In 2018 alone, CMS collected $1.2 billion in user fees with a two percent user fee and relatively low enrollment. Conservatively, one could estimate that through 2022, CMS will have collected $6 billion in user fees, enough to pay for a state-based technology for a state with twice the enrollment of Oregon more than 400 times. The Marketplace estimates that a customizable, state-based enrollment and eligibility platform and a state-controlled call center would save Oregonians roughly $10 million per year.

- **No ownership of data, stifled innovation.** Oregon does not have direct access to the data of any of its residents enrolled through HealthCare.gov. While CMS provides some data periodically, it frequently requires the Marketplace to keep these data confidential. This poses a problem for the types of targeted outreach and education the Marketplace must engage in to be most effective. Access to more demographic data would enable the Marketplace to make the most effective and efficient decisions regarding how to allocate resources to boost enrollment, especially leading up to and during an open enrollment period. It is necessary for the specialized outreach required to begin to end health inequities in the individual health insurance market.
  - This inability to create and/or share reports at a desired frequency with specific demographic data also limits the Marketplace's ability to provide information regarding health policy initiatives that the Governor or the Legislature may be considering, such as a public option, increasing subsidies to middle income consumers, or a state premium assistance program to help more marginalized and underserved Oregonians more easily afford health insurance. Since the Marketplace is often the mechanism for states to enact these initiatives, starting an effort without a functioning, state-specific technology already in

place could add years to an implementation timeline for an executive or legislative priority program.

- **Barriers to health equity.** Use of the FFM precludes the state from using input it receives from its various and diverse communities and partners. Implementing Oregon-centric approaches into the operation and administration of many aspects of the Marketplace to address health inequities is all but impossible. For example, if people in Oregon ask for the use of additional languages (currently available only in English and Spanish) or even simply alternate verbiage on the enrollment platform, the Marketplace cannot act because the FFM does not operationalize single state solutions. Moreover, because the Marketplace does not own or control the data of its enrollees, there is no baseline for Oregon to know the extent of any problems faced by people of color, non-English speakers, people with disabilities, or people who identify as LGBTQIA2S+. Simply put, use of the FFM is a barrier to OHA's goal of ending health inequities by 2030.
    - Data collection, particularly on race and ethnicity, is widely recognized as fundamental to understanding enrollment disparities. The FFM's race and ethnicity application data is unreliable because of a low response rate, and the FFM has failed to improve data collection through the application by asking questions differently and does not have the ability to engage insurers in data collection and reporting like the Marketplace does.
    - Without additional, more reliable data, the Marketplace cannot refine its outreach and communication strategies, both overall and in real-time, to reach communities who have been economically and socially marginalized and underserved.

2. What would this policy package buy and how and when would it be implemented?

The Marketplace anticipates a two-phase funding process. This policy package funds the initial phase of Oregon's transition away from the FFM to use of a state-based enrollment and eligibility platform and call center for operation and administration of Oregon's health insurance exchange. Funds would be used for research and planning purposes through the request for proposals (RFP)

stage, drafting of the required federal blueprint to transition from an SBM-FP to a full SBM, and vendor selection under Phase 1. This phase would also include the initial stage-gate review by Enterprise Information Services (EIS).

OHA would release an RFP for a state enrollment and eligibility platform and a call center. OHA would seek bids from vendors with proven versatile, adaptable technologies capable of the following:

- Coordinating with Oregon's Medicaid systems to address churn.
- Coordinating with other state agency systems to implement innovative, easy eligibility checks to help increase the rate of insurance among Oregonians.
- Improving the QHP shopping and customer service experience for Oregonians.
- Implementing input from Oregon's various and diverse communities into every step of technology and call center implementation.
- Collecting, analyzing, and storing enrollment data, including REALD/SOGI data to:
    - Recognize trends and inform policy development and decision-making that affects communities who have been economically and socially marginalized and underserved.
    - Allow for real-time, micro-focused outreach and education to communities who have been economically and socially marginalized and underserved.
    - Create a baseline that will inform outreach and education resource allocation to ensure that the Marketplace effectively and efficiently reaches those impacted most by the inequities inherent in current systems.
- Customizing open and special enrollments to meet the needs of Oregonians and address the specific circumstances Oregonians are facing in real time.
- Embedding health equity principles in every aspect of an SBM – guiding policy decisions, contracting and hiring, consumer support, and community engagement. These decisions can

help to enroll disproportionately uninsured groups, including people of color, people with low-incomes, rural residents, and immigrants.
- Saving Oregonians money.

Some high-level research has already been performed and the Marketplace has started the initial drafting of the business case for the stage-gate process. However, additional work is needed. The Marketplace would rely on internal, external, and contracted sources for specialized expertise in the fields of project management, technology integration and implementation, procurement, quality assurance, data, legal, security, and privacy.

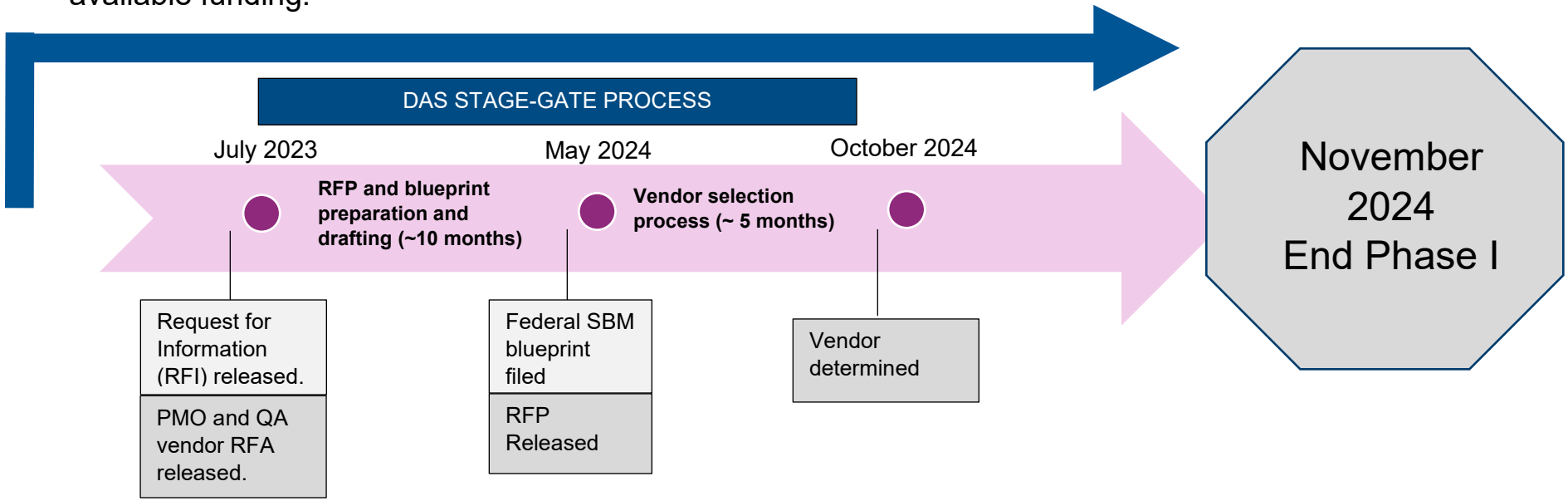
The Office of Information Services (OIS) would provide specialized expertise in technology project management, technology/architecture, planning, research, and experience with large multi-million-dollar stage-gate projects. The project management support, in collaboration with the Marketplace team, would include coordination with the various internal, external, and contracted roles including procurement teams for expertise in the RFP development, solicitation, review, and vendor selection process. The Marketplace anticipates that these divisions would bill for the services they provide and could need additional staffing to support this effort. The Marketplace expects that it would be required to contract for a quality assurance (QA) vendor beginning in Phase I and through to implementation and close out of the project. Additional resources would be necessary for drafting of the SBM blueprint that must be submitted to, and approved by, the federal government prior to transitioning from an SBM-FP to a full SBM. Although the Marketplace believes it can absorb some work with existing staff, this project would require at least one Business Analyst, which the Marketplace does not currently employ. Additional resources may be necessary as determined by Enterprise Information Services (EIS) and OIS during the project initiation phase. Costs including

staffing for Phase II will be informed through the vendor selection process and detailed project planning.

It is believed that OHA requires the following positions for Phase I:

1. PCS 3 Procurement Specialist
2. ISS8 MMN Senior Technical Project Manager
3. OPA4 VMS Contracts Specialist
4. Business Analyst

The implementation timeline below illustrates the estimated timing of Phase I, which would leave twelve months for IT implementation and testing for open enrollment readiness in November 2025 for plan year 2026. Leading up to vendor selection, the Marketplace would determine the appropriate method for funding Phase II. Timing of contracting with the selected vendor would be determined by available funding.



3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

This policy package would fund the initial stage required to obtain a state-based call center and eligibility and enrollment platform. The platform would further OHA's mission to end health inequities by 2030 and increase access to quality, affordable health care through:

- Coordination with Oregon's Medicaid systems to address churn, which benefits individuals with lower incomes, a group that often includes people who have been historically oppressed and marginalized.
- Coordination with other state agency systems to implement innovative, easy eligibility checks to help increase the rate of insurance among Oregonians, especially those who qualify for APTC, making coverage more affordable and removing barriers to access to care.
- Improvement of the QHP shopping and customer service experience, making it easier for all Oregonians to enroll in health care that will address their specific needs.
- Implementation of input from Oregon's various and diverse communities into every step of technology and call center implementation, which would help ensure that existing barriers to health equity are not perpetuated in the new systems.
- Collection and analysis of enrollment data, including REALD & SOGI data to:

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

  - Recognize trends and inform policy development and decision-making that affects groups who have been economically and socially marginalized and underserved.
  - Allow for real-time, micro-focused outreach and education to groups who have been economically and socially marginalized and underserved.
  - Create a baseline to inform outreach and education resource allocation to ensure that the Marketplace effectively and efficiently reaches those impacted most by long-standing systemic health and social inequities.
- Customization of open and special enrollments to meet the needs of Oregonians and address the specific circumstances Oregonians are facing in real time.

Inclusion of health equity principles in every aspect of an SBM, guiding policy decisions, contracting and hiring, consumer support, and community engagement. These decisions can help to enroll disproportionately uninsured groups, including people of color, people with low-incomes, rural residents, and immigrants.

Quantifying results

4. What are the long-term desired outcomes?

Because this policy package would fund only the initial stage required to obtain a state-based call center and eligibility and enrollment platform, the long-term desired outcomes are contingent on a second, separate policy package for purchase and implementation of a call center and state-based platform with proven versatile, adaptable technologies capable of achieving the outcomes outlined in the response to question 3. The desired outcome of Phase I is federal approval of Oregon's blueprint

to transition from an SBM-FP to an SBM, determination of a vendor that can provide a state-based eligibility and enrollment platform, and determination that Phase II should be pursued.

Failure to fund this policy package would require that the Oregon's health insurance exchange remain reliant on the FFM and its accompanying disadvantages, which are detailed in the response to question 1 (in the discussion regarding the disadvantages of the FFM). They include the following:

- **Inflexibility of the FFM technology.** Because the HealthCare.gov is a one-size-fits-all solution, it is designed for use by many states and cannot be customized according to Oregon's needs, preferences, or requirements.
- **Lack of control over operations, customer service, and service levels.** Oregonians can face long wait and hold times and when finally able to speak with a customer service representative, there is no guarantee that the information provided will be accurate.
- **Unpredictable and opaque charges.** The fee for using the FFM is paid directly to CMS by Oregon insurance companies and is passed on to consumers in the form of increased insurance premiums.
- **No ownership of data, stifled innovation.** Oregon does not have direct access to the data of any of its residents enrolled through HealthCare.gov.
- **Barriers to health equity.** Use of the FFM precludes the state from using input from diverse communities and partners.

5. How will OHA measure the impacts on health inequities of this policy package?

As noted, this policy package would fund only the initial stage required to obtain a state-based call center and enrollment and eligibility platform. Impact on health inequities would not be measurable or realized until after the completion of the second phase, which is contingent on a second, separate policy package for purchase and implementation of a call center and state-based platform.

How achieved

6. **What actions have occurred to resolve the issue prior to requesting a policy package?**

   The Marketplace has advocated for changes to the federal platform to broaden input from different voices across race, ethnicity, language disability, gender, gender identity, sexual orientation, social class, geographies, and intersections among these communities and identities in the decision-making and design of the FFM. The Marketplace has also advocated for changes to the FFM that would allow for culturally specific responses to address the distinct needs of Oregonians.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   Maintaining the status quo was rejected because doing so will not result in meaningful change or contribute to OHA's coverage and health equity goals.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   None.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   Yes. LC #471 would require OHA to implement a state-based enrollment and eligibility platform and call center and allocate funding to do so.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

This policy package would fund only the initial phase required to obtain a state-based call center and enrollment and eligibility platform and does not affect other state, Tribal, or local government agencies. Phase II, implementation of the platform and call center, may have some impact on the Oregon Department of Human Services (ODHS), the state agency that controls the federal data hub. A state exchange platform must interface with the hub so some coordination with ODHS would be necessary.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable):

12. What assumptions affect the pricing of this policy package?

Staffing and contracting would continue through Phase II (implementation) if it is determined that transition off the FFM is in the best interests of Oregonians. Phase II funding would be obtained through a policy package for the 2025-27 biennium.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

The Marketplace would rely on internal, external, and contracted sources for specialized expertise in the fields of project management, technology integration and implementation, procurement, quality assurance, data, legal, security, and privacy.

OIS would provide specialized expertise in technology project management, technology/architecture, planning, research, and experience with large multi-million-dollar stage-gate projects. The project management support, in collaboration with the Marketplace team, would include coordination with the various internal, external, and contracted roles including procurement teams for expertise in the RFP development, solicitation, review, and vendor selection process. The Office of Contracts and Procurement (OCP) would require a Procurement Contract Specialist 3 to support Phase I, and into Phase II if implemented. The Marketplace would require at least one Business Analyst during Phase I, and into Phase II if implemented. Additional resources may be necessary as determined by EIS and OIS during the project initiation phase. Costs including staffing for Phase II will be informed through the vendor selection process and detailed project planning.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

Existing Marketplace staff (Administrator and four Operations and Policy Analysts) will absorb much of the additional work, which includes the following:

- Drafting the federal blueprint for the transition from an SBM-FP to an SBM
- Working through the Stage-Gate Process
- Drafting the RFP(s) for platform and call center vendors
- Obtaining community and partner (carrier, agent-grantee, community partner-grantee) input

However, additional staff would be needed. At least one Business Analyst would be necessary for working through the requirements of the project and determining the business processes to operationalize the SBM. Business process development would need to be worked on in preparation for the on-boarding of the vendor. The Marketplace does not currently employ staff who are business analysts or have this skillset.

OIS would require the following positions for Phase I, and unless otherwise noted, Phase II if implemented. These positions would provide specialized expertise in technology project management, technology/architecture, planning, research, and experience with large multi-million dollar stage-gate projects. The project management support, in collaboration with the Marketplace team, would include coordination with the various internal, external, and contracted roles including procurement teams for expertise in the RFP development, solicitation, review, and vendor selection process. The Office of Contracts and Procurement (OCP) would require a Procurement Contract Specialist to support Phase I, and into Phase II if implemented.

1. PCS3 Procurement Specialist
2. ISS8 MMN Senior Technical Project Manager
3. OPA4 VMS Contracts Specialist

16. What are the start-up and one-time costs?

The staffing resources listed in the response to question 15 would be required for Phase I. Some of these resources would be required for Phase II if it is determined that the project should move into Phase II. A separate policy package would be requested for Phase II funding.

17. What are the ongoing costs?

None. Additional funding for stage two of this project would be requested in a policy package for the 2025-27 biennium.

18. What are the potential savings?

The initial stage of this project would not result in savings. If implemented pursuant to the second stage of this project would result in estimated platform savings of approximately $10 million per year.

19. What are the sources of funding and the funding split for each one?

Other Funds are Health Insurance Exchange Fund moneys in excess of operating expenses and reserves (estimated at $1.4 million). General Fund may be required if, and only if, excess moneys are not sufficient to fund Phase I. Phase II may require the Marketplace to raise its assessment or the receipt of General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$1,717,507		$1,717,507	4	3.25
Services & Supplies		$342,357		$342,357		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$2,059,864**	**$0**	**$2,059,864**	**4**	**3.25**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Environmental Public Health
Policy package title:	Environmental Justice Mapping
Policy package number:	417
Related legislation:	House Bill 4077 (2022)

Summary statement:

House Bill 4077 (2022) was Governor Brown's bill to reinvigorate the Environmental Justice Task Force as the Environmental Justice Council (EJC) with expanded membership and duties, and to direct Department of Environmental Quality (DEQ) and OHA to staff the EJC in developing an Environmental Justice Mapping Tool. OHA's fiscal impact statement identified the need for a high-level limited duration Research Analyst 4 position for this work for 2 years, and then rely on staff of an existing CDC grant-funded program for ongoing informatics support to update data and maintain the tool. However, in June 2022, the CDC notified OHA of a 25 percent cut to the Environmental Public Health Tracking cooperative agreement for the 2022-27 period, eliminating the position that would have taken over the work from the limited-duration position. OHA is therefore now requesting a permanent Research Analyst 4 position to develop and maintain the Environmental Justice Mapping Tool.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$191,854**	**$0**	**$0**	**$191,854**	**1**	**0.75**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

House Bill 4077 (2022) was Governor Brown's bill to reinvigorate the Environmental Justice Task Force as the Environmental Justice Council (EJC) with expanded membership and duties, and to direct DEQ and OHA to staff the EJC in developing an Environmental Justice (EJ) Mapping Tool. OHA's fiscal impact statement identified the need for a high-level limited duration Research Analyst 4 position for a minimum of two years to complete this work, which has a deadline of September 15, 2025 (Section 18). OHA then planned to provide data and system update support through our federally funded CDC Environmental Public Health Tracking Program; OHA could not divert CDC funds to pay for staff to develop the tool. The budget report for House Bill 4077 included the following note: "The funding and position are intended to be one-time, but due to the measure's timing OHA may need the position for a portion of the 2023-25 biennium. If OHA determines a need for the position in the next biennium, it should be included in the agency's 2023-25 budget request." In June 2022, the CDC notified OHA of a 25 percent cut to the Environmental Public Health Tracking cooperative agreement for the 2022-27 period, eliminating the position that would have taken over the work from the limited duration position. OHA is therefore now requesting a permanent Research Analyst 4 position to develop and maintain the Environmental Justice Mapping Tool.

2. What would this policy package buy and how and when would it be implemented?

House Bill 4077 (2022) provided OHA a limited duration Research Analyst 4 position to start when the EJ Mapping Tool provision of the bill becomes operative August 1, 2022 and set a completion

deadline for the tool of September 20, 2025. However, House Bill 4077 only funded the OHA position through the 2021-23 biennium. This policy package funds a permanent Research Analyst position, starting July 1, 2023, using General Fund to ensure continued development and subsequent updating and maintenance of the EJ Mapping Tool.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   The purpose of the Research Analyst 4 position is for OHA and DEQ to serve as the lead agencies assisting the EJC, with support from the Portland State University Population Research Center and Oregon State University Institute of Natural Resources, in the development of an EJ Mapping Tool. This position would provide subject matter expertise in environmental public health and health equity policy, epidemiology, informatics, data, and data visualization to create a tool with meaningful participation of, and to identify and assess inequitable environmental health burdens on "communities of color, communities experiencing lower incomes, communities experiencing health inequities, Tribal communities, rural communities, remote communities, coastal communities, communities with limited infrastructure and other communities traditionally underrepresented in public processes and adversely harmed by environmental and health hazards, including seniors, youth and persons with disabilities."

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Quantifying results

4. What are the long-term desired outcomes?

House Bill 4077 contemplates a wide array of outcomes from an Oregon EJ Mapping Tool. A core outcome is understanding the nature of environmental justice communities to assess benefits and disproportionate burdens on these communities and understand negative environmental consequences resulting from industrial, municipal and commercial operations or the execution of federal, state, local and Tribal environmental programs and policies. This outcome in turn is intended to inform changes to policies, systems and budgets to reduce disproportionate environmental justice burdens and increase benefits, including “the distribution of resources to communities that have experienced underinvestment.”

5. How will OHA measure the impacts on health inequities of this policy package?

The EJ Mapping Tool will help agencies and organizations identify inequities that could be addressed through policy and action. OHA is defined in statute as a “natural resource agency” required to track and report on policies, programs and budget priorities that address environmental justice concerns. OHA will document actions carried out directly by OHA and through collaboration with other natural resource agencies that reduce environmental health burdens and increase resilience to those burdens among priority populations, and those experiencing current or historical health inequities.

How achieved

6. **What actions have occurred to resolve the issue prior to requesting a policy package?**

   OHA requested two years of funding (i.e., through June 2024) to implement the legislative directive. The Legislature approved funding only through June 2023 and directed OHA to submit a policy package to request permanent funding and position authority, as needed.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   OHA has no viable alternative source of funding to support the technical position needed to develop the EJ Mapping Tool.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   The EJC is the oversight entity for this work and for engaging inclusive community participation in development of the EJ Mapping Tool. OHA will carry out this work with DEQ as the primary partner and the Department of Administrative Services Enterprise Information Services Office, Oregon State University and Portland State University, as supporting partners named in the bill.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

All state, Tribal and local governments would have access to accessible and user-friendly information that has never been brought together before about who is most impacted by climate and other hazards, the location of their communities, associated priority health concerns, and opportunities for supportive policies, programs and interventions to reduce environmental health burdens.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

One Research Analyst 4 position is needed to complete and maintain the EJ Mapping Tool, as directed by the legislation.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Not applicable.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

One Research Analyst 4 is needed to complete and maintain the EJ Mapping Tool. OHA would fill this position with a current Research Analyst 3 (step 10) working out of class as Research Analyst 4, who has the technical expertise and whose position would otherwise be eliminated due to a recent cut in CDC grant funding. General Fund would cover the ongoing need for this position.

16. What are the start-up and one-time costs?

This policy package does not include one-time costs.

17. What are the ongoing costs?

The ongoing cost of the Research Analyst 4 position.

18. What are the potential savings?

Savings may be realized through policies becoming better informed with respect to health inequities and environmental justice.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$173,575			$173,575	1	0.75
Services & Supplies	$18,097			$18,097		
Capital Outlay						
Special Payments						
Other						
Total	**$191,854**	**$0**	**$0**	**$191,854**	**1**	**0.75**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Center for Prevention and Health Promotion
Policy package title:	Universally offered Home Visiting
Policy package number:	425
Related legislation:	Senate Bill 526 (2019), Senate Bill 1555 (2021)

Summary statement:

The policy package would continue to provide the resources required to implement and scale up the next phase of universally offered home visiting (UoHV) in Oregon with the early adopter communities and the next cohort. It also focuses on building out the community alignment, engagement, and health equity work of the initiative. Without this funding, OHA would not be able to fully implement the program as statutorily mandated in ORS 433.301. This would undermine the goal of establishing a more cohesive and comprehensive home-visiting system that is evidence-based and connects every family with a newborn with local resources that are individualized, non-stigmatizing and meet them where they are with what they need. As the program would be implemented at the local level, there would be an impact of reduced capacity to adequately serve families during the biennium.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$5,924,191**	**$0**	**$156,129**	**$6,080,320**	**5**	**3.75**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

A safe and healthy environment during childhood forms the foundation for a lifetime of physical and mental well-being and healthy relationships. The birth of a child is a big change for any family and impacts a family's social, emotional, financial, and physical environment. Most families welcome support as they move through this transition. However, our current health system does not have a universal touchpoint with all families of newborns to support them at this critical time. This policy package provides an opportunity to impact those earliest moments of life and change the trajectory of individuals, families, and communities by bringing together community partners to create and connect families of newborns to a preventive system of care through a universal, short-term, postnatal nurse home visiting program. Health care systems, public and private agencies, and community-based organizations work together to strengthen the local system of care and connect families of newborns to those resources. The system of care utilized by families improves the overall health outcomes of not only the family, but also the entire community. This is achievable through universal reach, rigorous evaluation, and creating a model for sustainable funding.

Rates of maternal mortality have been on the rise in the United States and there are significant inequities by race/ethnicity due to the long understood intergenerational effects of systemic racism. Despite maternal mortality rates in Oregon being lower than the national average, Oregon experiences similar inequities to those experienced in other states. Washington State's Maternal Mortality Review Panel included a recommendation to expand efforts to provide early and frequent home visits to prevent pregnancy-related deaths and improve maternal health care.

Existing home visiting programs play an integral role in preventing adverse childhood experiences

(ACEs), which can harm developing brains and increase lifelong risk for many chronic diseases and other serious problems. Existing home visiting programs provide a critical preventive system of care for families; however, these programs have eligibility criteria, are long-term, intensive and don't have enough funding or dissemination strategies required for population change. This universal effort would not replace more intensive targeted home visiting programs, but identify what families need and want from local resources and provide an individualized, non-stigmatizing entry into their community's system of care.

Statewide access to this service is anticipated by 2027. In 2019, the Oregon Health Authority (OHA) partnered with the then Early Learning Division (ELD) to explore the feasibility of implementing a universal home visiting program. Both Senator Elizabeth Steiner and Governor Kate Brown joined the effort and supported achieving universally offered nurse home visiting to families of newborns in Oregon. As a result, the 2019 Legislature passed Senate Bill 526, which states OHA "shall design, implement and maintain a voluntary statewide program to provide universal newborn nurse home visiting services to all families with newborns residing in this state to support healthy child development and strengthen families. The authority shall design the universal newborn nurse home visiting program to be flexible to meet the needs of the communities where the program operates."

Oregon selected the Family Connects model, which is the only evidence-based model of universal nurse home visiting that meets the criteria set in Senate Bill 526 (2019): Recognized by the Home Visiting Evidence of Effectiveness review project by the US Department of Health and Human Services (HomVEE[1]). Policy package #401 of the 2019-21 Legislatively Adopted Budget (LAB) provided critical start-up funding and staffing needs to identify and stand up the program in early adopter communities, with the expectation that additional phases of funding and staffing resources

[1] https://homvee.acf.hhs.gov

would be needed to continue building out the program towards eventual statewide access. Policy package #418 of the 2021-23 LAB continued to build out the state level infrastructure, support local implementation, support contracts, and provide the Medicaid match to reimburse providers for services to Medicaid members.

The project began with a statewide solicitation of Letters of Intent (LOIs) from interested communities which resulted in the engagement of eight self-selected, early adopter communities to gain lessons learned and apply them to subsequent cohorts across the project lifecycle. Originally, the early adopter communities were slated to begin service delivery July 1, 2020. Due to the impact of the COVID-19 pandemic response on local public health authorities and the health system generally, service delivery with early adopter's did not begin until Spring/Summer 2021. One community postponed to a subsequent cohort and three others continue to be paused in the wake of the COVID-19 response. With funding for the current 2021-23 biennium provided in policy package #418, OHA is hiring a Community Alignment Coordinator, an Informaticist, and a manager specifically for the initiative. OHA has improved support to local sites to include startup funds until they reach sustainability. In addition, Senate Bill 1555 (2022) provided clarity to ensure full program costs are reimbursed by health benefit plans adequately.

2. What would this policy package buy and how and when would it be implemented?

This policy package continues building out the UoHV initiative as directed in ORS 433.301. The 2019-21 policy package #401 and 2021-23 policy package #418 provided initial investments to establish core state infrastructure, support key implementation contracts, and resource early adopter community implementation including support for Medicaid reimbursement. The focus for this next investment is ensure health equity impacts are analyzed and addressed in communities and to center the initiative around community engagement practices through infrastructure development

within the Maternal and Child Health section, contractual support and additional community level support.

This policy package would support developing more diverse provider teams that incorporate Traditional Health Workers (THWs), assure fiscal sustainability and viability, develop nursing workforce pipeline opportunities with a focus on THWs, fully anchor the universal offering of the service in communities currently participating in the program, including Tribal partners in those communities, and scale in the next cohort of communities. This would require intentional investments in health equity, workforce and community alignment capacity at the state and community levels and centering practices and policies to address health inequities facing Oregonians during pre-and post-natal health care and that all families have the opportunity for support of a home visiting option.

This policy package contains five additional state staff to support equity, workforce and operations:

- Nurse Consultant (Public Health Nurse 2): Focus on expanded capacity to support the clinical aspects of the program and develop and implement the workforce development strategies.
- Health Equity Specialist (Operations and Policy Analyst 3): Working with community and providers, develop and implement the initiative's health equity plan.
- Continuous Quality Improvement (CQI) Specialist (Operations and Policy Analyst 3): Develop and implement a CQI plan that monitors program implementation for fidelity and effectiveness and works with community partners on improvements.
- Fiscal Analyst 2: Provide necessary fiscal analyst capacity to manage the fiscal aspects of the initiative.
- Communications Specialist (Operations and Policy Analyst 3): Provide coordinated communications and marketing across both the state and local level.

It also includes supporting contracts to ensure effective implementation and model fidelity:

- Family Connects International: Support the model's developer and partner in implementation.
- Program Evaluation: Support to continue evaluating and monitoring program implementation.
- Business Consultation: Support for marketing, branding, business processes, health system integration.
- Health Equity Consultation: Support the development, centering and implementation of health equity in the initiative.
- Medical Director: Support for Medical Director to provide medical oversight and collaborations with the provider and hospital communities.
- Steering Committee Consultation: Support in developing processes and facilitation of the Steering Committee.

Lastly, it supports local capacity, sustainability, and centers equity at the community level:

- Community alignment support: Funds to support the onboarding of new Community Alignment Lead Agencies.
- Service provider start-up support: Funds to support new service providers until revenues reach a sustainable level.
- Small community support: Funds to support small communities where revenue would not reach a sustainable level until their sustainability can be established locally through regionalization of functions and model adaptations.
- Tribal implementation: Funds to support implementation with Tribes — either as part of an ongoing community or independent implementations.
- Health equity support: Funds specific to support communities to analyze, recommend and implement the health equity strategies.
- Medicaid match: Provide the Medicaid match needed to support the additional number of newborns on Medicaid receiving services during the biennium.

- Workforce development: Funds to support continual nursing workforce development, such as International Board-Certified Lactation Consultation (IBCLC) certification and nursing recruitment and retention.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[2] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

Unaddressed health inequities during the earliest years can lead to intensified health problems and widening social, educational, and economic gaps. The initiative plans to address early childhood health inequities and achieve health equity through its goals to: create and strengthen community level systems of care for families of newborns; offer support to all new parents in Oregon (regardless of risk and insurance status); center racial, cultural and linguistically responsive care for families and communities, increase access to community services and supports; promote collaboration and coordination across Oregon's early childhood and home visiting systems; and improve health outcomes for families across the life-course.

Family Connects has been shown to increase families' connections to community resources and strengthen parenting supports; it has also been found to improve parents' mental health, enhance the quality of home environments, reduce infants' emergency medical care, and increase parents' utilization of higher quality childcare for their children, and reduce emergency medical care (hospital overnights, emergency department and emergency doctor visits) for infants at 6 months, 12 months, and 24 months. The model achieves this by addressing social determinants of health that impact health outcomes and by addressing structural racism in health care and increasing the access and

[2] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

availability of social supports.

In addition, this policy package aims to further the agency's goals of lowering and containing health care costs. Evaluation of the Family Connects Model has shown reduced emergency medical care (hospital overnights, emergency department and emergency doctor visits) for infants at 6 months, 12 months, and 24 months. The FC evaluation estimates that for every dollar invested in the program, there is a $3.17 savings, primarily from reduced infant emergency medical care. Additionally, this policy package offers OHA the opportunity to further the mission of the Department of Early Learning and Care to support all of Oregon's young children and families to learn and thrive.

This policy package would move this work forward by building a more complete picture of what health equity looks like across Oregon. OHA's Maternal and Child Health (MCH) section commits to working towards racial equity by addressing racism, acknowledging implicit bias, and building equity-based approaches into our state and local programming. The section acknowledges that government has a role in perpetuating inequities that have intentionally harmed Oregon's communities, including Black, Tribal, and indigenous communities. This has led to historical and ongoing trauma. The section envisions an Oregon where all families thrive, and where all women, adolescents, and children enjoy health and health care free of racial inequities.

Quantifying results

4. What are the long-term desired outcomes?

Health Outcomes

Supporting all families in identifying and accessing needed resources and attending to time

sensitive family needs in the first month of life would promote positive early childhood experiences and lay the foundation for lifelong health and further the agency's goals of supporting behavioral health needs and addressing the social determinants of health. Evaluation of the Family Connects has shown:

- More family connections to community resources at 6 months
- More positive parenting behaviors with their infant (such as hugging, reading) at 6 months
- Less clinical anxiety reported by mothers at 6 months
- Higher quality home environments (such as safety, books, toys, and learning materials) at 6 months.

Research has shown the successful implementation of an evidence-based universal, short-term, postnatal nurse home visiting program for Oregon's Medicaid population would impact several the metrics for Oregon's coordinated care organizations including:

- Emergency department utilization
- Childhood immunization status
- Cigarette smoking prevalence
- Depression screening and follow up plan
- Developmental screening in the first 36 months of life
- Effective contraceptive use among women at risk of unintended pregnancy
- Patient-centered primary care home enrollment
- Timeliness of postpartum care

5. How will OHA measure the impacts on health inequities of this policy package?

This policy package would provide key capacity and expert guidance to center health equity. The funds requested would allow the program to bring on a Health Equity Coordinator and contract with a

health equity expert to advise and support the team in the development and execution of a comprehensive health equity plan based in meaningful impact and outcome measures. We anticipate measures such as program participation and non-participation by race/ethnicity, the extent the workforce represents the communities served, and improved culturally specific community services would be central. We aim to build out a comprehensive set of outcome measures that center impact on health inequities, particularly for communities of color. The package would also provide supplemental funding for small communities without the birth rates to fiscally sustain the program to fidelity, while the UoHV team works toward long term solutions with these communities.

Portland State University (PSU) conducted a Year 1 evaluation of the Universally offered Home Visiting initiative which included input from communities, providers, and state and model developers. The evaluation illuminated 4 key implementation gaps:

1. Aligning equity values with practice.
2. Addressing adequate state level capacity to build infrastructure needed to engage community partners to participate in a systematic home visiting model approach in policy and partnership that ensures an equity focus to support communities as they implement their programs.
3. Ensuring sustainable revenue streams that support local program viability.
4. Strengthening communication and coordination.

This policy package seeks to ensure the distribution of resources as needed to support local program implementation and remove barriers for small counties with low birth populations, as well as to provide the infrastructure necessary within the state to prioritize and support equity and community engagement at the level needed to address health inequity and effect change in the home visiting system in Oregon. Each of these four gap areas are key to reaching all communities and achieving universal access to these services for newborns and their families. Led by

communities, PSU and OHA work with communities to develop meaningful measurement of the impact of this initiative on health inequities.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Oregon has been working to build a home visiting system and is poised to build on existing evidence-based and evidence- informed home visiting programs. However, the initial connection, coordination and triage for families was missing. ORS 433.301 addressed this gap by requiring all families of newborns be offered nurse home visiting services. This policy package is the next phase of designing and implementing the initiative as outlined in the bill.

7. What alternatives were considered and what were the reasons for rejecting them?

Implement a universal short-term, postnatal nurse home visiting program through Oregon's Department of Early Learning and Care. LPHAs have experience delivering nurse home visiting programs and the partnerships in place to create the preventive system of care required to support families. The current state plan amendment (SPA) to support the delivery of Targeted Case Management (TCM) by Nurse Home Visiting programs would need expansion and approval by CMS to provide federal support to the delivery of this model.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

While OHA is the only state agency requesting funding to address this problem, the following agencies are collaborating on this policy package as key partners:

- Department of Early Learning and Care (DELC) has assisted with connections to Oregon's early

learning system.

- Department of Consumer and Business Services (DCBS) has assisted with implementation for parents with commercial health benefit plans.
- OHA's Health Systems Division (HSD) and CCOs would integrate this service into Oregon Health Plan member benefits, reimbursing service providers and participating in development and maintenance of a community level system of care for families with newborns.
- OHA's Health Policy and Analytics Division (HPA) has assisted with health policy coordination.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

- Local Public Health Authorities, Early Learning Hubs and Tribes would be asked to implement this program which would require additional staff and new partnerships.
- The home visiting programs of the Department of Early Learning and Care would be integrated into the preventive system of care being created for families.
- Families would be referred to resources and services of the Oregon Department of Human Services including TANF and ERDC.
- Department of Consumer and Business Services (DCBS) would be required to continue partnering with OHA to support the commercial health plans' integration of UoHV into their member benefits, reimbursing service providers, and coverage for Oregonians with plans not covered by Senate Bill 526.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

OHA assumes birth rates will remain stable and the split between public and private insurance coverage for newborns will remain stable.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

None outside of those that come with an additional five employees.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This universal effort would not replace more intensive targeted home visiting programs, but referrals for more intensive home visiting would be made into eligible programs, including Healthy Families Oregon, Early Head Start, Parents as Teachers, Family Spirit, Babies First! and CaCoon. Families enrolled in home visiting programs prenatally (Nurse Family Partnership, Babies First!, Early Head Start and Healthy Families Oregon) would not receive Family Connects services to reduce duplication.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

No modifications would be needed on existing staff. New staff in this policy package are priced for 18 months given the time needed for recruitment and hiring. They include:

- Nurse Consultant (Public Health Nurse 2): Focus on expanded capacity to support the clinical aspects of the program and develop and implement the workforce development strategies.
- Health Equity Specialist (Operations and Policy Analyst 3): Working with community and providers, develop and implement the initiative's health equity plan.
- Continuous Quality Improvement (CQI) Specialist (Operations and Policy Analyst 3): Develop and implement a CQI plan that monitors program implementation for fidelity and effectiveness and works with community partners on improvements.
- Fiscal Analyst 2: Provide necessary fiscal analyst capacity to manage the fiscal aspects of the initiative.
- Communications Specialist (Operations and Policy Analyst 3): Provide coordinated communications and marketing across both the state and local level.

16. What are the start-up and one-time costs?

Start-up costs are focused on local communities until such time each local program is sustainable through service reimbursement (Medicaid, commercial payors).

Category	Total Funds
Special Payments	

Community alignment funding for existing and new communities	$304,819
Service provider start up support	$900,000
Tribal implementation support	$150,000

17. What are the ongoing costs?

Ongoing costs would include state-level infrastructure and contracts for evaluation, model developer, health equity, business processes, etc.

Category	Total Funds
Personal Services	$873,618
Services and Supplies	$1,201,883
Special Payments	
Medicaid match	$304,819
Consultation services (business, healthcare systems, health equity, Medical Director, Training/facilitation, model developer support, program evaluation)	$900,000
Small community sustainability support	$150,000
Health equity support for implementing sites	$500,000
Nursing workforce development	$200,000

18. What are the potential savings?

Evaluation of the Family Connects Model has shown reduced emergency medical care (hospital overnights, emergency department and emergency doctor visits) for infants at 6 months, 12 months, and 24 months. With the demonstration of positive impacts of home visiting on life-long health, the programs have also been proven to be a cost-effective strategy for states. An investment in home visiting programs have shown to offer returns on investment ranging from $1.75 to $5.70 for every dollar spent. This benefit is acquired through

savings across the life-course through reduced costs of K-12 special education and grade retention, criminal justice expenses, and child protection. Specifically, the Family Connects® home visiting model, through cost-benefit analyses, has been shown to produce a return on investment of $3.17 for every dollar spent from reduced costs for emergency medical care for ED visits and overnight hospital stays. They estimated a local average of $432 per emergency outpatient visit and $3,722 per hospital night.

19. What are the sources of funding and the funding split for each one?

This package is primarily General Fund, with some Federal Funds from Medicaid.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$725,272		$148,346	$873,618	5	3.75
Services & Supplies	$1,194,100		$7,783	$1,201,883		
Capital Outlay						
Special Payments	$4,004,819			$4,004,819		
Other						
Total	**$5,924,191**	**$0**	**$156,129**	**$6,080,320**	**5**	**3.75**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Systems Division
Program:	Program Support and Administration, Medicaid, Behavioral Health Non-Medicaid
Policy package title:	Child and Family Behavioral Health Continuum of Care
Policy package number:	426
Related legislation:	None

Summary statement:

This policy package seeks to address gaps identified by youth and families to strategically expand the continuum of services available to children, youth and families experiencing behavioral health challenges, using low-barrier procurement processes centering communities of color and people with lived experience in the development and implementation of investment and infrastructure.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$11,524,509**	**$0**	**$1,459,217**	**$12,983,726**	**0**	**0.00**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

This policy package seeks to eliminate health inequities in addressing gaps and quality in the children's behavioral health service continuum as part of OHA's goal to eliminate health inequities by 2030. The children's behavioral health system in Oregon must provide a full spectrum of effective supports, from prevention to intensive acute care, to be meaningfully responsive to the needs of children, youth, and young adults (ages 0 to 25 years).

The policy package seeks to improve access to providers who are culturally or linguistically responsive, to further reduce and eliminate disparities in access to and utilization of health care for people who are African American, Black, Latinx/a/o, Asian and Pacific Islanders, indigenous and American Indians and Alaskan Native tribal members. The proposal works toward eliminating gaps in the provision of services for children and youth who have co-occurring intellectual or developmental disabilities in addition to behavioral health challenges. The proposal also seeks to make needed services available to youth who identify on the LGBTQIA2S+[1] spectrum, who are in need of specific supports and therapeutic services for commercial sexual exploitation, and to those youth and young adults who need support as they transition to adulthood. The proposed programs and services address the needs of the child, youth, and young adult population with an intersectional intention in service access.

[1] Lesbian, Gay Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit and all the other ways individuals may identify.

The Child and Family Behavioral Health (CFBH) unit continues to develop capacity and support workforce development to ensure availability and access to a broad, flexible array of effective services and supports for youth from all backgrounds, in all regions of the state. Elements of this policy package create expansion of three existing programs:

1. Expansion of Behavior Rehabilitation Services (BRS) to incorporate youth with serious behavioral challenges and for services and supports for youth who have experienced any form of sexual exploitation. Children and youth through age 20 are served in BRS. Serving youth in BRS with needs for behavioral rehabilitation support will mitigate existing risk in provision of services to all who need them.
2. Expansion to provide incentives and funding to increase and retain the number of Child Psychiatrists and Developmental Pediatrician fellows (CP/DP) trained in Oregon.
3. Expansion of the number and reach of Transition Age Youth (TAY) Hubs for statewide availability.

This policy package seeks to solve problems in existing services*:*

Behavioral Rehabilitative Services (BRS)

Continued capacity and access issues exist across the continuum of care, including in BRS. Lack of access to BRS presents a risk to the State Plan for Medicaid in Oregon. Without funding for this policy package, access for this program would continue to be limited to children in the custody of the Oregon Department of Human Services (ODHS) Child Welfare, Oregon Youth Authority (OYA) or limited county juvenile systems. Agreeing to voluntary custody through Child Welfare may be distressing to parents, and they may feel they have no choice but to do this to get help for their

children. Other states have experienced lawsuits over relinquishment of custody for families to obtain services.

At this time, there are no other accessible options for youth and families who need and would benefit from BRS services. This is especially problematic for Black, African American, Native American Indians/ Alaskan Natives, Latino/a/x, and immigrant families because of historical trauma, and fear of being “in the system” which could mean a threat to their survival or possible deportation. Families experiencing inequities based on their race and ethnicity frequently experience that they only get help when the situation becomes dire and escalated, rather than earlier when it would be far less difficult. Many parents use the emergency department or call law enforcement to address challenging behavior because of a grim lack of resources.

Survivors of sexual exploitation have lived through complex emotional, physical, and sexual trauma requiring specific both a structured living environment, and specific treatment interventions. Survivors experience emotional, behavioral, and mental health symptoms that often go unidentified or misdiagnosed. Without proper support and treatment, the risk for being re-victimized is high, and many youth affected by commercial sexual exploitation go without the care and support they need. This is as true for male as it is for female identified survivors, though much more acute for male-identified survivors, due to the lack of available services. This policy package aims to serve young survivors of all forms of sexual exploitation including male identified survivors of commercial sexual exploitation.

Adverse effects for these youth are significant. Sexual exploitation is a significant, complex trauma that may take many years to heal from. Many youth experience chronic symptoms of Post-Traumatic Stress Disorder (PTSD), resulting from this complex trauma and physical injury. PTSD is the most

common mental health diagnosis among trafficked and other sexually exploited victims, followed by depression and increased use of substances. Sexually exploited youth are at high risk for suicide. There are lifelong impacts to their psychosexual functioning that impact relationships with others. Learning how to get regulated and stay emotionally calm when interacting with others is a critical skill these youth need to develop and practice, directly related to their experiences.

The early significant trauma for trafficked and other sexually exploited youth creates lifelong risk for poor health outcomes overall, including physical disorders in addition to mental health and substance use disorders, due to the complex trauma acquired through sexual exploitation.

Child Psychiatrists and Developmental Pediatricians

Current wait times are not in an acceptable range for child psychiatrists' and developmental pediatricians' services. Families are forced to seek care during crises from resources not adequate for their root challenges, such as in a hospital emergency department. Children of all ages, including babies and toddlers, are waiting up to two years for an initial evaluation when there is concern about an intellectual or developmental difficulty. Lost time during very early developmental periods cannot be regained completely. The critical period for brain growth and development is at its peak during infancy through age 3.

Rural Oregon communities do not have adequate access to the services of developmental pediatricians or child psychiatrists. While telehealth can help bridge this gap, there are times when an in-person evaluation is critical. The potential for inadequate or poor treatment can produce consequences that are lasting for children and youth who are not accurately diagnosed and treated in a timely way.

Transition Age Youth (TAY) Hubs

The TAY Hubs directly impact available services and supports available to young people ages 14 to 25. Without access to comprehensive support and services, young adults are at higher risk for experiencing first episodes of psychosis and the emergence of serious mental health disorders.

When young adults transition between the child and adult behavioral health systems, it leads to disruption in continuity of care with disengagement from services likely to lead to poorer clinical outcomes. Some young people, such as those with neurodevelopmental disorders and complex needs, are at a greater risk of falling through the care gap during transition. Services need robust and high-quality evidence on the process and outcomes of transition so that effective intervention strategies can be developed.[2]

2. What would this policy package buy and how and when would it be implemented?

Behavior Rehabilitation Services (BRS)

The purpose of BRS is to support the child or youth's psychosocial, emotional, and behavioral health functioning by providing such services as behavioral intervention, counseling[3], and skills-training. Services are delivered in a way that integrates a young person's gender, culture, language, values, is trauma-informed, and developmentally appropriate.

Currently these services are provided using a Residential Care Model or a Proctor Care Model through ODHS Child Welfare or OYA, or county-based juvenile justice departments. BRS is currently

[2] Transition of care from child to adult mental health services: the great divide Swaran P Singh https://pubmed.ncbi.nlm.nih.gov/19417667/

[3] This is not to be equated to mean mental health services or therapy.

included in the Oregon Medicaid state plan. CMS[4] notes that BRS serves children and youth who "exhibit such symptoms as drug and alcohol abuse, antisocial behaviors that require close supervision and intervention and structure, sexual behavior problems, victims of severe family conflict, behavioral disturbances often resulting from psychiatric disorders of the parents, medically compromised and developmentally disabled children/youth."

BRS expansion through this policy package is focused on expanding BRS to youth covered by Medicaid, who are assessed as needing these services according to medical necessity criteria with population specific programming. This would include all youth and provide specific programming for youth who are sexually exploited, including youth who may have experienced family expulsion resulting in homelessness. This expansion would not result in a duplication of services across systems.

OHA currently funds a program (SAGE[5]) for young people who identify as female and who have experienced commercial sexual exploitation as children (CSEC). There are no residential programs currently able to support youth who identify as male. This policy package proposes adding one BRS facility to support male identified youth. The availability of supports and services in the state for youth who have been sexually traumatized and may be exhibiting sexually challenging behaviors is limited. These youth will be served in a BRS facility through a demonstration project to establish quality, specialized and culturally relevant services. BRS services, are in addition to built-in outpatient mental health services, which will provide appropriate treatment to youth and the critical opportunity to learn more adaptive skills, practice them, and apply them in relationships.

[4] Center for Medicaid and Medicare Services, US Department of Health and Human Services
[5] Support, Achieve their Goals, Grow, become Empowered

Federal statute requires state Medicaid agencies to offer BRS to all enrollees. The current practice in Oregon presents a significant risk to OHA because young people can only access BRS through the OYA, county juvenile justice contract (where a parent is required to authorize placement and services), by virtue of being in the guardianship of ODHS Child Welfare, or by requiring a parent to sign a voluntary placement agreement with ODHS Child Welfare. This may be distressing to parents, and they may feel they have no choice but to sign to get help for their children. Expanding BRS to meet the needs of youth outside of Child Welfare, OYA or through county-based juvenile justice contracts would assist to remediate these issues.

BRS service provision provides pathways for youth and families to get their needs met when behaviors have escalated to the point of being unsafe to manage in their home setting. In addition, BRS services may be an option for youth who have made gains in their treatment at the psychiatric residential level of care, but continue to demonstrate need for close supervision, intervention, and structure. Access to higher levels of care would be improved by the option of youth having a transition alternative with BRS, freeing up higher levels of care to meet existing need.

Funds are requested for an equity-oriented and trauma-informed approach in the development of BRS expansion. Project development for this type of care and startup costs are included in this funding request for up to four pilot projects across multiple regions in the state, prioritizing culturally specific programming. The startup funds will be utilized to contract with community providers for administrative review, development, training, and initiation of equity-oriented and trauma-informed BRS services and collection of outcome data. Expansion of training is needed to improve services to be more culturally specific and to reinforce how to create and maintain trauma informed services.

Child Psychiatrists and Developmental Pediatricians

There is a longstanding shortage of both child psychiatrists and developmental pediatricians in Oregon, which has been exacerbated over the past several years due to impact from the COVID-19 pandemic. Physicians are needed with specialized expertise in assessing and treating youth with complex behavioral health conditions, including those who also have co-occurring intellectual and/or developmental disabilities, and those with neurodivergence[6]. Access is severely limited to these important specialty services.

This policy package increases the number of child psychiatrists and developmental pediatricians trained in Oregon by providing incentives and funding to attract child psychiatry and developmental pediatrics fellows with priority given to residents with diverse backgrounds, to work in various settings related to child and family behavioral health, to increase available specialty physician workforce within Oregon. One strategy to assist with retention would include incentivizing trained physicians in this program to work in Oregon following completion of their fellowship.

OHA would provide continued support to OHSU Division of Child Psychiatry for an additional 3 slots for child psychiatry and assist them to fund their plan to add two more slots over the next three years (beginning in mid-2024) for a total of 10 residency slots; and with OHSU Child Development and Rehabilitation Center (CDRC) to add two Developmental Pediatrician training slots per year.

Developmental Pediatricians are critical providers in addressing the needs of children with intellectual and developmental disorders, and for children and youth who are neurodiverse, including

[6] Neurodivergence is the term for people whose brains function differently in one or more ways than is considered standard or typical.

those with autistic spectrum disorders, attention deficit hyperactivity disorder (ADHD), and other learning disabilities. Developmental Pediatricians are specialized in their knowledge of child development for youth who are neurodivergent, youth with intellectual and developmental disorders and in addressing educational, learning and behavioral challenges resulting from neurodivergence. Other types of neurodivergence include Tourette's Syndrome, dyspraxia, synesthesia, dyscalculia, Down syndrome, epilepsy, and chronic mental illnesses such as bipolar disorder, obsessive-compulsive disorder, borderline personality disorder, anxiety, and depression.

OHA is collaborating with the Division of Child Psychiatry and the CDRC housed at OHSU for this proposal. Target dates for implementation: July 2023 add three Child Psychiatry slots and July 2024 add two more Child Psychiatry slots. For developmental pediatrician residency slots, OHA proposes to add two each July of the biennium in beginning in July 2024.

Transition Age Youth (TAY) Hubs

Young adults in transition (ages 14 to 25) are underserved across the continuum of care in Oregon. Young adults, specifically ages 18 to 25, have the highest prevalence of mental health conditions of any age group and yet have the lowest rates of engagement with behavioral health services. They have high rates of emergency department usage with inadequate follow-up.[7]

TAY Hubs are regionally unique programs designed to engage marginalized and disconnected young adults who may have behavioral health and/or other needs, through accessible, holistic, non-stigmatizing and developmentally appropriate services. Services are provided for young people who have:

[7] Unpublished data from Oregon Health Authority, Health Policy and Analytics, Office of Health Analytics, 2022

- Become disconnected from resources to such an extent that they are unlikely to access available insured services through outpatient programs.
- Become marginalized and disconnected from other supports, due to situational and social circumstances, such as youth with LGBTQIA2S+ or other identities, youth and young adults experiencing homelessness and/or with high suicide risk.
- Prior involvement in state systems, including foster care and psychiatric or substance abuse residential treatment.
- Previously been diagnostically screened out of Early Assessment and Support Alliance (EASA) (50 percent of EASA referrals or approximately 1,000 young people/year in Oregon[8]).

Hub programs are tailored to specific sites and may include the following services based on the assessed needs of the community:

- Culturally responsive services
- Mental health support services
- Case management
- Skills training
- Peer support services
- Educational support services
- Employment support services
- Housing support services
- Substance Use Disorder services

[8] Data provided by Oregon Health & Science University EASA Center of Excellence

The lack of housing is a significant barrier to positive behavioral health outcomes, which has been stressed repeatedly by youth and young adults in engagement sessions conducted by OHA. When young adults and transition aged youth with serious mental disorders are unhoused or reside in settings that do not provide adequate supports, they are less likely to access treatment and experience stability, and more likely to become court involved. They are at high risk for sexual exploitation. The hubs provide a housing support specialist to help young people secure and maintain housing. An existing contract administrator of the hub sites at OHA will ensure that housing supports in Oregon are tailored to the needs of youth and young adults, by building a network of state agency staff across multiple agencies with the applicable expertise.

This policy package includes funding for new Young Adult Hub programs based on the best practice experience of the existing TAY Hubs. These new sites will be an addition to the current program counties of Multnomah, Clackamas, Washington, Deschutes, Crook, Jefferson, Jackson and Lane. All sites will be re-bid under a request for proposal (RFP). Hub programs allow young adults who are uninsured, under-insured, enrolled in Medicaid with open card, or privately insured, access to these developmentally responsive programs. All youth with Tribal membership can be served at Hub sites regardless of where they live. Tribes will be able to apply for Hub funding and can develop a model that fits the needs of their specific communities.

This investment will enhance services for transition-age youth and young adults by utilizing strategies and supports identified through youth engagement in the policy development process. Best practice models provide:

- Community-based, holistic, non-stigmatizing and culturally responsive, relevant services.

- Services which include longer engagement periods, flexibility in programming, integrated use of technology, a strong focus on independent living skills, and an integrated multi-system approach with housing, employment, and education support.
- Robust peer support and holistic care team relationships.
- Services tailored to the developmental needs of youth and young adults.
- Integration between various state agencies and behavioral health systems.
- Valuing of strong youth voice and client feedback component that directs development, implementation, quality improvement and technical assistance.
- Services provided without ability to pay or without regard to insurance coverage.

The current TAY Hubs have operated since 2014. During this time, an increase in the need to support transition age youth served in hubs has been demonstrated. Data from the period of July 2019 to June 2021 shows there were over 18,613 visits by young people between ages 14 and 25 years old to an emergency department for a mental or substance use related service. Eleven percent of these young people remained in the ED for longer than 24 hours and 15.2 percent of the total were readmitted to an ED within 30 days[9]. This represents an average, with higher rates over age 18. These data suggest that there are insufficient community services to prevent crises and for adequate crisis support, services at higher levels of care were unavailable for immediate entry and that problems continued after discharge.

The RFP process would focus on culturally specific providers, expanding the hubs into regions that do not currently offer services and support to transition aged youth and young adults, to better meet

[9] Unpublished data from Oregon Health Authority, Health Policy and Analytics, Office of Health Analytics, 2022

the statewide need for supporting Oregon's youth ages 14 to 25 years. OHA would encourage culturally responsive organizations to apply and include support for smaller organizations in the RFP process to ensure more equitable opportunity to apply. OHA would implement this expansion by adding funding to direct contracts. It is anticipated that this process will take three to six months, beginning July 2023, with newly expanded services starting with the 2024 contract year.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[10] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   OHA has one strategic goal: to eliminate health inequities in Oregon by 2030. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including Tribal governments, to address: "The equitable distribution or redistribution of resources and power; and Recognizing, reconciling and rectifying historical and contemporary injustices".

   To eliminate health inequities, the children's behavioral health system needs to do things differently by de-centering whiteness. Oregon is a state with 565,177 Latinos/as/x residents, comprising 13 percent of the state's population. As only one example, the lack of behavioral health practitioners in Eastern Oregon, where the majority of the Latino/as/x community resides is significant. Morrow,

[10] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Malheur and Hood River are 34 percent Latino/a/x identified and have an average ratio of 180 residents per full time licensed mental health providers[11].

This report by the Oregon Commission on Hispanic Affairs states: “This report’s workforce demographic summary shows the agency [OHA] experiences pervasive and ongoing challenges with underrepresentation and inequitable outcomes for people of color and people with disabilities in the overall workforce, within management, and in hires, promotions and separations. The COVID-19 pandemic has underscored systemic racism and health inequities faced by people of color, Tribal members and other communities in Oregon and across the country. This reality has shown it is vital to OHA’s mission to develop and support a workforce that is culturally responsive and reflects the racially, ethnically, linguistically, ability- and gender diverse populations across the state.”

The adverse effects of not funding this policy package would be significant impact on many of Oregon’s most vulnerable children, youth and families, particularly Tribal youth and youth of color. Those who are African American, Black, American and Latino/a/x are disproportionately impacted by ODHS Child Welfare involvement. Neurodiverse children have lifelong challenges and while they may not always qualify for entitlement programs, such as developmental disabilities, the challenges are long term and similar supports are often needed as individuals in intellectual/developmental disabilities (I/DD) programs. Youth who identify as LGBTQIA2S+ may be reluctant to seek out services because they do not find providers who they can identify with, they are not trusting of adults who may have discriminated against them (including their own families) and they are generally

[11] Oregon Commission on Hispanic Affairs Crisis De Nuestro Bienstar; a report on Latino Mental Health in Oregon. (https://www.oregon.gov/oac/Documents1/Crisis_de_Nuestro_Bienestar_-_Latino_Mental_Health_in_Oregon.pdf)

disconnected from support. This reluctance is further heightened if they have an intersectional identity.

Youth in Oregon are languishing because Oregon's behavioral health care is in crisis, with headlines on newspapers across the state. Enhancing the current services and supports and diversifying the workforce offered is a critical step in providing adequate services for children, youth, and families in Oregon.

This package represents an intention to respond to needs identified by youth and families in communities throughout Oregon. Not funding this policy package would keep the children's behavioral health service array status quo, with youth continuing to use emergency departments and higher levels of care (which are not always immediately available) to meet their psychiatric needs, and with parents/caregivers turning to ODHS Child Welfare for assistance in safely managing the intense needs of their children, when behavioral health services are not available or adequate, and with some children and youth and their families completely unable to access services.

This policy package furthers OHA's mission of ensuring that all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health by improving the children's continuum of care. This policy package supports the OHA Health Equity initiative.

Funds would be prioritized to culturally specific infrastructure in organizations serving populations who have not been adequately served, or served at all, in prior years. Emphasis in contracts and requests for proposals would encourage the hiring and training of provider staff who resemble the

clients they are serving demographically. The proposed programs and supports improve quality of life, increase the availability, use and quality of community based, integrated health care services.

This policy package is rooted in feedback given to OHA from youth and families, through local Systems of Care barrier identification, listening sessions, monthly meetings with families, 'Think Tanks' with Oregon's youth and input from the Children's System Advisory Council (CSAC), a key advisory council for the Child and Family Behavioral Health unit. The System of Care Advisory Council (SOCAC), a governor appointed oversight group for the Systems of Care, have endorsed this package. It is fully supported by the Oregon Council for Behavioral Health, Oregon Alliance of Children's Providers and the Oregon Alliance to Prevent Suicide.

In specific programs proposed:

Behavioral Rehabilitative Services (BRS)
More equitable health outcomes will be met by providing additional options for youth and families to get their complex needs met within an equity and trauma focused framework, within their communities. Youth of color land in both child welfare and juvenile justice settings, including OYA, in overrepresented numbers, and they are not getting the services and supports needed to prevent this. The goal of this policy package is to interrupt that process and get youth the help they need in their communities and with their families. Youth who identify as LGBTQIA2S+ and children/youth of color are statistically overrepresented in existing services and as a group, are at higher risk for sexual exploitation, and to be in need of these services. Again, the goal of this policy package is to prevent youth from experiencing further harm and re-traumatization in addition to the trauma they may have already experienced, and to intervene earlier to assist them with their needs. Providing a safe

environment with supervision and options for skills training and providing community support can serve to mitigate their long-term risk while youth participate in needed outpatient treatment.

Child Psychiatrists and Developmental Pediatricians
Making a larger pool of child psychiatrists/developmental pediatricians available in Oregon would increase care to African American/Black, Latinx/a/o, American Indian/ Alaskan Native, Asian, Pacific Islander communities and improve access to care for all; we recommend that applicants of color be prioritized as the presence of providers who are of similar ethnic and racial and other diverse backgrounds can facilitate populations impacted by health inequities in seeking out services. Having adequately prepared providers reflective of populations who've experienced health inequity will also assist with continued engagement in care.

Transition Age Youth (TAY) Hubs
TAY Youth and young adults experience some of the highest rates of behavioral health challenges with the lowest rates of engagement. Youth and young adults with intersectional identities, who identify as transgender and African American, Latino/a/x and Native American experience higher rates of anxiety, depression, alcohol and nicotine use and experience suicidal ideation and attempt suicide more often. Adverse behavioral health outcomes increase for youth and young adults with intersecting identities that experience frequent health inequity. Having youth and young adult programs that are culturally specific and having systems in place that provide programs with frequent feedback supports the goal of achieving health equity.

Suicide attempts are seriously considered by 42 percent of LGBTQIA2S+ young people. Suicide attempt rates for LGBTQIA2S+ young people are higher among American Indian/Alaskan Native, indigenous, Black, multi-racial, and Latino/a/x young people than their white peers. Additionally,

symptoms of anxiety are reported in more than three in four transgender and nonbinary young people and symptoms of depression are reported in more than two in three of transgender and nonbinary young people.[12]

From 2015 to 2019, the Oregon Violent Death Reporting System (OVDRS) identified 10 suicides among transgender youth. An additional five suicides were identified among youth who identified as lesbian, gay, bisexual or having a sexual orientation other than straight or heterosexual. These deaths accounted for 2.7 percent of Oregon youth suicides between 2015 and 2019. This is likely an undercount of LGBTQIA2S+ youth (compiled as youth 10-24 years of age) who died by suicide, due to existing data collection methods.[13]

Quantifying results

4. What are the long-term desired outcomes?

Behavior Rehabilitation Service expansion is critical to provide upstream tertiary prevention of more intensive system involvement for youth and families. It ensures that there are shorter wait times and easier access to structured residential services when youth need them. There would be improved communication from acute and secure behavioral health residential programs by linking youth with these service options, when youth are psychiatrically stable, as a potential transition.

[12] https://www.thetrevorproject.org/survey-2021/

[13] Youth Suicide Intervention and Prevention Annual Report, Oregon Health Authority, 2021. Accessed from: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8874_2021.pdf

This prevention strategy would also support families and youth by providing interventions that are accessible and closer to their home communities. CSEC services in a BRS setting would provide access for male identified youth to a structured residential service when assessed as needed. CSEC services would seek to divert youth from entering the juvenile justice system by linking youth and families to services earlier in the cycle of risk.

The CFBH unit also has a long-term goal of creating a mechanism for training and technical assistance to behavioral health providers. This builds capacity to identify and serve sexually exploited children who experience significant trauma and require staffing support from people with special knowledge, skills and abilities in providing trauma specific and trauma-informed services specific to their needs.

Increasing access to practicing child psychiatrists and developmental pediatricians and expanding current workforce to include more African American, Latinx/o/a, Tribal and LGBTQIA2S+ identified practitioners who are available to serve children, youth and young adults would address current inadequacies in access to timely appointments and service providers who are culturally responsive and who ideally have similar cultural backgrounds to their clients.

The long-term desired outcomes of expanding TAY Hubs are to create transition programs that help youth and young adults feel more prepared for a successful adulthood with coping tools and connection. This would have a positive preventive effect on the adult behavioral health system because the system would treat individuals at younger ages, hopefully changing the course of their behavioral health trajectory.

5. How will OHA measure the impacts on health inequities of this policy package?

OHA would take a multi-pronged approach to measuring the efficacy and success of this policy package:

- Audits to ensure Medicaid compliance (BRS/CSEC)
- Rules and contract language (BRS/CSEC, TAY Hubs)
- Use of a data dashboard (outcomes, addressing inequities, access, qualitative) (BRS/CSEC, TAY hubs)
- Continue to obtain feedback from youth and families across community sectors
- Provide REALD data for American Indian/ Alaskan Native children and youth enrolled in programs (Wraparound, BRS/CSEC, TAY Hubs)
- Utilize the School Health Survey data, MHSIP (Mental Health Statistical Improvement Project) survey data and Child Welfare Data Book data to inform/monitor this work
- Staff oversight and coordination through contract monitoring and follow-up (all)

<u>Behavioral Rehabilitative Services (BRS)</u>
Success would be measured by the increased operational capacity for behavior rehabilitation services, outcome measures of the programs and diminished requests from families for voluntary ODHS Child Welfare placement to meet their child's behavior support needs. REALD /SOGI[14] data would be tracked to assess impact on health inequities. CSEC success would be measured by the increased operational capacity for supporting youth and families identified with need for specialized supports to address sexual exploitation, identifying youth at risk earlier in the larger population for potential sexual exploitation, outcome measures (including use of the Hope scale) of the programs and diminished requests from families for voluntary ODHS Child Welfare placement to meet their child's needs.

[14] Race, Ethnicity, Language and Disability; Sexual Orientation and Gender Identity

Long term desired outcomes include:

- Broader identification of youth at risk, including male-identified, female-identified and non-binary youth
- Access for male identified youth to structured residential services when needed
- Criminal justice diversion by linking youth and families to services earlier in the cycle of risk and as a component of transition, when stable in structured psychiatric residential services
- Outreach and collaboration through coordination with Oregon's nine federal recognized Tribes and the Urban Indian Health Program

Child Psychiatry and Developmental Pediatricians

Success would measure by tracking the following in the next five years to ensure adequate increases in workforce and in youth and family satisfaction:

- Number of CP/DP who currently serve Medicaid members,
- Number of assessments for intellectual and developmental disabilities and neurodivergent conditions such as ADHD or Autistic Spectrum Disorder,
- Number of Child Psychiatrists/Developmental Pediatricians trained who remain in and practice in Oregon with 40-50% of their practice being devoted to underserved communities/groups as defined herein; and,
- Number of CP/DP who identify as African American, Latina/o/x, American Indian/ Alaskan Natives, Asian/Pacific Islander and LGBTQIA2S+.

Transition Age Youth (TAY) Hubs

All Hub programs would be required to collect feedback from youth and young adults in their program annually. Youth participation in identifying relevant outcome measures would be strongly

recommended. Programs would be expected to report to OHA on numbers of youth engaged, including REALD/SOGI data, outcomes and satisfaction through surveying youth directly.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Behavioral Rehabilitative Services (BRS) Policy package 409 (2021) approved funds to implement the addition of in-home service location for BRS. The services will function as a diversion for those children at risk for out-of-home placement and decrease the need for voluntary ODHS Child Welfare custody or involvement with Juvenile Justice. We need to respond to the needs of all Oregonian children, especially those who have not had access to culturally specific services that meet their needs. Children and families of color are disproportionately represented in BRS, CSEC, Child Welfare, OYA, and in those receiving behavioral health services.

Child Psychiatry and Developmental Pediatricians

OHA's CFBH unit has addressed the lack of child psychiatry availability since 2014, by standing up the Oregon Psychiatric Access line (OPAL-K), a child psychiatry consultation service housed at OHSU. This service is available to physicians around Oregon, including primary care, psychiatric mental health nurse practitioners, and other providers with questions related to child psychiatry, particularly medication management.

OHA currently funds a portion of child psychiatry residency training: three child psychiatry residents per year are required to work three days per week in settings certified by OHA under the Intensive Treatment Services (ITS) or substance use residential settings. OHA has not taken prior actions to increase the workforce of developmental pediatricians but has worked closely with one of the OHSU

providers to better understand the barriers that prevent children from being evaluated in a timely manner.

Transition Age Youth (TAY) Hubs
OHA continues to provide support services to Youth and Young Adults which includes:

- Funding two sites through a SAMHSA Healthy Transitions grant through September 2023. The sites focus on engagement and serving youth and young adults, notably those who are marginalized or disconnected from services. The grant also funds a statewide steering committee and three sub-groups focusing on coordination and collaboration, data and evaluation, and youth and young adult voice. There is no funding to sustain this work after September 2023.
- Four regionally unique Young Adult Hubs were started as a pilot project to engage marginalized and disconnected youth and young adults through developmentally responsive services regardless of insurance status. Funding is currently unavailable to expand capacity and pivot services to more adequately represent the needs that youth and young adults have articulated to OHA in multiple listening sessions and 'think tanks.'

7. What alternatives were considered and what were the reasons for rejecting them?

Due to the scope and nature of the continuum of children's behavioral health services and current need, the follow alternatives were considered:

Behavioral Rehabilitative Services (BRS)

- The CFBH team, in partnership with ODHS Child Welfare and the Social Determinants of Health team in HSD, is working on additional capacity expansion projects in higher levels of care.

- Concurrently, the Intensive In-Home Behavioral Health Treatment (IIBHT) service is growing and will attend to some of the needs of these youth. This BRS expansion option would aid in lessening the barriers to service for youth and families with high, complex needs.
- In-home BRS development and implementation funded in the 2021 session will aid in lessening the needs for residential level of care. This policy option in BRS expansion would be available for youth and families with complex and high needs who are not appropriately served in-home.
- Previous strategies have included seeking an additional request for proposals for residential Services for children you experienced CSEC, but it was determined it would be more cost appropriate and feasible to implement the use of Medicaid match utilizing BRS funds.
- Combining services at other residential levels of care for male identified youth needing CSEC supports were considered. This strategy puts youth at risk for possible re-traumatization and there is additional concern that available psychiatric providers may not have highly developed skills and training needed for this option.
- It has been considered to conduct basic CSEC training with the IIBHT providers; however, community risk patterns are changing and evolving rapidly through internet and other technology means, requiring highly specialized training that needs to be far more thoughtfully considered and planned for.

<u>Child Psychiatry and Developmental Pediatricians</u>

- Approaching other training programs in other states and utilize incentives to attract physician residents interested in these specialties to Oregon. More research needs to be done about the feasibility/cost of this option.
- Telehealth is an option being used to improve access; yet the virtual environment is not appropriate for the evaluation and observation of some children’s diagnostic needs.

- Based on implementation of OPAL-K, OHA is aware that use of ancillary providers such as physician associates and psychiatric mental health nurse practitioners (who can be specially trained to do some aspects of these evaluations) is an option, but this would still not provide the level of expertise and knowledge base for children with the greatest challenges.
- This evaluation and treatment work is highly specialized because the disorders can be difficult to treat and may frequently exist with other mental health conditions. Appropriate evaluation and treatment are best provided by specialty physicians.
- HPA one-time investments: Legislative funding recently created a 30/30/30 plan with funding to OHSU, however, the targeted providers were not at this level.

Transition Age Youth (TAY) Hubs

- Investing in child and family and adult outpatient program providers to work with transition age youth more effectively. This is not being pursued due to the current need and acuity within the age range of 14 to 25 years.
- Young adults are struggling when they age out of child and family behavioral health and into adult services. More capacity is needed that can support a young person in the transition process and for a warm hand off, which is a critical element of prevention.
- Expansion of EASA: While EASA has expanded, it does not meet the needs of many young adults whose behavioral health diagnoses do not line up with the intent of the program and who have other needs for behavioral health support and treatment, which are critical to meet at this developmental transition time.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

The full Governor appointed SOCAC voted in support of this policy package. The Oregon Alliance of Children's Providers, the Oregon Council for Behavioral Health and the Oregon Alliance for Suicide Prevention also have offered full support. CSAC also supports this proposal.

These concepts were explored and supported in 2020 and 2021 in response to our Policy Vision[15] paper and during extensive feedback through community engagement with children, youth, young adults and families.

Behavioral Rehabilitative Services (BRS)
ODHS Child Welfare and ODDS, and OYA have been involved in conceptualizing needed expansion for children and youth with complex needs. Our agencies are working together on several projects related to better meeting access needs for supporting youth with complex needs. In addition, community providers who have residential programs have weighed in on the needs for capacity expansion. **CSEC**: Collaboration through the Department of Justice Trafficking Intervention Advisory Committee which is providing funding for research and use of the Hope Scale. The ODHS-CW Temporary Lodging workgroup has also provided an opportunity for collaboration around the needs of youth identified as at risk for or who are commercially sexually exploited and in need of further supports.

Child Psychiatry and Developmental Pediatricians
OHA has consulted and collaborated with Health Policy and Analytics division, and outreached system partners providing graduate medical education.

[15] https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/draft-vision-paper2020.pdf

Transition Age Youth (TAY) Hubs
Healthy Transitions grantees, Early Assessment and Support Alliance and Adult Behavioral Health have all collaborated.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

This policy package would not require any changes to existing statute.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

This policy package was created with the knowledge that the children, youth and families receiving behavioral health services can also be served by all other child serving state agencies, Tribal health programs, coordinated care organizations, community mental health programs and community-based organizations. Program information dissemination would be provided to all nine Oregon Federally Recognized Tribes and the Urban Indian Health Program. Of the four proposals in this policy package the following entities would be affected:

Behavioral Rehabilitative Services (BRS)

- OHA would work with the Tribes on cultural needs within the placement, and on transitional services as needed. Tribal and county agencies would be contacted to participate in development of specific programs at the BRS service level that would be focused on their specific needs including more localized supports to help families get their needs met.
- Tribal Leaders would receive Dear Tribal Leader Letters providing the opportunity for consultation prior to rule implementation.

- Tribes would receive information and invitation to collaborate with BRS programs, and information on new developments.
- ODHS Child Welfare would have other options for youth who are might have been voluntarily signed over to state custody due to their behavioral needs.

Commercial Sexual Exploitation as Children (CSEC)

- With earlier identification, Tribes may be better able to support their youth through the use of the Hope Scale.
- Tribes would receive outreach from OHA staff and invitation to collaborate to meet the need of tribal communities.
- Youth in custody of ODHS-CW often have a long wait time to services; increased support of a community-based team would offer appropriate supports and prevent escalating behaviors that could progress to the need for higher levels of care.
- Provide diversion opportunities and intervention for youth if they are referred to BRS services under OHA, prior to juvenile justice involvement or penetration into the OYA system to prevent detrimental outcomes of system involvement.

<u>Child Psychiatry and Developmental Pediatricians</u>

- All populations are underserved for this specialty level of care and particularly those communities who have been historically marginalized and who've had poor or no access to care overall.
- Tribes and other underserved populations need access to child psychiatrists and developmental pediatricians at a much higher rate than the wider population given their ongoing health inequities. Tribes will receive outreach from OHA staff and invitation to collaborate to meet the need of tribal communities.

- All child serving state agencies would be impacted by improved diagnostic and follow up services to populations most in need, which include our most vulnerable populations.

Transition Age Youth (TAY) Hubs

- Tribes may apply for funding for Hub programs and would have the opportunity to develop a unique model from the counties if they choose.
- Tribes would receive outreach from OHA staff and invitation to collaborate to meet the need of tribal communities.
- Rural public entities (county mental health programs) may apply for funding for Hub programs to augment existing services.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

In September 2020, the Secretary of State audit[16] focused on the children's behavioral health system. The audit highlighted the crisis that Oregon's Children's Behavioral Health system has been experiencing, how OHA is failing to serve children, youth and families who are involved with multiple systems and have complex needs.

The report highlights five key areas: data shortfalls, chronic workforce shortages, weakness and limitations of state statutes that have contributed to the fragmented service delivery model, inadequate monitoring of General Fund spending, and a lack of consistent leadership, strategic vision and governance**.**

[16] https://sos.oregon.gov/audits/Documents/2020-32.pdf

Staffing and fiscal impact

Implementation date(s): July 2023 to June 2025

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

This policy package assumes three core impacts: Long-term Medicaid savings, inflation and the current work force shortage impacting the children's behavioral health system.

Behavioral Rehabilitative Services (BRS)

The costs of emergency department use, and costs incurred from acute care settings assumes savings in Medicaid, which will gradually begin after six months of implementation. In 2023-25, the percentage of decreasing emergency department visits, subacute and psychiatric residential treatment services would still be low and slowly increasing over the 2025-27 biennium. OHA may realize long-term savings in OHP expenditures due to more cost-effective, high-quality care being delivered to OHP members. To the extent savings occur, they would be reflected in subsequent years' coordinated care organization (CCO) rates, which are based on past expenditures, and incorporated into the OHA budget as part of the capitation rates for CCO-enrolled OHP members.

Transition Age Youth (TAY) Hubs

The assumptions that affect the pricing of the TAY Hubs are the variability in the cost of running a hub program. In the last seven years, four hubs have been operationalized throughout Oregon with varying staff and infrastructure. Budgets for the programs range from $130,000 to $520,000 annually. The RFP process for all sites will allow for additional programs, some of whom may have

existing infrastructure and staff, and others who have a significant unmet need in their community to support transition aged youth.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

- BRS/CSEC expansion would be absorbed by existing staff in the CFBH unit for administrative and technical assistance and writing of rules and contracts related to expansion activities, and by an existing Operations & Policy Analyst 3 position for the Medicaid unit. There would be impact to ODHS's Child Caring Licensing unit for the licensing of BRS programs.
- Child Psychiatry and Developmental Pediatrician expansion would be managed by the CFBH unit utilizing existing staff.
- TAY Hubs expanded work would be taken on by current Child and Family Behavioral Health staff, one person in the Office of Behavioral Health contracts unit, two to four people in the Medicaid Policy Unit, staff from the Licensing and Certification Unit for ongoing CMHP site reviews and by the HSD rules coordinator.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Yes, this policy package seeks to expand four current services and supports to children, youth and families. It would make BRS available solely based on behavioral challenges and not require entry into child welfare custody nor juvenile justice involvement to access these services. OHA would like to start by adding four pilot sites and hope to expand at a future date. Feedback indicates that the need is already existing for these services. Facility-based care in BRS services would be developed for male identified victims of sexual exploitation, including CSEC.

Once implemented, the goal of the policy package is to expand support and services for transition age youth through an RFP process. Because this is a difficult to reach population, quantifying exactly how many will access the programs is challenging. We are striving to use feedback from youth and young adults to improve the appeal and usefulness of services to young people.

By expanding services and supports it is hoped there will be a decrease in emergency department use, emergency department boarding, a need to access services through ODHS child welfare, and a decrease in overdoses secondary to substance use and deaths from suicide, which is Oregon's leading cause of death for young people.

Currently, OHA only has Medicaid OARs and oversight for ABA regarding access and payment. Oversight of ABA programs and services is needed, to include working with licensing bodies, coordinating with ODDS and Medicaid, certifying programs, developing program rules, improving payment options, and addressing community concerns. This treatment model is an area of focus for the Legislature in the 2023-25 biennium with legislative hearings and presentations beginning in September 2022.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

The BRS program would utilize an existing Policy Analyst 3 position to support the program administration, coordination and oversight. The Child and Family Behavioral Health Unit would provide technical assistance to BRS programs, rule writing, contracting, and ongoing consultation for sites on implementation. Medicaid Unit would also utilize an existing Operations & Policy Analyst 3 position to manage contracts, provide technical assistance, submit a State Plan Amendment and develop rules to administer this program.

The CFBH unit will provide support for CP/DP fellows by providing technical assistance and aiding in compliance with ABA, develop rules and processes in partnership with ODDS and provide oversight to providers doing the work.

16. What are the start-up and one-time costs?

Startup costs are requested for BRS/CSEC, to include property development, hiring, staffing, training and purchase of furniture and equipment at four sites.

17. What are the ongoing costs?

In Non-Medicaid, there would be ongoing costs for the following:

- BRS/CSEC outcome data tracking
- Three additional training slots at OHSU for child psychiatry, two more child psychiatry training slots over three years, and two new training slots for developmental pediatricians per year
- Increasing and right sizing the budget to support 10 Transition Age Youth hubs (current budget supports 4 hubs)
- CSEC services expansion, which includes personnel to address the psychotherapeutic needs of the residents in the CSEC program

For Medicaid, ongoing costs would be for the expansion of BRS services to youth covered by Medicaid, who are assessed as needing these services according to medical necessity criteria with population specific programming.

18. What are the potential savings?

Behavioral Rehabilitative Services (BRS)The existing continuum of care offers youth and families a variety of ways to get their needs met depending on location, acuity and access. By focusing on prevention in expanding the workforce rather than creating additional downstream intensive services (such as the existing psychiatric and substance use residential programs, Fidelity Wraparound, IIBHT, Mobile response and stabilization services), this policy package seeks to provide supports and services to families to prevent worsening of the behavior challenges of youth and families, which result in their needing higher levels of care.

Most importantly, this policy package would save youth and families time, energy and offering services and supports when they are most needed, thereby reducing human suffering. As such, potential savings are directly correlated to savings in emergency department use, and access to inpatient and residential behavioral health services. Oregon has silos, where state agencies such as ODHS or OYA also support and help the same children, youth and families with a slightly different lens and programs. Accordingly, this policy package extends savings to our state partners and to law enforcement. There will be no duplication of services under this policy package.

Medicaid match dollars would provide savings for OHA and reduce utilization of higher levels of care in each system. There would also be cost savings resulting from decreased use of emergency departments and higher levels of mental health care, such as psychiatric residential treatment services, including subacute, and substance use residential services.

Transition Age Youth (TAY) Hubs

TAY hubs offer prevention for youth who could, without adequate and supportive developmentally based services, be more likely to become involved with law enforcement, use substances and receive care from an emergency department, and become homeless.

19. What are the sources of funding and the funding split for each one?

This policy package is funded with General Fund only in Non-Medicaid and both General Fund and Federal Funds for Medicaid.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services					0	0.00
Services & Supplies						
Capital Outlay						
Special Payments	11,524,509		1,459,217	12,983,726		
Other						
Total	**$11,524,509**	**$0**	**$1,459,217**	**$12,983,726**	**0**	**0.00**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Center for Public Health Practice
Policy package title:	PPE and Medical Supply Management
Policy package number:	428
Related legislation:	House Bill 4068 (2022)

Summary statement:

During the COVID-19 pandemic, the Oregon Health Authority (OHA) learned many lessons relevant to health security, preparedness, and response. One vital lesson learned is that Oregon needs to have a robust and operational stockpile and inventory management system for lifesaving PPE and medical supplies to effectively respond to major events such as pandemics, wildfires, and other disasters. This stockpile and management systems should always be operational to be effective for saving as many lives as possible in emergency response. Currently, most of Oregon's PPE and medical supply stockpile will need to terminate when FEMA COVID reimbursement ends, which is expected in 2023.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$1,000,000**	**$0**	**$0**	**$1,000,000**	**2**	**1.50**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. **Why does OHA propose this policy package and what problem is OHA trying to fix or solve?**

   This policy package proposes to transition the federally-funded COVID-19 medical supply stockpile into a core state-funded stockpile program in order to provide a focused supply of PPE, testing supplies and other medical supplies to organizations and communities who are unable to purchase or procure those supplies and have immediate life safety or public health risks. The Oregon Health Authority (OHA) will further refine the allocation model and stakeholder support for limiting distribution to organizations and community-based organizations that serve vulnerable Oregonians, such as older Oregonians, communities of color, migrant and seasonal farm workers, rural health care organizations with limited buying power.

   OHA holds large volumes of life-saving inventory at multiple locations, including PPE; vaccines and vaccine ancillary kits; tests and related supplies; ventilators, tubing, other medical countermeasures; and the Oregon Medical Station. These supplies are being reduced as the COVID-19 response, including FEMA reimbursement, reduces. Without implementation of this policy package, OHA's capacity to maintain the stockpile will end when federal COVID-19 related funding ends, which is expected in mid-2023. Further, OHA is due to pivot the scope and strategies for managing this stockpile. This will ensure that Oregonians have timely and equitable access to lifesaving PPE and medical supplies in the event of an emergency.

2. **What would this policy package buy and how and when would it be implemented?**

   This policy package would provide Oregonians with a focused stockpile of supplies that protect them from certain health risks encountered in public health emergencies and disasters. In responding to COVID-19 it became clear that OHA needs to have a stockpile of health and medical supplies that is

up-to-date and ready for deployment to meet urgent needs. This policy package would furthermore provide more independence from potential national supply chain shortage issues seen in larger disaster response situations.

Specifically, this policy package includes warehouse space rental, personnel, inventory and cold chain management by a vendor(s), and purchases of replacement inventory after planned rotations or shipments to community partners. Large-scale distribution and purchases due to an emergency would need to be supplemented by emergency funds allocated at a later time.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   This policy package enhances OHA's ability to ensure Oregon has equitable availability of mitigation resources, such as PPE and medical supplies for populations that have been economically and socially marginalized. As demonstrated during the COVID-19 response, OHA would continue to use the stockpile to prioritize communities disproportionately affected by an emergency or disaster or those that are facing underlying resource needs caused by historic and contemporary inequities. Oregon could use this medical stockpile to support partners who are unable to procure medical supplies due to limited resources or increased scarcity and national supply chain costs. Without the support of a public body, many community health partners are unable to procure sufficient medical supplies needed to meet large surges evident in a public health crisis. This policy package would

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

help ensure these partners would be able to meet needs in tandem with large health systems who may have more resources and buying power to meet surge needs.

Planning resources will be dedicated to assessing how less central stockpiles, placed in regions with community partners, could be stood up at a later date if additional investment becomes available.

Quantifying results

4. What are the long-term desired outcomes?

- Public health, health care, and community partners that support low-income and disproportionately affected community groups receive life-saving medical supplies within short timeframes needed during an emergency, regardless of their ability to procure those supplies from the open market.
- OHA manages a core stockpile with a strong inventory management system, secure facilities, and shipments to partners in need of medical supplies to meet urgent equity-related needs. Specific metrics will be developed for transparent reporting to all stakeholders statewide.

5. How will OHA measure the impacts on health inequities of this policy package?

Impacts would be measured primarily through process outcomes, partner feedback, and epidemiologic measures.

1) Process outcomes include tracking of PPE and supplies stored and distributed to partners who serve low income and disproportionately affected communities, such as community-based organizations (CBOs) or priority CBOs, such as those that support migrant and seasonal farmworkers.

2) Partner feedback would provide immediate feedback on supply needs, supply distribution, and gaps from valuable community partners who are best placed to identify community needs.
3) Epidemiologic measures would help indicate whether the provision of medical supplies as a public health intervention has helped reduce disease outcomes as seen in morbidity and mortality data. Furthermore, OHA would analyze disease outcomes by race, ethnicity, language, disability, sexual orientation and gender identity as available in order to ensure PPE and supplies are directed to communities most impacted in various areas across the state.

This policy package would enable OHA to support partners in accessing and deploying critical supplies to eliminate health inequities in health care delivery.

OHA would continue to support our CBOs, including the migrant and seasonal farmworker (MSFW) programs we prioritized in the pandemic. OHA would work with Tribal communities and communities of color to ensure equitable access to supplies during emergencies.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

During the pandemic, Oregon was able to procure millions of dollars' worth of federal supplies and purchase additional supplies to ensure there were adequate lifesaving PPE and medical supplies for Oregonians. The FEMA reimbursement is expected to end in 2023 and Oregon will need to develop an independent stockpile program or rely entirely on federal stockpiles in the future. OHA needs staffing and funding to be able to support an efficient and organized hybrid model to ensure Oregon's stockpile is sufficient to be immediately ready, avoiding unnecessary delays in the event of the next pandemic or a disaster.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   OHA has limited related federal funding under the HHS Public Health Emergency Preparedness and Hospital Preparedness Program cooperative agreements, which supports 1.00 FTE for Medical Counter Measures within the Health Security, Preparedness and Response program. OHA learned in the COVID-19 pandemic that the state needs a more robust and operational stockpile to appropriately meet the needs of a fragile commercial system. The current federal cooperative agreements only support warehouse fees for storage of the Oregon Medical Station in a limited low-cost space in the DAS surplus warehouse and cannot accommodate any of the costs now needed for sufficient stockpiles of PPE and other supplies.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   The Oregon Department of Human Services (ODHS), the Department of Administrative Services (DAS) and the Office of Emergency Management (OEM).

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    All counties, municipalities and Tribes would be receiving lifesaving emergency resources in the event of a pandemic or other emergency.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No. However, it was called out in the Governor's Office After Action Reports.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

The assumptions made are that a contractor/vendor is identified through an RFP process to be able to work on a hybrid approach to PPE and medical supply management that includes inventory management, regional storage and a just-in-time pipeline to lifesaving supplies.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Not applicable.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Not applicable.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package includes two new permanent positions (1.5 FTE) for an OHA PPE and medical countermeasures management team:

- One Operations & Policy Analyst 1 position (0.75 FTE)
- One Administrative Specialist 1 position (0.75 FTE)

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

This policy package is entirely ongoing costs.

18. What are the potential savings?

None anticipated.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Oregon Health Authority: 2023-25 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$298,536			$298,536	2	1.50
Services & Supplies	$701,464			$701,464		
Capital Outlay						
Special Payments						
Other						
Total	**$1,000,000**	**$0**	**$0**	**$1,000,000**	**2**	**1.50**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health
Program:	Environmental Public Health
Policy package title:	Domestic Well Safety Program
Policy package number:	432
Related legislation:	Not applicable

Summary statement:

This package would restore the previously federally-funded Domestic Well Safety Program (DWSP) by providing funding to permanently fill a vacant dedicated DWSP staff position. DWSP uses data collected under the state Domestic Well Testing Act to inform people in Oregon about the importance of testing drinking water from wells and provides guidance about how to improve poor water quality, leading to improved health outcomes. DWSP also conducts special projects, including the 2020 Wildfires-Impacted Domestic Well Testing project and the Lower Umatilla Basin Ground Water Management Area (LUBGWMA) project. This package funds public health interventions in LUBGWMA including outreach for domestic well screening and testing and where indicated, water treatment device installation and maintenance.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$3,000,000**	**$0**	**$0**	**$3,000,000**	**1**	**0.75**

Oregon Health Authority: 2023-25 Policy Package

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

In mid-2020, the federal Centers for Disease Control and Prevention (CDC) ceased funding the Domestic Well Safety Program (DWSP), housed in OHA's Environmental Public Health (EPH) Section. CDC had funded most of a position in EPH since 2013, allowing OHA to provide domestic well safety education and outreach to approximately 20 percent of Oregon's population who rely on domestic wells for their drinking water. Water insecurity, exacerbated by climate change, has been a growing concern in recent years given increasing scientific evidence that changes in precipitation, heat and wildfires will impair drinking water systems including domestic wells. Preventable direct health outcomes of water insecurity include water-borne illnesses, exposure to contaminants and toxins, dehydration and malnutrition. Indirect outcomes include emotional distress, depression and anxiety. Understanding water quality and quantity needs and inequities in access to safe water in Oregon is a prerequisite to developing community-specific and culturally-relevant water security strategies or policy solutions to help communities build adaptive capacity, strengthen resiliency and protect the health of all people in Oregon.

The threat of water insecurity was dramatically realized with the September 2020 Labor Day wildfires that impacted communities throughout central and western Oregon, leaving thousands with damaged or destroyed homes and wells and disproportionately impacting communities of color and with low incomes. Because OHA had suspended the DWSP due to lack of funding, OHA required legislative Emergency Board (2020) and 2021 legislative funding for staff and laboratory contracting funds to offer free domestic well testing to the estimated 2,000 homes impacted by wildfires. That project is funded through FY 2023. In summer 2021 hundreds of wells went dry in the Klamath Basin due to drought, and while OHA dedicated manager time to interagency drought council efforts, there

was no one able to provide public health information to people concerned about health impacts apart from the OHA website.

Most recently, the U.S. Environmental Protection Agency (EPA), responding to a legal petition under the Safe Drinking Water Act, is expected to require the State of Oregon, and OHA in particular as the agency with drinking water primacy under federal law, to mitigate exposure to nitrates in domestic well water to residents in the Lower Umatilla Basin Ground Water Management Area (LUBGWMA). The LUBGWMA, encompassing northern portions of Morrow and Umatilla counties, is designated due to high levels of nitrates from human activities.

EPA is requiring a plan from OHA to conduct outreach and education, domestic well testing and relief (bottled or trucked water, treatment systems, well repair or redrilling, connection to local systems) until high levels of nitrates fall under maximum contaminant levels of 10 milligrams per liter. There are two other Ground Water Management Area and other areas of concern in Oregon that may request similarly equitable treatment. Meanwhile, OHA receives results of domestic well tests conducted during Real Estate Transactions under the Domestic Well Testing Act (ORS 448.271). OHA is contacted by home buyers, sellers and realtors regarding these data. OHA has been unable to enter these data since the end of federal funding in 2020.

2. What would this policy package buy and how and when would it be implemented?

Because OHA already has permanent position authority for a 1.00 FTE permanent Program Analyst 2 from the years of sustained federal grant funding, this policy package is needed to provide funding only. OHA would be able to use the funds immediately to maintain and make permanent the limited duration staff carrying out day-to-day Domestic Well Testing Act work, coordinating special short and intermediate-term projects like the wildfire-impacted domestic well testing project and coordinating

long-term projects such as the LUBGWMA workplan, while carrying out recruitment for the permanent position.

- Contract funds to engage local public health authorities, community-based organizations, Tribes and nongovernmental organizations to develop and deliver well testing and safety outreach and communications, including conducting domestic well sample screening events; these funds will be deployed as soon as OHA establishes contracts.
- Contracts to certified environmental laboratories to conduct domestic well water analysis; these funds will be deployed as soon as OHA establishes contracts.
- Contracts to purchase, either directly or through local water treatment professionals, point of use water treatment systems to reduce nitrate contamination in domestic well water, prioritizing communities of color and with low income; these funds will be deployed as soon as OHA establishes contracts.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

At least 40 percent of all Oregon residents rely on public or private groundwater supplies for their drinking water (some public water systems rely on wells as some or all of their water source). In rural areas, 90 percent of Oregonians are dependent on groundwater and for many communities it is the only source of potable water. Oregon's rural populations experience elevated levels of poverty and compromised health status, particularly among communities of color. This makes groundwater protection and domestic well stewardship of critical public health importance. There are an estimated

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

350,000 active wells in Oregon. When this estimate is coupled with Oregon census estimates for household size, it suggests that approximately 23 percent of the state's population may be relying on private wells. With only 1 percent of state land use designated as urban, Oregon is primarily a rural state and private wells predominate. The Oregon Water Resources Department reports that every year 3,800 new exempt-use wells are drilled across the state. These small wells are exempt from the water-rights permitting process and regular water quality testing is not required leaving users of these wells at increased risk for adverse health outcomes stemming from exposure to well water contamination.

With respect to the LUBGWMA in particular, there are approximately 4,500 domestic wells serving an estimated 12,000 household members in an area of the state that tends to be more ethnically diverse, higher representation of Latino/a/e and American Indian/Alaskan Native populations and with a higher poverty rate than the state as a whole.

This policy package would improve awareness of domestic well sampling and water treatment, leading to decreased exposure to contaminants and improved general health outcomes. For the LUBGWMA, this work would include provision of free well water sampling and free water treatment for people impacted by poor water quality.

Quantifying results

4. What are the long-term desired outcomes?

We desire improved compliance with the Domestic Well Testing Act and increased general awareness of the importance of water testing (and utilization of free testing for the LUBGWMA project), improved drinking water quality based on action taken from test results and improved

general health outcomes due to decreased exposure to contaminants. An ultimate environmental outcome would be dissolution of the LUBGWMA due to reduction of groundwater nitrates below levels of concern.

5. How will OHA measure the impacts on health inequities of this policy package?

The clearest and direct measure of equity would be the decrease in the number of households exposed to contaminated well water for their daily living activities. Due to the complexity of environmental exposures, it is difficult to measure health impacts of nitrates in drinking water. Acute outcomes (primarily fetal and infant mortality from methemoglobinemia, also some birth anomalies) are rare and chronic outcomes (primarily stomach cancer) are difficult to ascribe to individual causes. OHA is currently collecting baseline data for the LUBGWMA to see if it is possible to measure health impacts. OHA can measure intermediate outputs, including uptake of well testing and implementation of water treatment by census geography which can be correlated with demographic information.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In 2021, US EPA was petitioned to resolve concerns and US EPA directed Oregon state agencies to deliver a plan. In December 2021 OHA, Oregon Department of Environmental Quality (DEQ) and Oregon Department of Agriculture (ODA) developed an interagency workplan in response. This policy package is based in large part on that workplan. In June 2022, Morrow County declared a state of emergency related to findings of high nitrates in portions of that county in LUBGWMA and requested support from state agencies. OHA expedited planning and requisition efforts.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   OHA asked US EPA for funding to address concerns; no funding has yet been identified from that source. OHA considered requesting federal Congressional Discretionary Spending and then learned that Morrow County requested congressional spending to monitor domestic wells and extend public water system lines. The county's application only covered a portion of the LUBGWMA project and public health action plan. OHA provided a letter of support.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   OHA partnered with DEQ and ODA in developing the workplan that forms the basis for this policy package. OHA is partnering with Morrow and Umatilla counties (as well as DEQ and ODA) on workplan refinement and long-term implementation.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    Tribal and/or local government agencies may receive funding to assist in outreach and education efforts.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

Position pricing assumes 1.00 FTE Program Analyst 2, step 3 based on current limited-duration staffing. For LUBGWMA, assumptions are 4,500 wells in the area to sample, 500 of which might be contaminated. Assuming half will need less expensive reverse osmosis water treatment and the other half will need ion exchange water treatment. Assuming treatment systems will be point-of-use (i.e., kitchen sink) versus whole-house treatment.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Office of Contracts and Procurement will need to support contracting for outreach and education, well sampling and water treatment. Office of Information Services will need to maintain existing information systems.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

OHA already has 1.00 FTE Program Analyst 2, permanent position authority as a result of federal grant support that started in 2013 and ended in 2020 for the OHA Domestic Well Safety Program. This policy package requests funding only (no new position authority) to restore the one-person Domestic Well Safety Program to carry out required statewide and LUBGWMA-focused work. (OHA would also need to dedicate time of existing Environmental Epidemiologist 2 and Compliance and Regulatory Manager 1 positions to support the work but is not requesting new funding or authority for those positions.)

16. What are the start-up and one-time costs?

Anticipate LUBGWMA contracting costs are initially high during first period of outreach and education and recruitment for well testing and water treatment implementation.

17. What are the ongoing costs?

Ongoing costs to maintain the day-to-day Domestic Well Testing Act work, coordinate special short and intermediate-term projects like the wildfire-impacted domestic well testing project. For LUBGWMA outreach and education, well testing and water treatment installation costs would taper off; water treatment system maintenance costs would remain until groundwater nitrate levels were no

longer hazardous. The other ongoing cost is maintaining the 1.00 FTE Program Analyst 2 to staff the OHA Domestic Well Safety Program.

18. What are the potential savings?

There are potential savings to be gained by improved individual and community health due to removal of exposure to harmful level of drinking water contaminants from domestic wells generally, and particularly in LUBGWMA.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$154,551			$154,551	1	0.75
Services & Supplies	$2,845,449			$2,845,449		
Capital Outlay						
Special Payments						
Other						
Total	**$3,000,000**	**$0**	**$0**	**$3,000,000**	**1**	**0.75**

Oregon Health Authority
2023-25 Policy Package

Division:	Health Policy and Analytics
Program:	Oregon Health Insurance Marketplace
Policy package title:	Marketplace Outreach and Operations
Policy package no.:	434
Related legislation:	None

Summary statement:

This policy package uses existing Marketplace funds to further the Oregon Health Authority's (OHA) goals of 98 percent coverage by 2024 and elimination of health inequities by 2030. Priority populations face significant barriers to accessing health care due to systemic racism, oppression, discrimination, and bias. Specialized and dedicated efforts are needed to mitigate historical and contemporary injustices and either build or rebuild trust to ensure people are connected to the resources they need. With current staffing and due to the increasing demand from the community, the Marketplace needs additional resources to maintain and expand outreach and education initiatives to the communities it serves, including those who are at a higher risk of being harmed by health inequities, experiencing disadvantage, and most affected by social inequities. With additional staff, these communities will have access to the most effective assistance available to gain access to potentially free or very low-cost health care.

Oregon Health Authority: 2023-25 Policy Package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$0**	**$0**	**$0**	**3**	**2.50**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

To meet the goals of eliminating health inequities by 2030 and achieving 98 percent health insurance coverage, OHA proposes this policy package, which relies on unused, excess Marketplace Other Funds that would otherwise be rebated back to commercial insurance carriers.

Priority populations face significant barriers to accessing health care due to systemic racism, oppression, discrimination, and bias. Specialized and dedicated efforts are needed to mitigate historical and contemporary injustices and either build or rebuild trust to ensure people are connected to the resources they need. The Marketplace's Outreach and Education Program is a critical effort focused on building relationships with community. Over the last five years, the Marketplace has employed five permanent outreach and education coordinators and two limited duration outreach and education coordinators.

Outreach and Education Coordinators (OECs) are the face of the Marketplace as health insurance and coverage experts, confident trainers, providers of excellent customer service to Oregonians, and trusted resources for the communities they serve. OECs serve every county in the state, providing school and college outreach; cultivating relationships with health insurance agents, community partners, community leaders, and local businesses; attending and supporting county, local, and regional government and community groups; partnering with OHA Regional Outreach Coordinator partners (ROCs); educating individuals throughout the state about how to get and use coverage; and working closely with WorkSource Oregon to give Rapid Response and Trade Act session presentations statewide for workers who have recently lost their jobs. In addition to outreach, the coordinators provide in-person and virtual Marketplace training to over 1,000 community partner assisters each year in both English and Spanish.

An ongoing challenge facing the Outreach and Education Program is staff turnover in the limited duration positions. The turnover resets relationships with the partners and communities; eliminates earned trust; and disrupts outreach, education, and enrollment assistance efforts. The development and training of these staff is lost when they move on to permanent employment elsewhere. The use of limited duration employees to fill these essential roles is neither sustainable nor effective to meet the needs of communities and ensure access to potentially free or very low-cost, high-quality health care.

With current staffing and due to the increasing demand from the community, the Marketplace needs additional resources to maintain and expand outreach and education initiatives to the communities it serves, including communities at higher risk of being harmed by health inequities, experiencing disadvantage, and most affected by social inequities. With additional staff, these populations will have access to the most effective assistance available to gain access to potentially free or very low-cost health care.

Another challenge facing the Marketplace's Outreach and Education efforts is the lack of a permanent staff member to operate and manage the call center. Per Oregon law, the Marketplace must operate "a call center dedicated to answering questions from individuals seeking enrollment in a qualified health plan" in a manner that will "mitigate health disparities linked to race, ethnicity, primary language and similar factors." ORS 741.002 and 741.001(4) (respectively). Following the transition of the Senior Health Insurance Benefits Assistance (SHIBA) team to the Oregon Department of Human Services (ODHS) on July 1, 2021, the Marketplace no longer has any Call Center Representatives to support the call center. The Marketplace did hire a limited duration call center representative, but a permanent position is required to provide necessary information to

consumers who use the call center; allow the Marketplace's outreach and education coordinators to remain in the field providing outreach, education, and enrollment assistance; monitor and reply to emails; help support constituent work; and to meet statutory requirements.

Finally, the Marketplace brings additional complex reporting and contracting requirements that were not fully recognized at the time the program was integrated with OHA after the passage of SB 65 (2021). Additional fiscal reporting and support has been identified as a need to successfully support the program, its grants, and federal reporting requirements.

2. What would this policy package buy and how and when would it be implemented?

This policy package requests the following three, full-time permanent Marketplace positions:

- One Outreach and Education Coordinator (Program Analyst 2)
- One Marketplace Customer Service Representative (Public Service Representative 4)
- One Budget Analyst (Fiscal Analyst 2)

The first two positions would provide outreach, education, and enrollment assistance to traditionally underserved and marginalized populations. The budget analyst would assist with budget reporting and tracking of federal grants, contracts, revenue and Marketplace expenditures.

<u>Outreach & Education Coordinator</u>
Program Analyst 2s support Outreach and Education in their assigned regions and provide Oregon-specific, in-person training to community partners. This position would serve both Central Oregon and the Gorge. Both regions have rural areas that are best served with in-person support and face-to-face relationship building. This OEC would serve the following counties, Jefferson, Wheeler, Crook, Deschutes, Hood River, Wasco, Sherman, and Gilliam.

Call Center Representative

A permanent call center representative would provide necessary information to consumers who use the call center, monitor and reply to emails, help support constituent work, and to meet the requirements of ORS 741.002 and 741.001(4). This role is integral to allowing the Marketplace's outreach and education coordinators to remain in the field serving and assisting community members.

Budget Analyst

A permanent budget analyst position would provide the necessary fiscal support for the Marketplace. This position would help ensure that the revenue, expenditures, federal reporting and other budget needs are done in a timely and accurate manner as required by ORS 291.100.

For all three positions, OHA would begin recruitment on the next business day after policy package approval, on or around July 1, 2023. OHA anticipates hiring permanent positions around January 1, 2024.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

Additional outreach and education, call center, and budget/operational staffing would help the Marketplace focus on, and effectively implement, strategies to serve traditionally underserved and priority populations to educate individuals about affordable health insurance options and assist them

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

with enrollment into affordable, high-quality health care. Increased coverage of communities at higher risk of being harmed by health inequities, experiencing disadvantage, and most affected by social inequities would contribute to OHA's mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

Quantifying results

4. What are the long-term desired outcomes?

Increased enrollment, especially of priority populations, in qualified health plans (QHPs) using maximum tax credits and/or cost-sharing reductions if applicable, or – depending on eligibility – in the Oregon Health Plan (OHP). While the Marketplace will continue to do its best to reach all people in Oregon eligible for QHP coverage and tax credits, failure to fund this policy package and the necessary permanent staff will limit the support the Marketplace is able to provide. As mentioned in question two, the additional budget position would help ensure that the revenue, expenditures, federal reporting and other budget needs are done in a timely and accurate manner as required by ORS 291.100.

5. How will OHA measure the impacts on health inequities of this policy package?

During open enrollment for 2024, the Marketplace will begin to require community partners, agent partners, outreach coordinators, and call center representatives to record data disaggregated by race, ethnicity, language, disability, sexual orientation, and gender identity. The Marketplace will also seek enrollment data from carriers required to obtain such data. The Marketplace will also use existing federal and state data resources to analyze year-over-year county changes and solicit

qualitative input and feedback from community partners. Information for 2024 would be used as a baseline to compare against future years after implementation of the policy package.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

The Marketplace hired limited duration Outreach and Education Coordinators and a limited duration call center representative, expanded coverage areas for existing permanent OECs, added statewide LatinX outreach to each OEC's workload, combined two regions for one OEC, required one OEC to perform statewide outreach, and worked with community partners and Tribal liaisons to help support regions. OECs have also helped cover phones. These attempted mitigation strategies taxed an already heavily burdened staff, resulting in a reduction in the quality and quantity of outreach and education to all communities, including those that are typically marginalized and underserved.

7. What alternatives were considered and what were the reasons for rejecting them?

The Marketplace originally covered the loss of the Call Center Representative when the SHIBA program moved to ODHS by hiring a limited duration position. A limited duration position was also hired to support the Outreach and Education team as a coordinator. As referenced above, limited duration positions result in too much turnover in jobs that require building trusted, lasting relationships with community and significant levels of training. The Office of Business Operations budget team has been managing the additional workload brought by the Marketplace through existing resources, but a permanent position is needed to sustainably meet the needs of both the Marketplace and the rest of the division.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   None.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    Tribal governments would be affected to the extent the additional staffing results in increased Tribal member enrollment in qualified health plans (QHPs) through the Marketplace. Increased Tribal member QHP enrollment could reduce required Tribal spending on health care, freeing up funds for other priorities.

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    No.

Staffing and fiscal impact

Implementation date(s): January 1, 2024

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

None.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package requests three permanent, full-time positions:

- One Program Analyst 2 (Outreach and Education Coordinator) would replace a current non-budgeted limited duration position. The limited duration positions have been ongoing as this work is permanent within the Marketplace.

- One Public Service Representative 4 (Marketplace Customer Service Representative) would replace a current non-budgeted limited duration position. The limited duration positions have been ongoing as this work is permanent within the Marketplace.
- One Fiscal Analyst 2 (Budget Analyst) would be responsible for providing the necessary fiscal support for the Marketplace by helping ensure that the revenue, expenditures, federal reporting and other budget needs are done in a timely and accurate as required by ORS 291.100.

16. What are the start-up and one-time costs?

Initial cost would include standard services and supplies costs for new staff including employee training, office supplies and telecommunications devices. Other initial costs include IT charges and assessments that include software, expendable property, and background checks and other shared services within OHA.

17. What are the ongoing costs?

Ongoing costs include employee salaries and benefits, office expenses, travel, and training.

18. What are the potential savings?

This policy package would minimize the need for annual recruitments for limited duration positions. Savings would include reduction in staff time that could be directed to other work or priorities in human resources, Health Policy and Analytics, and payroll; in specific costs associated with recruitment channels outside of State Jobs pages; and in time and costs associated with onboarding and training new employees.

18. What are the sources of funding and the funding split for each one?

This policy package is funded by existing, unused Health Insurance Exchange Fund moneys (Other Funds) that are legally required to be rebated back to commercial QHP issuers if unused. This is an ongoing funding source. The Fiscal Analyst position may be supplemented by cost allocation funding from other sources, but that amount is unknown at this time.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services		$468,644		$468,644	3	2.50
Services & Supplies		($468,644)		($468,644)		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$0**	**$0**	**$0**	**3**	**2.50**

Oregon Health Authority
2023-25 Policy Package

Division: Health Policy and Analytics
Program: Public Employees' Benefit Board
Policy package title: Affordable Care Act (ACA) Employer Reporting
Policy package number: 438
Related legislation: Affordable Care Act, March 2010
Summary statement:

In 2014 employer required Affordable Care Act (ACA) reporting was delegated to PEBB to complete on behalf of the state of Oregon. This includes 1095C mailings and 1095B mailings to eligible employees, and the electronic 1094C, 1095C, and 1095B to the IRS. There was not a full understanding of ACA reporting at that time. The most complex part of ACA reporting is the data related to offers of coverage owned by HRIS systems. No funding or positions were allocated for this effort. The Internal Revenue Service (IRS) ended "good faith" ACA reporting beginning with tax year 2021. Data gaps in HRIS makes accurate reporting challenging. The Chief Human Resource Office (CHRO) has not given an indication of any efforts to secure a position within their office to ensure required ACA data is captured. At this time, PEBB has not received an estimated timeline as to when HRIS will be able to include essential ACA data elements into its system PEBB is looking to outsource ACA reporting to a vendor with expertise in the field to limit liability for the state, and for other employers who participate in PEBB and elect to use the vendor for ACA reporting. If PEBB is not able to procure a vendor, positions would need to be added to fill expertise in ACA rules and regulations and changes, including 1095 coding requirements based on data available. Additional positions would be needed to address data needs, data gaps, compile IRS compliant files, mail 1095 forms and track mailings, corrections for compliance. Alternatively, ACA reporting as currently conducted is a liability for the state.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$0**	**$665,000**	**$0**	**$665,000**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

The state of Oregon does not have staff dedicated to ACA rules, coding expertise, or systems in place to adequately conduct ACA reporting required of Applicable Large Employers (ALEs).

In 2014, Affordable Care Act (ACA) employer reporting for Oregon was delegated to PEBB. This includes 1095C mailings and 1095B mailings to eligible employees, and the electronic 1094C, 1095C, and 1095B to the IRS. There was not a full understanding of ACA reporting at that time and the reasoning for delegating ACA reporting to PEBB was because PEBB has self-insured plans and the reporting requirement was looked at as primarily an enrollment reporting requirement. No funding or positions were allocated for this effort.

While ACA employer reporting has an enrollment element, the complexity of ACA reporting is tracking and determining whether an offer of coverage should be made and when it should be made. This typically is determined by the HRIS system. This includes tracking measurement periods and tracking of monthly hours worked and then determining a definite yes/no per month as it relates to an offer of coverage. PEBB is not the source of this data. This data is owned by the Human Resource Information System (HRIS) and the legacy payroll system (OSPS). The legacy HRIS system in place in 2014 did not have the capability to track and store the necessary data. The new HRIS system does not have the adequate data because ACA reporting requirements were not included in the scope of the new HRIS system project. It is not known when or if ACA reporting will be incorporated into the HRIS system.

The Internal Revenue Service (IRS) ended "good faith" ACA reporting beginning with tax year 2021. Data gaps in HRIS makes accurate reporting challenging. The Chief Human Resource Office (CHRO) has not given an indication an estimated timeline as to when HRIS will be able to include essential ACA data elements into its system and improve the data it provides to PEBB to report on their behalf.

PEBB is looking to outsource ACA reporting to a vendor with expertise in the field to limit liability for the state, and for other employers who participate in PEBB and elect to use the vendor for ACA reporting.

2. What would this policy package buy and how and when would it be implemented?

PEBB would seek services of a vendor for comprehensive ACA reporting that includes evaluation of data needs, data gaps, coordination of employer data gathering, evaluation and coding of offers of coverage, employee share, enrollment codes, mailing of 1095 forms, filings with IRS, correction filing, and responses to IRS inquiries.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

This package will improve accuracy and compliance with ACA reporting and regulations and aligns with OHA's goal for data integrity and reliability.

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[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Quantifying results

4. What are the long-term desired outcomes?

- Accurate and reliable ACA reporting
- Accountability for data source systems
- Limit the liability to agencies and other employers for inaccurate reporting or missed offers of coverage

5. How will OHA measure the impacts on health inequities of this policy package?

This is not applicable to this request.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In 2014, it was decided that PEBB would complete the required Affordable Care Act (ACA) employer reporting for the state of Oregon. This includes 1095C mailings and 1095B mailings to eligible employees, and the electronic 1094C, 1095C, and 1095B to the IRS. There was not a full understanding of ACA reporting at that time and the reasoning for delegating ACA reporting to PEBB was because PEBB has self-insured plans and the reporting requirement was looked at as primarily an enrollment reporting requirement. No funding or positions were allocated for this effort.

Since the initial year, the advisability of this reporting being conducted by PEBB has not been revisited. PEBB has made a good faith effort to accurately conduct ACA reporting based on data available from the various source systems.

The Internal Revenue Service (IRS) ended “good faith” ACA reporting beginning with tax year 2021.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   ACA reporting is an employer responsibility. The complexity of ACA reporting is primarily related to the tracking of hours worked and tracking measurement periods to determine if offers of coverage must be made. This data is owned by HR systems. HR and payroll systems do not have the capability currently to complete ACA reporting or enhance the data it provides to PEBB to complete ACA reporting on their behalf. The Chief Human Resource Office (CHRO) has not given an indication of any efforts to secure a position within their office to ensure required ACA data is captured. At this time, PEBB has not received an estimated timeline as to when HRIS will be able to include essential ACA data elements into its system.

   PEBB is looking to outsource ACA reporting to a vendor with expertise in the field to limit liability for the state, and for other employers who participate in PEBB and elect to use the vendor for ACA reporting. If PEBB is not able to procure a vendor, additional positions would need to be added to fill expertise in ACA rules and regulations and changes, including 1095 coding requirements based on data available. Additional positions would be needed to address data needs, data gaps, compile IRS compliant files, mail 1095 forms to member and track mailings, corrections for compliance.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   None.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

No.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

While PEBB is designated to conduct reporting on CHRO's behalf, other participating employers can utilize the same services. Universities, local governments that participate in PEBB will benefit from the professional services of an ACA vendor.

At such time that the state CHRO and payroll systems have incorporated their responsibility for ACA reporting in scope of their systems, PEBB will give universities and local governments who currently elect to use PEBB at least one year notice so they can find an alternative for ACA reporting.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

Assumptions are a rough estimate of comprehensive ACA reporting services starting on July 1, 2023 was provided by PEBB's actuarial consultant.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

None.

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

ACA reporting is required annually. The total costs will vary as the number of employees change and the regulations change.

18. What are the potential savings?

By outsourcing to a vendor who has expertise in ACA regulations and specializes in ACA reporting, the state will limit liabilities related to inaccurate reporting and avoiding penalties related to offers of coverage not being made.

19. What are the sources of funding and the funding split for each one?

Funding source is Other Funds revenue from administrative fees assessed on PEBB Core Benefits. The administrative fee is paid by members and state agencies through an assessment added to medical and insurance premiums and premium equivalents.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services					0	0.700
Services & Supplies		$665,000		$665,000		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$665,000**	**$0**	**$665,000**	**0**	**0.00**

Oregon Health Authority
2023-25 Policy Package

Division:	Oregon State Hospital
Program:	Oregon State Hospital Operations
Policy package title:	Asset and Equipment Replacement
Policy package number:	439
Related legislation:	None

Summary statement:

The Oregon State Hospital (OSH) Salem facility began construction in 2009, was completed in 2011, and is over 11 years old. The Junction City facility is now over 6 years old. As aging occurs, much of the expendable property and capital assets in operation have outlived or have soon expiring useful lives. Replacement of these items is necessary to provide a safe and secure environment for patients and staff, as well as maintain critical continuity of hospital operations.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$3,000,000**	**$0**	**$3,000,000**	**0**	**0.00**

Purpose

1. **Why does OHA propose this policy package and what problem is OHA trying to fix or solve?**

   OSH campuses in Salem and Junction City have a considerable volume of equipment at or near the end of their useful lifecycle that must be replaced to maintain critical operational continuity and provide 24-hour hospital level of care to patients needing intensive psychiatric treatment for severe and persistent mental illness.

   Lifecycle replacement of equipment is part of the requirement for accreditation by the Joint Commission and for Medicare reimbursement through the Centers for Medicare and Medicaid Services (CMS). Much of the existing equipment was purchased at the time of hospital opening, while other pieces were transferred from the old facility. This equipment has experienced the wear and tear of a production environment and is requiring upkeep or replacement beyond existing budget resources. Replacement of these items is necessary to provide a safe and secure environment for patients and staff, as well as maintain critical continuity of hospital operations.

2. **What would this policy package buy and how and when would it be implemented?**

   The Salem campus of OSH relies on a Programmable Logic Control (PLC) system to interface with monitoring cameras and access control, primarily including the sally ports that allow staff and patients ingress and egress from different sections within the secure perimeter of the hospital. This system is outdated and frequently malfunctions, necessitating the utilization of Security personnel to manually operate the sally ports. Additionally, the PLC system is a custom, proprietary script that requires a specific vendor to troubleshoot and resolve issues. OSH proposes the replacement of the existing system with an “off the shelf” program that is easier to maintain and more reliable. Coupled

with the ARPA funding received in 2021-23 for security cameras, this will make monitoring and access control more robust and provide a safer environment for patients, staff, and visitors..

The PLC System is eligible for Bond Financing. This would result in $3,000,000 of the above total financed through Other Funds, with central OSH debt services taking an additional $45,000 as Cost of Participation (COP).

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

As good stewards of the public trust and public dollar, OSH strives to achieve the highest standards and outcomes in all aspects of work, including the maintenance of state facilities. Through regulatory and infrastructure improvements, OSH is able to meet the needs of both patients, and staff working towards OHA's mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

Quantifying results

4. What are the long-term desired outcomes?

OSH will continue to comply with regulatory requirements and maintain good stewardship of state assets in its mission to provide a safe and therapeutic environment of care to some of Oregon's most vulnerable populations.

5. How will OHA measure the impacts on health inequities of this policy package?

The replacement of critical depreciable assets helps ensure a safe, secure, and therapeutic environment for treating some of Oregon's most vulnerable populations.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OSH has attempted to use budgetary resources to resolve lifecycle issues in a break/fix capacity, as budget constraints did not allow a resolution for the quantity of items in need of replacement. A preventative maintenance plan has been established to include lifecycle equipment replacement schedules projected out 25 years to predict future lifecycle funding needs.

7. What alternatives were considered and what were the reasons for rejecting them?

There are no viable alternatives to lifecycle asset replacement and preventative maintenance replacement.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   None.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    None.

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    No.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): June 30, 2025

12. **What assumptions affect the pricing of this policy package?**

    Standard procurement practices may impact purchasing and implementation dates.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

None.

16. What are the start-up and one-time costs?

Salem Campus			
Requested Bond Financing	**Qty**	**Est. Cost**	**Total**
PLC system replacement	**1**	$3,000,000	$3,000,000
Total Bond Request			**$3,000,000**
Total Salem Campus Request			**$3,000,000**

17. What are the ongoing costs?

None for this request. As some equipment replacement is incremental per biennium, those needs would be addressed in a future request.

18. What are the potential savings?

Avoidance of higher urgent repair and replacement costs.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent bond-financed Other Funds.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services					0	0.00
Services & Supplies						
Capital Outlay		$3,000,000		$3,000,000		
Special Payments						
Other						
Total	**$0**	**$3,000,000**	**$0**	**$3,000,000**	**0**	**0.00**

Oregon Health Authority
2023-25 Policy Package

Division:	Public Health Division
Program:	Center for Public Health Practice
Policy package title:	Oregon Environmental Laboratory Accreditation Program
Policy package number:	440
Related legislation:	Senate Bill 5526 fee ratification bill

Summary statement:

The statutorily mandated Oregon Environmental Laboratory Accreditation Program (ORELAP) was established in 1999. ORELAP accredits Oregon drinking water, environmental, cannabis, and psilocybin laboratories based on consensus standards to ensure laboratories are following federal and state regulations. ORELAP is a fee-based program experiencing a budgetary shortfall. This policy package would support a fee increase and an update to the ORELAP fee structure for simplification and ensure that fees are appropriate for the work required to perform laboratory accreditations of differing and increasing complexity. A fee increase is needed to ensure ORELAP can provide timely quality accreditations that meet established standards and regulatory requirements to best serve ORELAP's clients and protect the health of all Oregonians.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE

Policy package pricing:	**$0**	**$809,530**	**$0**	**$809,530**	**0**	**0.00**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

Environmental laboratories conduct analysis of air, drinking water, wastewater, solid and chemical waste, biological tissue and, in Oregon, cannabis and psilocybin. Analyses performed by these laboratories are used to ensure compliance with federal, state, and local regulations that may have a direct effect on human and environmental health.

The Oregon Environmental Laboratory Accreditation Program (ORELAP) established in 1999 operates under ORS 438.605 to 438.620, ORS 475A.606, and ORS 475C.560. ORELAP accredits laboratories based on standards established by the National Environmental Laboratory Accreditation Program (NELAP) under the guidance of the Clean Air Act, Clean Water Act, Safe Drinking Water Act, the Resource, Conservation and Recovery Act and Oregon statutes related to cannabis & psilocybin.

ORELAP accredits Oregon drinking water, environmental, and cannabis & psilocybin laboratories. ORELAP also provides primary and secondary accreditation to laboratories outside of Oregon. ORELAP provides on-site assessment for accredited laboratories every two years and new laboratories seeking accreditation to ensure compliance with accreditation standards.

ORELAP is a fee-based program within the Oregon State Public Health Laboratory that supports a team of eight. Funding of ORELAP is accomplished using fees to reimburse the program for cost of performing all accreditation activities performed by ORELAP staff to ensure compliance to all standards set by The NELAC Institute (TNI), federal regulations and state rules and statutes. ORELAP has received state funding for work connected with House Bill 3000 (2021) and work for

Ballot Measure 109 related to psilocybin. The program also receives a small amount of federal funding for drinking water work.

ORELAP is projected to have a budget shortfall in the next biennium. ORELAP's current fees, which are some of the lowest in the country, have not increased for in-state laboratories since the inception of the program in 1999 despite increasing costs and required scope of work. A fee revision is needed to ensure that ORELAP can provide timely and quality accreditations that meet established standards and regulatory requirements to best serve ORELAP's clients and protect the health of Oregonians. In addition, there are proposed changes to the ORELAP fee structure for simplification and to ensure fees are appropriate for the work required to perform laboratory accreditations of differing complexity. Importantly, this policy package would help ORELAP accredit laboratories that respond to critical emerging needs, such as cyanotoxin exposures from algal blooms and Per- and polyfluoroalkyl substances (PFAS) chemicals in drinking water.

2. What would this policy package buy and how and when would it be implemented?

The policy package proposes changes to the ORELAP fee structure and increases to its fees. ORELAP's fees use a complex tiered structure that scales up based on each laboratory's accreditation needs. The proposed fee increases are wide-ranging and impact all ORELAP clients; the proposed fees include a switch from three tiers to a five-tier system to better address the disparity in program time required to assess small laboratories as compared to very large laboratories. In-state annual application fees would increase by $750 to $4,200. If the policy package is enacted, biennial on-site assessment fees would increase by $110 to $500 for the first program in each field of accreditation, while a biennial "Trip Fee" for on-site assessments would be eliminated. Out-of-state application fees would see increases of $1,450 to $7,190. Out-of-state assessment fees would be brought in line with in-state fees through increases of $80 to $340. These changes would

ensure the sustainability of ORELAP and support current ORELAP staff to perform timely and quality accreditations of drinking water, environmental and cannabis and psilocybin laboratories to established national and state standards to protect the health of Oregonians.

If enacted, the proposed fee increase would be made permanent on July 1, 2023, following Department of Administrative Services approval and an OAR update during the 2021-23 biennium (via the Senate Bill 333 process).

The policy package would support:

- ORELAP staff, including the below activities:
    - Preparing for and conducting on-site assessments for accredited laboratories every two years, when a new laboratory seeks accreditation and when a laboratory adds a new testing method to ensure laboratories are compliant with established testing standards.
    - Writing and responding to assessment corrective actions to ensure deficiencies found during the on-site assessment are addressed.
    - Review of proficiency tests to ensure testing at accredited laboratories are performed accurately.
    - Providing client services to laboratories regarding accreditation, including addressing questions related to obtaining and maintaining accreditation and providing recommendations for improvement. Assessors may assist laboratories with technical questions related to laboratory operations.
    - Continued training for ORELAP assessors in advanced testing technologies.
    - Billing services enhancements to ensure billing is timely and accurate.
    - Investigating and collaborating with other agency partners regarding complaints.

- Information Technology (IT) support for the ORELAP electronic database.
    - The ORELAP Data Input and Edit (ODIE) state database application is the interface between ORELAP and accredited laboratories. Support will improve ORELAP operations and ensure client ease of usability.
- Travel associated with on-site assessments.
    - ORELAP accredits laboratories throughout Oregon and other states to ensure all Oregonians have access to accredited laboratory services to protect and promote the health of their communities.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[1] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

ORELAP plays a vital role in protecting and promoting the health of all people and communities by helping ensure the water that people in Oregon drink, the air they breathe, and the environment they live in is free of chemicals, toxins and other substances that negatively impact health and disproportionately impact communities of color, Tribal communities and low-income communities through policies that have increased risk in these communities.

Specifically, ORELAP-accredited laboratories play a critical role in testing for lead in school drinking water and cyanotoxins from harmful algae blooms. In addition, ORELAP helps protect public health

[1] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.

by ensuring that laboratories testing cannabis and psilocybin provide accurate data on potency and potential contaminants.

Importantly, ORELAP helps respond to critical public health events by accrediting laboratories that test for emerging contaminants that impact health, such as cyanotoxin exposures from algal blooms and exposure to PFAS chemicals.

ORELAP serves all drinking water, environmental, and cannabis and psilocybin laboratories in the state, including laboratories that support rural communities. For example, upon a real estate transaction containing a well, the well water needs to be tested for nitrates, arsenic and total coliform at an ORELAP accredited laboratory to inform the safety and health of communities sourcing water from wells.

Promoting the sustainability of ORELAP is critical for protecting the health and ensuring the safety of all Oregon communities.

Quantifying results

4. What are the long-term desired outcomes?

Environmental laboratories, in part, perform tests on air, drinking water, environmental, and cannabis and psilocybin samples to detect and measure potentially harmful microbes, chemicals and other substances that could potentially affect the environment and health of individuals. ORELAP accredits the laboratories performing these tests to federal and state standards to certify that test results produced are accurate, therefore promoting the safety of drinking water, cannabis/psilocybin products, and the environment. The proposed fee increase would ensure fees are appropriate for

work performed, allowing ORELAP to operate sustainably and continue to provide quality, timely accreditations to protect the health of Oregonians.

5. How will OHA measure the impacts on health inequities of this policy package?

With appropriate resources, ORELAP will be able to provide timely accreditation services to the testing laboratories that help keep Oregonians safe. This includes any Oregonian that drinks water from a public water system, recreates in public waters, breathes air, and uses cannabis or psilocybin products. Including those from rural communities and historically underserved populations.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

ORELAP has implemented several process improvements to make operations more efficient and use existing resources as best as possible. These include:

- Reorganizing how ORELAP assessors are sent on on-site assessments to reduce the number of assessors traveling per on-site assessment.
- ORELAP conducted a six-month touch-time analysis to determine the true time and cost to accredit laboratories and other work necessary to perform accreditations in line with established international standards. This analysis helped inform programmatic decisions and the proposed fee changes in this policy package.
- Enhancement of the ORELAP Data Input and Edit (ODIE) state database application (the interface between ORELAP and accredited laboratories) to improve ORELAP operations and ensure ease of usability by clients.

- Reorganization and delegation of ORELAP staff job duties to streamline the accreditation process.
- Notifying international clients, and out-of-state clients involved in radiochemistry testing, that they will need to seek primary accreditation through another accrediting body other than ORELAP to ensure staff resources are utilized most efficiently.

7. What alternatives were considered and what were the reasons for rejecting them?

ORELAP recently completed a touch-time analysis where time spent on all activities was recorded for 6 months. The purpose of this project was to better understand the time, costs, and laboratory capacities required for different accreditation processes to inform program strategic and business plans. This also included researching other state's fee structures. The data from this analysis helped inform the discussions and decisions that formed the proposed updates to the ORELAP fee structure.

Some of the different fee structures and program changes considered included a fee-for-service fee structure and a fee based on how many different methods needed by laboratories for accreditation.

Ultimately, the proposed fee structure was determined to be the most appropriate based on the amount of work required to accredit laboratories of different complexities. The simplest and most familiar structure for clients is one that incorporates flexibility, is sustainable, and able to support timely, quality accreditations for accredited laboratories and their clients.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   The ORELAP Executive Team consists of the OSPHL Laboratory Director, DEQ Laboratory Director, and ODA Laboratory Manager. This team guides the strategic direction of ORELAP. The ORELAP Executive Team provided input throughout analysis of the ORELAP fee structure to help identify a final decision on the proposed policy package to ensure it best reflects the needs of ORELAP, partners, clients, and the health of Oregonians. These agencies are not requesting funding in relation to this policy package. ORELAP also conducted a rules advisory committee (RAC) as part of administrative rulemaking to revise accreditation fees. This RAC included members of the accredited laboratory community who helped design the proposed fee structure.

9. **Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.**

   No.

10. **What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    ORELAP accredits laboratories throughout Oregon to ensure communities have access to needed accredited laboratory services, including a non-profit environmental laboratory owned and operated by The Klamath Tribes. ORELAP may also accredit environmental laboratories performing work for Tribal entities. In addition, ORELAP accredits municipal laboratories performing analysis of drinking water, wastewater, and solid waste. All accredited laboratories would experience increased fees under the proposed policy package.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

The Secretary of State Audits Division completed an audit report of the Oregon Health Authority marijuana programs entitled Oregon's Framework for Regulating Marijuana Should Be Strengthened to Better Mitigate Diversion Risk and Improve Laboratory Testing (2019-04). Two findings from the report may be addressed by this policy package:

Key Finding #3: All recreational marijuana in Oregon must be tested for pesticides and solvents, but most medical marijuana is not required to be tested. Also, OHA does not require heavy metal and microbiological testing, in contrast to some other states. These contaminants could pose a risk to consumers.

- The inclusion of heavy metals and microbiological testing will require ORELAP to offer new fields of accreditation for cannabis testing laboratories. This policy package would help sustain ORELAP staff, potentially supporting the addition of these new fields of accreditation for cannabis laboratories.

Key Finding #4: Without a mechanism for verifying test results, Oregon's marijuana testing program cannot ensure that test results are reliable, and products are safe. Limited authority, inadequate staffing, and inefficient processes reduce OHA's ability to ensure Oregon marijuana labs consistently operate under accreditation standards and industry pressures may affect lab practices and the accuracy of results.

- The update to the fee structure and fees proposed in this policy package would provide ORELAP staff ability to examine and work to address the findings of the Oregon Secretary of State, particularly the assessment of potential process improvements.

Staffing and fiscal impact

Implementation date(s): July 1, 2023

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

The key assumption of this package is that the ORELAP program will retain the bulk of its current client base after increasing its fees, thereby generating additional revenue. Although fees charged by other NELAP accrediting bodies use a wide variety of structures that are difficult to directly compare to ORELAP's, the program's analysis indicates that the increased rates will remain competitive in the industry. Other assumptions include continued partial funding of the ORELAP program by House Bill 3000 (assumed $487,278 in the 2023-25 biennium) and some direct funding of ORELAP staff by the OHA psilocybin program and the EPA Drinking Water Primacy grant (total of $465,000 per biennium).

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There would be no new responsibilities for OHA associated with the policy package. It would promote the sustainability of ORELAP and support current ORELAP staff to perform timely and quality accreditations to international standards and in accordance with ORELAP's mandate ORS 438 and 475A & C.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This policy package would not directly result in a change to the ORELAP client caseload.

Currently ORELAP accredits approximately 120 laboratories. This policy package would help support the services provided to these laboratories by ensuring timely and accurate accreditations and performance reviews; highly trained assessors that can accredit to national and state standards; and support accreditation services.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

This policy package does not require new positions or modifications to existing positions. It would support current ORELAP staff and ensure the sustainability of ORELAP to provide quality services to accredited laboratories and protect the health of Oregonians.

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

The ongoing costs are personnel costs including employee services, supplies, travel, shared services, and State Assessments & Enterprise-wide costs.

18. What are the potential savings?

None.

19. What are the sources of funding and the funding split for each one?

The policy package is requesting Other Funds limitation to support a fee increase paid for by laboratories needing accreditation.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services					0	0.00
Services & Supplies		$809,530		$809,530		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$809,530**	**$0**	**$809,530**	**0**	**0.00**

Oregon Health Authority
2023-25 Policy Package

Division(s):	Health Systems Division & Public Health Division
Program(s):	HSD: BH Non-Medicaid, Program Support & Administration; PHD: Center for Prevention and Health Promotion
Policy package title:	Youth and Adult Suicide Intervention and Prevention Plans
Policy package number:	446
Related legislation:	House Bill 4124 (2014), Senate Bill 561 (2015), Senate Bill 48 (2017), Senate Bill 707 (2019), Senate Bill 52 (2019) Adi's Act, House Bill 2315 (2021)

Summary statement:

Suicide remains a persistent, pervasive, and yet largely preventable cause of death. Oregon's suicide rates remain above the national average. Every death by suicide in Oregon carries a substantial and long-lasting ripple effect into our communities. The important work to prevent youth suicide (ages 5–24) remains a top priority for OHA. Now through intensive community engagement, Oregon has developed a plan for reducing adult suicide. The work of this policy package includes initiatives as broad as creating connection and meaningful experiences and as specific as training providers to treat suicidal ideation confidently and effectively. This policy package has equity, cultural responsiveness, and community voice woven throughout.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$7,715,940**	**$0**	**$0**	**$7,715,940**	**4**	**3.00**

Purpose

1. Why does OHA propose this policy package and what problem is OHA trying to fix or solve?

The Oregon suicide rate for all ages has been above the national average for the past four decades. Trends in suicide rates by age group and populations have fluctuated. Since the Legislature approved funding to OHA for youth (5–24 years of age) suicide prevention in 2019, Oregon's youth suicide rate has showed a decreasing trend. Oregon's adult suicide rate has had an increasing trend over the past decade; however, Oregon was one of seven states to see a statistically significant decrease in suicide rates (across the lifespan) in 2020. For 2021, preliminary data indicate an increase in suicide across the lifespan and well above the national average. As Oregonians grapple with recovery from the pandemic, it is a time of increased suicide risk and it is anticipated that the 2022 rates may reflect this.

A comprehensive approach to suicide prevention, intervention and postvention[1] is needed to produce long-lasting decreases in suicide rates. This policy package addresses Oregon's high suicide rate across the lifespan and fuels prevention work grounded in local communities. It funds needed support for school suicide prevention from the Youth Suicide Intervention and Prevention Plan (YSIPP), launches the Adult Suicide Intervention and Prevention Plan (ASIPP), and creates an OHA Suicide Prevention unit.

[1] It should be noted that throughout this policy package suicide prevention, intervention, and postvention will be referred to as "suicide prevention" for the sake of brevity. Readers should be aware that suicide prevention encompasses the work to create connection (prevention) as well as the work to create safety (intervention) and the work to heal after a suicide death (postvention).

This policy package grows out of the new Oregon Suicide Prevention Framework (the "Framework"), developed by OHA in collaboration with community partners based on the National Strategy for Suicide Prevention (NSSP), the Centers for Disease Control (CDC) Technical Package on Suicide Prevention, and the unique needs of Oregonians. The goal is that local communities can use the Framework to guide suicide prevention creating shared language and initiatives across the work. The Framework, informed and shared by extensive community input, allows for Oregon to see where there are local and statewide successes and momentum, and where gaps exist to target funding and support at the state and local level. The Framework includes:

- **Strategic pillars and strategic goals:** These pillars and corresponding goals are pulled from the NSSP and CDC Technical Package. They are the starting point for all suicide prevention work in Oregon. These strategic pillars are interrelated and interactive, rather than independent areas. The strategic pillars are:
  - **Pillar 1:** Healthy and Empowered Individuals, Families and Communities: This pillar aims to create supportive environments that will promote general health of the population and reduce risk for suicidal behaviors and related problems. The goals and initiatives in this pillar are directed to **all Oregonians** or what are known as prevention strategies.
  - **Pillar 2:** Clinical and Community Prevention Services: Goals of this pillar seek to promote wellness, build resilience, and prevent suicidal behaviors among various groups. Strategic goals here are **focused on groups that are at a higher risk** of considering suicide and aim to prevent the onset of suicidal behaviors or what are known as selective strategies.
  - **Pillar 3:** Treatment and Support Services: This pillar focuses on promoting suicide prevention universally as a core component of health care services and providing specific assessment, management, and treatment for suicide in addition to underlying conditions for individuals identified with suicide risk. Pillar 3 also includes providing care and support to individuals affected by suicide deaths and attempts to promote health and implement

community strategies to help prevent further suicides. These are known as indicated strategies — meaning they are **targeted to high-risk individuals that are experiencing suicidal ideation or have been impacted by a suicide death**.

- **Data and Evaluation:** In the Framework, data and evaluation are a central foundation to ensuring work is meeting intended impacts. For the purposes of this policy package, specific activities related to data and evaluation will be under this heading.

This policy package funds needed growth of comprehensive suicide prevention in Oregon. This work builds on existing YSIPP work and supports several ASIPP initiatives. This policy package includes additional funding to meet identified gaps through the Framework pillars (including data/evaluation), infrastructure (local/state) and equity considerations.

2. What would this policy package buy and how and when would it be implemented?

This policy package:

- Creates **structure and alignment** of the OHA suicide prevention positions across OHA divisions to make meaningful progress addressing Oregon's high suicide rates using the Oregon Suicide Prevention Framework.
- Increases **capacity in local communities** in more areas of Oregon to provide prevention, intervention and postvention support to those most at risk by local leaders.
- Facilitates the development of and increased access to **culturally responsive suicide prevention**.
- Allows OHA to build upon surveillance of suicide attempts and fatalities and to increase **availability of effective and responsive prevention strategies** according to increased suicide activity.

- Expands **suicide prevention initiatives to include added care across the lifespan** providing community postvention support when the decedent is 25 and older, creating an advisory board and a coordinator position to oversee adult suicide prevention implementation, and increasing community-rooted data and evaluation of adult suicide prevention work to guide implementation.

These strategies would be implemented in close collaboration and consultation with the Oregon Alliance to Prevent Suicide, the University of Oregon Suicide Prevention Lab, local suicide prevention leaders, and community partners. Implementation for all projects would begin on or before January 1, 2024.

Specific activities of this policy package include:

Pillar 1: Healthy and empowered individuals, families and communities

- **Maintain support for schools, school districts and education service districts to build and implement equity-focused suicide prevention plans:** Adi's Act (ORS 339.343) requires Oregon K-12 schools to develop and implement suicide prevention plans. Current funding from the Oregon Department of Education will not available in the 2023-25 biennium for this work. This policy package would allow OHA to maintain this essential support.

- **Expand youth suicide prevention programming and add training to adult populations:** Expand funding for existing YSIPP suicide prevention training and programming exclusively for adults working with youth, as applicable, to support training and programming to serve age 25 and older populations.

- **Provide an annual Oregon Suicide Prevention Conference:** Provide funding to hold an annual suicide prevention conference focused on the lifespan to provide training and learning opportunities for the Oregon suicide prevention community and create networking and connection opportunities. Unsustainable federal grant funding has been used to support this conference in the past with overwhelmingly positive feedback from conference attendees.

- **Expand suicide prevention funding in more Oregon counties and Tribal Nations**: There has been limited state funding to support local county suicide prevention efforts. OHA provides limited funding to Oregon's nine federally recognized Tribal Nations. Funding would allow more counties to establish and grow local suicide prevention efforts such as increasing and targeting outreach, training, and services to organizations and community; implementing a system-wide crisis response plan for health care organizations and providers; and supporting local training implementation. Funding would allow OHA to consult with Oregon Tribes on needs and allocation of additional funding.

- **Create and Support Advisory Council for Implementation of the ASIPP:** Effective implementation of the ASIPP will require creation of an advisory council to ensure community advisement including from those with lived experience of suicide loss, attempt and ideation. Having an advisory council to support YSIPP implementation has been imperative to success that is truly community driven. This ASIPP council would support a similar structure as the YSIPP advisory council. The advisory council has been requested by the Oregon Alliance to Prevent Suicide to allow coordination with YSIPP activities. The advisory council has also been requested by numerous partners involved in the development of the ASIPP.

Pillar 2: Clinical and community prevention services

- **Expand existing suicide training capacity in Spanish and continue to identify culturally appropriate suicide prevention training:** While OHA has established suicide prevention programming and training through the YSIPP, many programs were developed with a focus on white cisgender populations. Funding would allow for exploration of establish training adaptations for diverse communities and identification of additional trainings to implement. Many of the existing suicide prevention trainings need to be culturally tailored and translated into Spanish language. The development and retention of Spanish-speaking and bi-cultural trainers to provide training to the over 350,000 Spanish speakers in Oregon is also needed.

- **Create a Suicide Prevention Training Coordinator Position:** House Bill 2315 (2021) requires that specified licensed professionals complete continuing education in suicide assessment, management and treatment. The workforce that currently falls under this legislative mandate is approximately 41,000. This legislation and position request came directly from the Oregon Alliance to Prevent Suicide to ensure successful implementation of this legislation. This position, housed in the Equity and Inclusion Division (OEI), would create an approval process for trainings that meet requirements, modeled off the existing Oregon Cultural Competence Continuing Education Program, coordinate with licensing bodies to promote and provide trainings, and coordinate with larger suicide prevention efforts.

Pillar 3: Treatment and support services

Data and Evaluation Support

- **Provide evaluation of some initiatives in the ASIPP:** The YSIPP has existing evaluation support through an Oregon university which has been imperative to understand progress and

success of YSIPP activities. The development of the ASIPP will require similar funding to provide robust evaluation and track implementation efforts.

Infrastructure Needs

- **Create a formal OHA Suicide Prevention Unit:** OHA has informally coordinated across suicide prevention staff in Health Systems Division (HSD) and Public Health Division (PHD) working on YSIPP implementation, ASIPP development, data needs, and additional federal grant activities. While this informal coordination has greatly supported state suicide prevention, such as development of the Oregon Suicide Prevention Framework and coordination across these multiple programming efforts, dedicated management and coordination is needed to support these efforts in addition to increased staffing to support increased partner data needs and ASIPP implementation. Therefore, the policy package includes funding to create a cross-divisional OHA Suicide Prevention Unit housed in PHD's Injury and Violence Prevention Program (IVPP) composed of existing and newly proposed staff:
    - Existing OHA Suicide Prevention Staff: There are five existing suicide prevention staff at the agency that would be part of this team. In HSD, positions include a youth suicide prevention program coordinator, youth suicide prevention policy coordinator, and adult suicide prevention program coordinator. In PHD, positions include a public health suicide prevention coordinator and Zero Suicide in health systems coordinator.
    - Suicide Prevention Unit Manager (Public Health Manager 1): OHA Suicide Prevention Unit manager to provide oversight and coordination across HSD and PHD suicide prevention work including YSIPP, ASIPP, and federal grant funds and provide management support to existing and requested OHA suicide prevention staff.

- Adult Suicide Prevention Policy Coordinator (Operations & Policy Analyst 4): Similar to the YSIPP implementation, the ASIPP implementation phase would require an additional position to support policy considerations of the ASIPP above programming related efforts currently covered by the adult suicide prevention coordinator.
- Suicide Research Analyst (Research Analyst 4): With the creation of the YSIPP and ASIPP, OHA has seen a dramatic increase in data requests and projects related to suicide. IVPP has existing research analysts and an injury epidemiologist supporting data systems used in analyze suicide data (such as the National Violent Death Reporting System and state hospitalization data set), however existing staff are not able to coordinate nor do they have capacity to meet data requests and projects of partners, including Oregon Alliance to Prevent Suicide. This position would allow for coordination with existing data staff, the OHA Suicide Prevention Unit and internal and external partner requests.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[2] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

This policy package helps increase safety and support for populations at increased risk of suicide which include those who identify as LGBTQ2SIA+,[3] People of Color including Black persons and American Indian or Alaskan Native persons, veterans and persons that have served in the military,

[2] Health Equity: When all people can reach their full potential and well-being and are **not disadvantaged by their race, ethnicity, language, disability,** gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances.
[3] Lesbian, Gay, Bisexual, Transgender, Queer, Two Spirit, Intersex, Asexual, and the myriad ways people identify their sexual orientation and gender identities.

people who live in rural and frontier areas, and those with intersecting identities across these groups. Oregon continues to have suicide rates higher than the national average and the communities referenced above experience higher impacts from suicide in addition to experiencing broader health inequities.

Data shows that American Indian or Alaskan Native persons in Oregon consistently have rates of suicide higher than any other race/ethnicity. Based on national data, Black males have experienced disproportionate increases in suicide rates — this demographic has increases higher than any other race/ethnicity. This group also has low rates of accessing behavioral health services, likely due to stigma, discrimination, culturally inappropriate services, and lack of access to diverse providers. State and national data show that youth who identify at LGBTQ2SIA+ experience higher rates of suicide ideation. This policy package seeks to address these health inequities.

An important overall strategy that is embedded throughout this policy package is to increase the availability of culturally responsive community interventions (prevention) and training programs providing education on suicide risk identification and referral to help (intervention).

Nearly all the currently utilized evidence-based trainings and treatments for suicide prevention and intervention have been normed for white people and lack cultural or linguistic diversity. The OHA suicide prevention team has voiced these concerns to the national proprietors of these programs which has been met with limited response. To create a culturally responsive evidence base, the interventions, programs and services need to be developed or adapted by community. They must be accessible to community members. And they must have access to an evaluation team to understand if intended outcomes are being met.

The Oregon Suicide Prevention Framework has centering values to guide all efforts including equity, trauma informed practices, lived experience voice, collective impact and collaboration. Specific

activities requested in this policy package related to equity, as discussed in question #2 above, include:

- Funding and evaluation support to local suicide prevention coalitions to increase equity-centered opportunities for connection and coping
- Creating or supporting Spanish language options for all supported suicide prevention training programs
- Adding capacity for Spanish speaking trainer support for suicide prevention training programs, including a learning collaborative for these trainers
- Expand suicide prevention funding in Oregon counties, including rural and frontier, and Tribal Nations to increase capacity and implementation of community appropriate intervention, trainings, treatment options and postvention response support
- Increasing systemic approaches to meaningful young adult voice and the voice of people with relevant lived experience through representation on the ASIPP Advisory Council
- Growing suicide prevention efforts in rural and remote areas through increased suicide prevention to Oregon counties and Tribes
- Expanded support for education systems to build and implement equity-focused suicide prevention plans

All these strategies are rooted in the community guidance and feedback work done to build the ASIPP and update the YSIPP in 2020 and 2021 as further discussed in question #8.

This policy package aligns with broader OHA efforts to eliminate health inequities in Oregon by 2030. OHA's mission seeks ensure that "all people and communities can achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care". The activities in this policy package seek to ensure that diverse communities across the state are guiding state-led suicide prevention, intervention and postvention efforts and that local efforts are

funded and supported to meet the unique needs of Oregon communities. The activities expand and adapt existing intervention and trainings to ensure cultural relevance to diverse communities in the state. This policy package aligns with broader OHA efforts to eliminate health inequities in Oregon by 2030 included in the agency's Strategic Plan development. Specific goals that align between this policy package and broader agency efforts include improving access and quality of behavioral health services and decreasing behavioral health inequities and to advance health equity in our communities. Components of this policy package also seek to meet goals included in Healthier Together Oregon. Specific alignment between this policy package and HTO includes increasing resources for culturally responsive suicide prevention programs for communities most at risk within the Behavioral Health priority.

Quantifying results

4. What are the long-term desired outcomes?

Long-term, this policy package creates a suicide prevention, intervention and postvention system that is connected, representative of the community, and increases wellness for all Oregonians. Success would be measured by the growth and strength of local infrastructure, connectivity in programming, and equitable access to programming across the state and specifically in communities with increased risk factors. OHA would partner with data and evaluation experts to measure and monitor the work of this policy package, including YSIPP and ASIPP implementation efforts.

5. How will OHA measure the impacts on health inequities of this policy package?

The impact of this policy package would be seen in increased access to care for suicidality within populations of higher risk, specifically populations who identify as LGBTQIA2S+, People of Color including Black persons and American Indian or Alaskan Native persons, veterans and persons that

have served in the military, people who live in rural and frontier areas, and those with intersecting identities across these groups. Oregon continues to have suicide rates higher than the national average and the communities referenced above experience higher impacts from suicide in addition to experiencing broader health inequities.
Until suicide prevention work is grounded in equity and in local energy, it will not reflect and connect with local communities including communities that have increased suicide risk. To mitigate this risk and increase protective factors for these communities, Oregon's suicide prevention work must be locally driven with support from responsive statewide infrastructure.

The YSIPP currently has evaluation support with a request to include evaluation support for the ASIPP included in this policy package. Impacts of policy package activities would be embedded into existing YSIPP evaluation efforts and ASIPP evaluation efforts would be modeled after YSIPP evaluation. YSIPP evaluation includes process objective, impact objective and long-term objective measurement. An annual report including YSIPP initiative progress and suicide-related data tracking is provided each spring to the Legislature. This report is also distributed to partners including the Oregon Alliance to Prevent Suicide. A similar report is envisioned to track ASIPP initiatives. OHA suicide prevention staff would continue to engage with Healthier Together Oregon staff to report out on and support HTO goals. The impact of this policy package would be seen in increased access to care for suicidality within populations at higher risk, specifically populations that identify as Black, Indigenous, and people of color as well as American Indian or Alaskan Native populations, LGBTQ2SIA+ populations, English Language Learners, and people with disabilities. Until suicide prevention work is grounded in equity and in local energy, it will not reflect and connect with local communities including communities that have increased suicide risk. To mitigate this risk and increase protective factors for these communities, Oregon's suicide prevention work must be locally driven with support from responsive statewide infrastructure.

This would be measured by access to trainings, appropriateness of trainings per population, access to care, appropriateness of care per population, availability of providers that represent Oregon's diversity and experience, prevention and intervention activities in local communities and among those with health inequities listed above, and access to data that accurately depicts suicide in Oregon communities.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA has secured limited federal funding through several SAMHSA grants (Garrett Lee Smith Youth Suicide Prevention, Zero Suicide in Health Systems and COVID-19 Emergency Response for Suicide Prevention grant) and Centers for Disease Control and Prevention (CDC) grants (Comprehensive Suicide Prevention, Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes and Firearm Injury Surveillance Through Emergency Rooms) to support suicide prevention efforts in the state. While these grants have supported state and local suicide prevention work, several grant periods are already closed and funding is uncertain after June 2024 for all, but the SAMHSA Zero Suicide in Health Systems grant, which has a closeout date of August 2025 and the CDC Comprehensive Suicide Prevention grant, which has a closeout date of September 14, 2026.

With funding from the Legislature in 2019 for the YSIPP, OHA has developed and supported a strong suicide prevention, intervention and postvention infrastructure in Oregon. This funding did not fully fund the YSIPP, and the remaining funding needs for the YSIPP's implementation are included in this policy package.

In 2019, the Legislature provided position authority and funding for OHA to hire an adult suicide prevention coordinator tasked with developing the Adult Suicide Intervention and Prevention Plan.

While the position is secured and the plan has been developed, ASIPP-related policy package initiatives are new based upon the tremendous amount of partner feedback that went into ASIPP development that is currently without funding to support implementation. OHA has been awarded the CDC Comprehensive Suicide Prevention grant focused on supporting ASIPP implementation, given there is no current program budget to support work. OHA anticipates being notified of award status in September 2022. While this funding will contribute to moving ASIPP implementation forward, with a budget of $855,000 in year one with anticipated renewal over a 5-year period, it does not adequately fund commencement of ASIPP implementation and evaluation as is requested in this policy package.

Even with continued federal support, additional funds are needed to continue and grow activities covered in this policy package to address the many factors that affect suicide rates.

7. What alternatives were considered and what were the reasons for rejecting them?

The Youth Suicide Intervention and Prevention Plan is only partially funded based on previous funding requests and cannot cover the expense of new adult focused initiatives included in the ASIPP. The Adult Suicide Intervention and Prevention Plan needs its own budget to move its initiatives forward. There will be coordination between YSIPP and ASIPP implementation to avoid duplication of work and maximize efficient use of funding where activities may overlap.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

These strategies were identified largely by the Oregon Alliance to Prevent Suicide during the development of the YSIPP 2021-2025 and by the 130 community members who participated in the development of the ASIPP. The Oregon Alliance to Prevent Suicide is comprised of members and affiliates from the community, family members, those with lived experience, subject matter experts, professionals, youth, young adults, legislators, and leadership from state agencies. Specific

recommendations for funding were received by OHA in January 2022 from the Oregon Alliance to Prevent Suicide. Those recommendations are included in this policy package. Additionally, Oregon Consumer Advisory Committee (OCAC) recommended funding the ASIPP in June 2022.
All the proposed strategies were gathered and driven by community partner feedback. The process of updating the YSIPP included input from hundreds of people with relevant lived experience, and providers of behavioral health and physical health services along with review of evidence and best practices and rigorous research review. Feedback was gathered through a variety of methods including:

- Focus groups with interest groups such as Youth Era's Youth and Young Adult Engagement Advisory, Oregon Alliance to Prevent Suicide committees, and OHA agency and state partners
- Formative interviews with 30 individuals from diverse backgrounds including Alliance committee chairs, CBOs, OHA advisory groups, legislators, and relevant professionals in counties; and
- Surveys completed by 109 individuals from the Alliance's Lived Experience workgroup distribution effort and the Youth and Young Adult Engagement Advisory.

The ASIPP was developed by 130 partners throughout the state that met for approximately one year. Input and feedback were gathered from across Oregon through:

- A large, diverse, and engaged group of 130 partners that met monthly.
- Several small workgroups that were predominately made up of members from the large partner group. The small workgroups were based on populations that have disparate rates of suicide or populations that have been historically underserved. Those groups include LGBTQ2SIA+, ages 18–24, those employed in the construction industry, veterans and military connected personnel, older adults, those with disabilities and chronic illness, Black, Indigenous, and people of color (BIPOC) and American Indian or Alaskan Native (AI/AN), men, individuals living in rural and remote areas, and lived experience.

- Focus groups with Oregonians from the following communities: LGBTQ2SIA+, persons with chronic illness or disability, attempt survivors, persons residing in rural communities, persons experiencing housing insecurities, older adults and veterans.
- Two statewide surveys which included county suicide prevention coordinators and members of suicide prevention coalitions and councils throughout the state.

9. Does this policy package require any changes to existing statute(s) or require a new statute? If yes, identify the statute and the legislative concept.

No.

10. What other state, Tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Local government would be positively affected by fiscal and technical support for dedicated suicide prevention efforts in local communities.

Presently suicide prevention efforts in each of Oregon's 36 counties are extremely wide-ranging and dependent upon county capacity and resources. Some counties are well funded and have one or more staff dedicated to suicide prevention efforts, others have part-time positions or shared positions while others have negligible or no coordinated suicide prevention activities. Creating support for county suicide prevention activities would:

- Equip more counties that have few or no resources for suicide prevention in line with other counties that are better-resourced.
- Increase collaboration between OHA, more of Oregon's 36 counties and 9 federally recognized tribes and increase collaboration among counties.

- Promote the Oregon Suicide Prevention Framework, encouraging all counties to familiarize themselves with the framework and adapt it as a framework for their county suicide prevention work thus creating better alignment and connection statewide.

Oregon Tribal Nations are currently provided youth suicide prevention funding and all nine Tribal Nations in Oregon are leading important suicide prevention work. This funding would allow for better discussion with Tribal Nations to understand how statewide infrastructure can best support them and be connected to the work of creating safety and wellness for young people. Expansion through this policy package would allow the OHA suicide prevention team to better collaborate and connect with Tribal Nation prevention leaders and support the expansion of Tribal prevention to inclusion of lifespan.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No.

Staffing and fiscal impact

Implementation date(s): YSIPP: Ongoing; ASIPP: July 1, 2023

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

The YSIPP was mandated by House Bill 4124 (2014), developed by partners in 2015, and adopted in 2016. The plan was recently updated to reflect work put in place since 2016 and to add new and innovative initiatives needed to progress work.

The ASIPP was developed by partners in 2020-2021 and is being finalized for publication, anticipated in March 2023. This is the first suicide plan focused on the adult population. While aspects of existing YSIPP programming and training supports adult suicide prevention and intervention, additional funds are needed to fully implement the vision for a suicide-safer state for all Oregonians across the lifespan. When applicable, YSIPP activity budgets were referred to and scaled up to support ASIPP activities, given the larger population ASIPP activities are proposed to support.
There is coordination between YSIPP and ASIPP efforts through the OHA Suicide Prevention team. Consideration has been made to ensure there is alignment, not duplication, of funding between YSIPP and ASIPP efforts. Additional funds are needed maintain YSIPP activities and to begin implementation of ASIPP activities. While the OHA suicide prevention work has made significant progress with previous investments, current funding does not fully fund the YSIPP. There is not funding currently for the work outlined in the ASIPP. Existing YSIPP programming and training costs were considered in ASIPP funding requests.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There is no anticipated impact for Shared Services beyond support for the positions outlined below in question #15. The impact on OHA to meet the scope of work emerging from the ASIPP would be completed within the suicide prevention unit from the existing and added positions created through this policy package.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

The YSIPP and ASIPP activities would increase access to services for population groups though they do not support direct service staff. The four new positions in OHA would create technical assistance, training, and programming to support direct service providers throughout the state and help troubleshoot programmatic and systemic issues in implementation and providing suicide safer care.

15. Describe the staff and positions needed to implement this policy package, including whether existing positions would be modified and/or new staff would be needed.

OHA has informally coordinated across suicide prevention staff in the Health Systems Division (HSD) and Public Health Division (PHD) working on YSIPP implementation, ASIPP development, and additional federal grant activities. This informal coordination has greatly bolstered state suicide prevention, such as development of the Oregon Suicide Prevention Framework and coordination across these multiple programming efforts. Yet, dedicated management and coordination and additional staffing is needed to formalize and strengthen these efforts to meet increased partner data needs and ASIPP implementation. The policy package includes funding to create a cross-divisional **OHA Suicide Prevention Unit** housed in PHD's Injury and Violence Prevention Program (IVPP) composed of existing and newly proposed staff:

- **Suicide Prevention Unit Manager**- (Public Health Manager 1): OHA Suicide Prevention Unit manager to provide oversight and coordination across HSD and PHD suicide prevention,

intervention and postvention work including YSIPP, ASIPP, and federal grant funds. Provide management support to existing and required OHA suicide prevention staff

- **Existing OHA Suicide Prevention Staff**: There are five existing suicide prevention staff at the agency that will be part of this team. In HSD, positions include a youth suicide prevention program coordinator, youth suicide prevention policy coordinator, and adult suicide prevention program coordinator. In PHD, positions include a public health suicide prevention coordinator and Zero Suicide in health systems coordinator.
- **Adult Suicide Prevention Policy Coordinator**- (Operations & Policy Analyst 4): Similar to the YSIPP implementation, the ASIPP implementation phase will require an additional FTE to support policy considerations of the ASIPP above programming related efforts currently covered by the existing adult suicide prevention coordinator.
- **Suicide Research Analyst**- (Research Analyst 4): With the creation of the YSIPP and ASIPP, OHA has seen a dramatic increase in data requests and projects related to suicide. IVPP has existing research analysts and an injury epidemiologist supporting data systems used in analyze suicide data (such as the National Violent Death Reporting System and state hospitalization data set); however, existing staff are not able to coordinate nor do they have capacity to meet partner, data requests and projects, including those of the Oregon Alliance to Prevent Suicide. This position would allow for coordination with existing data staff, the OHA Suicide Prevention Unit and internal and external partner requests.

House Bill 2315 (2021) requires that specified licensed professionals complete continuing education in suicide assessment, management and treatment. This legislation and position request came directly from the Oregon Alliance to Prevent Suicide to ensure successful implementation of this legislation. This policy package includes funding for a new **Suicide Prevention Training Coordinator** (Operations & Policy Analyst 3), housed in the Equity and Inclusion Division (OEI), to create an approval process for trainings that meet requirements, modeled off the existing Oregon Cultural Competence Continuing

Education Program, coordinate with licensing bodies to promote and provide trainings, and coordinate with larger suicide prevention, intervention, and postvention efforts.

16. What are the start-up and one-time costs?

One-time costs, aligned with activities described in question #2, include:

There are no one-time or startup costs included in this policy package.

17. What are the ongoing costs?

Most of the requests in this policy package are for ongoing costs that build local and statewide programming and infrastructure to ensure safety and wellness for all Oregonians. This includes these ongoing strategies that align with activities described in Question 2:

- Maintain support for schools, school districts and education service districts to build and implement equity-focused suicide prevention plans as required by Adi's Act (ORS 339.343)
- Expand suicide training capacity in Spanish
- Expand youth suicide prevention programming and training to adult populations
- Provide an annual Oregon Suicide Prevention Conference
- Provide evaluation of the ASIPP
- Formalization of the OHA Suicide Prevention Team with additional staffing
- New Suicide Prevention Training Coordinator
- Expand local suicide prevention funding in more Oregon counties and Tribal Nations

- Create and support Advisory Council for implementation of the ASIPP

Total ongoing costs for activities in this policy package come to $7,715,940 million per biennium.

18. What are the potential savings?

Suicide has an immeasurable impact on communities. Research has shown that each suicide death can result affect an estimated 135 individuals who may need clinical services or support following a suicide[4]. Beyond the shock and grief that accompanies each death, there are economic costs associated with suicide. According to the CDC, suicide and nonfatal self-harm cost the nation nearly $490 billion in medical costs, work loss costs, value of statistical life and quality of life costs[5]. Suicide prevention, intervention and postvention initiatives may help reduce the economic costs of suicide as well as the psychological effects.

19. What are the sources of funding and the funding split for each one?

This policy package is 100 percent General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$753,074			$753,074	4	3.00
Services & Supplies	$72,866			$72,866		

[4] Cerel et al. (2018). How many people are exposed to suicide? Not Six. Suicide and Life-Threatening Behavior, 29(2): 539-534. https://doi.org/10.1111/sltb.12450

[5] Peterson C, Miller GF, Barnett Senate Bill, Florence C. Economic Cost of Injury — United States, 2019. MMWR Morb Mortal Wkly Rep 2021;70:1655–1659. DOI: http://dx.doi.org/10.15585/mmwr.mm7048a1

Capital Outlay						
Special Payments	$6,890,000			$6,890,000		
Other						
Total	**$7,715,940**	**$0**	**$0**	**$7,715,940**	**4**	**3.00**

PLACEHOLDER- details are not available at this time

Oregon Health Authority

Annual Performance Progress Report

Reporting Year 2022

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KPM #	Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
4	MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with DHS (foster care).
5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
16	PQI 01: Diabetes Short-Term Complication Admission Rate -
17	PQI 05: COPD or Asthma in Older Adults Admission Rate -
18	PQI 08: Congestive Heart Failure Admission Rate -
19	PQI 15: Asthma in Younger Adults Admission Rate -
20	ACCESS TO CARE - Percentage of members who responded "always" or "usually" to getting care quickly.
21	MEMBER SATISFACTION OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
22	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
24	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
26	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
27	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
28	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
31	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
32	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
33	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
34	CUSTOMER SERVICE - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.

Proposal	Proposed Key Performance Measures (KPMs)

Proposal	Proposed Key Performance Measures (KPMs)
Delete	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
Delete	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
Delete	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
Delete	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
Delete	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
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Delete	PQI 05: COPD or Asthma in Older Adults Admission Rate -
Delete	PQI 08: Congestive Heart Failure Admission Rate -
Delete	PQI 15: Asthma in Younger Adults Admission Rate -
Delete	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
Delete	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
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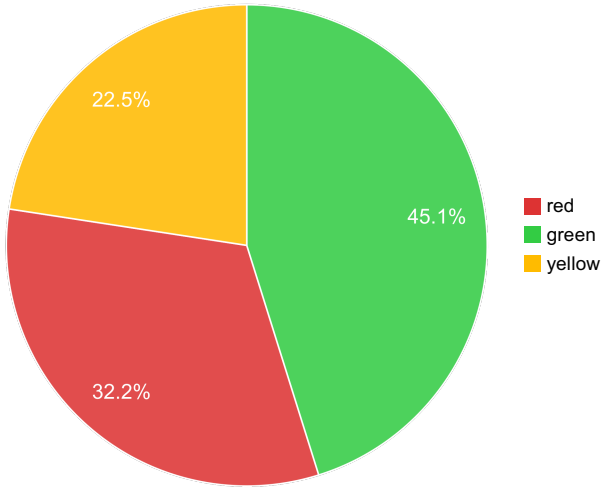
Delete	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
Delete	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
New	Health Equity Measure – component #1: Meaningful language access to culturally responsive health care services for CCO members - Component 1 is based on an annual language access self-assessment survey and designed to evaluate the development of structures and workflow processes to provide quality and consistent interpreter services.
New	Health Equity Measure – component #2: Meaningful language access to culturally responsive health care services for CCO members - Component 2 is based on the reporting of quarterly utilization data on interpreter services and designed to measure quality of interpreter services.
New	Infant Mortality Rate - Rate of infants who die in the first year of life. Numerator: # of deaths of infants <365 days of age in specified time period. Denominator: 100,000 live births in specified time period. Rate = (Num/Denom)*100,000
New	Reduction of Severe Maternal Morbidity - TBD
New	Comparison of OHA Workforce to Potential Labor Market - Comparisons of the OHA workforce to the potential labor market provide a measurement of parity, defined as: achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) in OHA's workforce to the same proportion in the potential labor market.
New	Comparison of OHA Non-Supervisory Managers to Potential Labor Market - Comparisons of OHA non-supervisory managers to the potential labor market provide a measurement of parity, defined as: achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) who are OHA non-supervisory managers to the same proportion in the potential labor market.
New	Comparison of OHA Supervisory Managers to Potential Labor Market - Comparisons of OHA supervisory managers to the potential labor market provide a measurement of parity, defined as: achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) who are OHA supervisory managers to the same proportion in the potential labor market.
New	Comparison of OHA Voluntary Separations to All Agency Separations - OHA defines parity as achieving comparable representation of Tribal communities, communities of color, people with disabilities and females (binary gender for now) in OHA's workforce to the same proportion to OHA's potential labor market.
New	Comparison of OHA Involuntary Separations to All Agency Separations - Parity is determined by a ratio of OHA involuntary separations—dismissal, dismissal during trial service or layoff—(numerator) and all agency separations (denominator). If the ratio score is greater than or equal to 0.90 for Tribal communities, communities of color, people with disabilities or females, then there is a relatively high representation of that group in involuntary separations from the agency. Excludes deaths and unknown separations.

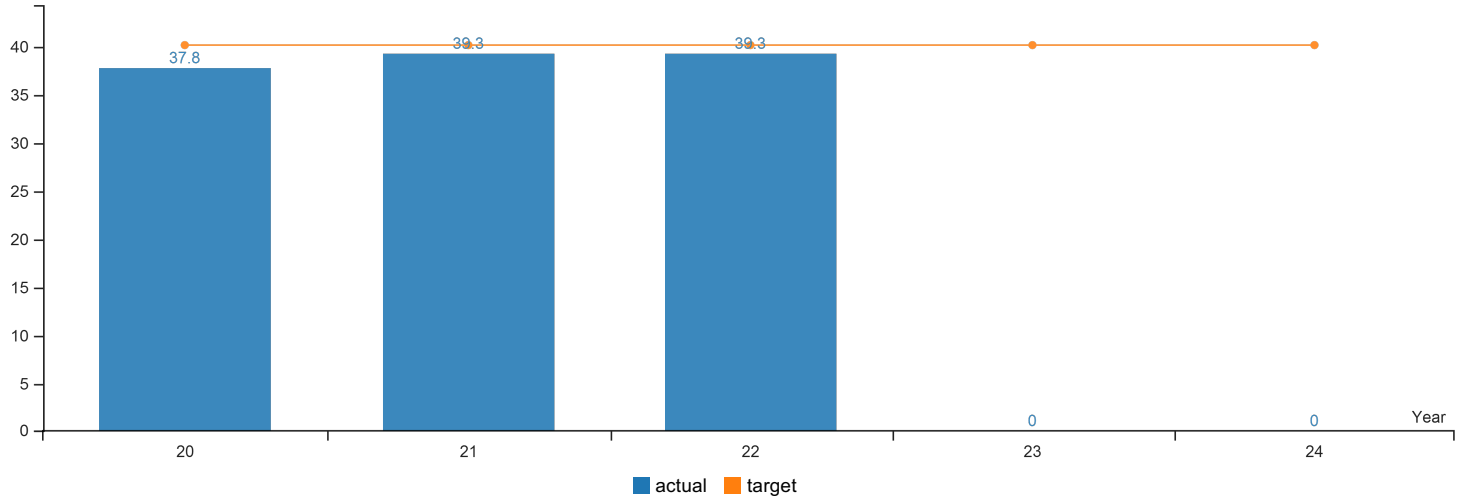
Proposal	Proposed Key Performance Measures (KPMs)
New	Quality of Life - Poor Physical Health - Average number of physically unhealthy days in the past 30 among adults. Measuring health-related quality of life helps build understanding around people's lived experience with disabilities and chronic diseases across the population. Self-report of days when physical health was not good is a reliable estimate of recent health status.
New	Quality of Life - Poor Mental Health - Average number of mentally unhealthy days in the past 30 days (age 18+). Measuring health-related quality of life helps build understanding around people's lived experience with disabilities and chronic diseases across the population. Self-report of days when mental health was not good is a reliable estimate of recent health status.
New	Premature Death - Number of years of potential life lost (YPLL) per 100,000 before age 75. Premature death is measured by summing the years between age at death and age 75 across all people who died before reaching that age. It's a way of quantifying the societal impact of early deaths in a population. Causes of death that are more likely to affect younger people – such as congenital anomalies and accidental injuries – contribute to higher rates of premature death.
New	Mortality from Drug Overdose - Number of deaths per 100,000 from drug overdoses excluding suicide. Drug overdose deaths account for a major proportion of all premature deaths and are largely preventable.
New	Tobacco Use - Teens - Percent of 11th graders who use tobacco (past 30 days). Cigarette smoking is the most common cause of preventable death and disease. It is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Many teen smokers become adult smokers. Measuring the prevalence of tobacco use in the youth population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for prevention programs or the effectiveness of existing programs.
New	Obesity - Teens - Percent of 11th graders who are obese (BMI >= 95th percentile for age/sex). Obesity is the second leading cause of preventable death in Oregon. It is a major risk factor for high blood pressure, high cholesterol, diabetes, heart disease, and cancer. Obese teens are at an increased risk of becoming obese adults.
New	Statewide Sustainable Cost of Care - Comparison of health care cost changes to personal income changes
New	OHA Sustainable Cost of Care - Difference between real personal income and health care inflation
New	Critical events meeting the 14-calendar day timeline to provide correspondence to Tribal Leaders - To track compliance with the OHA Tribal Consultation Policy timelines, % of critical events meeting the timeline. Total number of critical events meeting the timeline/total number of identified critical events.
New	Tribal consultations meeting the 30-calendar day timeline for reporting of outcome of consultation - To track compliance with the OHA Tribal Consultation Policy timelines, % of consultations reporting outcome within 30 calendar days. Total number of consultations meeting reporting timeline/total number of consultations
New	Timeliness of Translations During Emerging Public Health Events - To allow for equitable access to important public health information during public health events. Meet Federal and state legal obligations to provide information in alternative languages and formats, including Title VI of the Civil Rights Act. Compliance with agency policies, including DHS|OHA-010-013 Alternate Formats and Language Access Services. Number of hours from Incident Manager approval of an important (expedited) public information document for an identified public health event to the return of translated documents to the incident's Joint Information Center.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	45.16%	22.58%	32.26%

KPM #1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Initiation of alcohol and other drug dependence treatment					
Actual	37.80%	39.30%	39.30%		
Target	40.20%	40.20%	40.20%	40.20%	40.20%

How Are We Doing

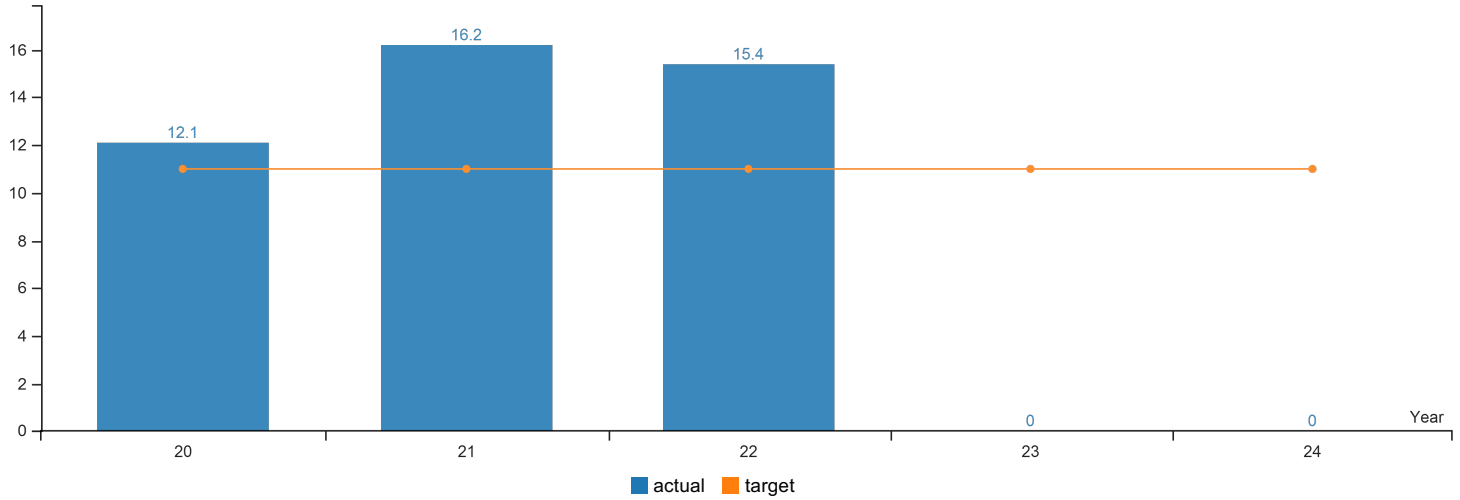
The percentage of members ages 13 and older newly diagnosed with alcohol or other drug dependencies who initiated treatment within 14 days stayed the same at 39.3% from 2020 to 2021. Data prior to 2020 are not directly comparable to 2020 and 2021 data due to a methodology change.

Factors Affecting Results

It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure in 2020 resulted in an increase in initiation of alcohol and drug treatment, as more individuals with risky or problematic substance use are identified and referred to treatment services.

KPM #2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received two or more services within 30 days of initiation visit.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Engagement of alcohol and other drug dependence treatment					
Actual	12.10%	16.20%	15.40%		
Target	11%	11%	11%	11%	11%

How Are We Doing

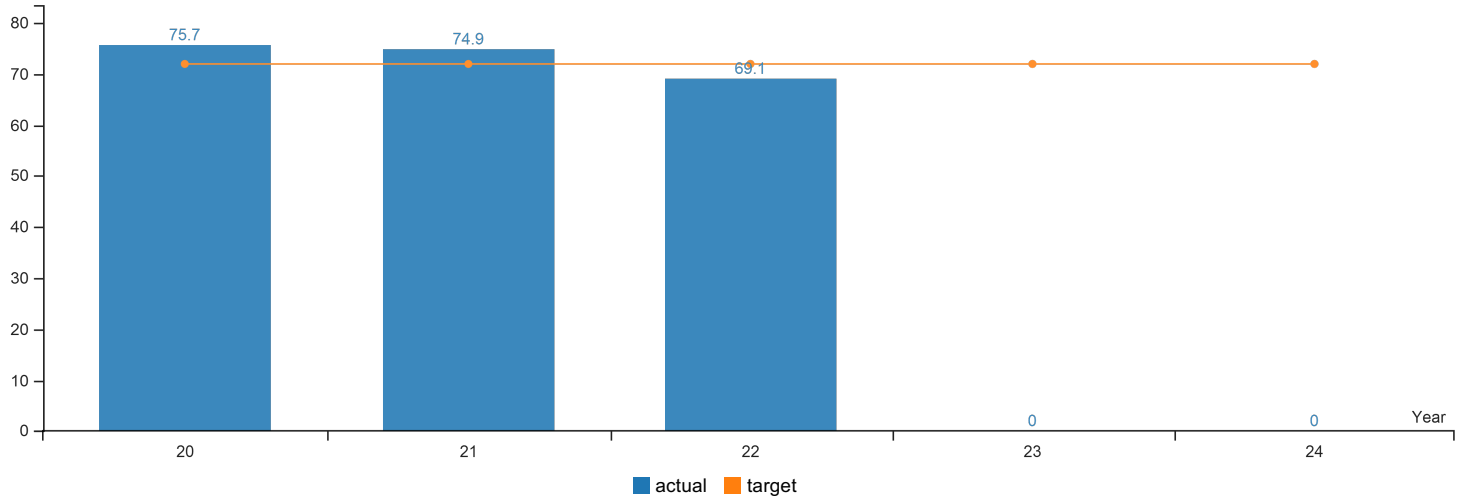
The percentage of members who continued their treatment decreased from 16.2% in 2020 to 15.4% in 2021. However, Data prior to 2020 is not directly comparable to 2020 and 2021 data due to a methodology change.

Factors Affecting Results

This was selected to be an incentive measure beginning in 2020, which possibly brought increased focus on this measure. However, the COVID-19 pandemic may have impacted initial gains.

KPM #3	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS - Percentage of enrollees 6 years of age and older who were hospitalized for treatment of mental health disorders and who were seen on an outpatient basis or were in intermediate treatment within seven days of discharge.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Follow-up after hospitalization for mental illness					
Actual	75.70%	74.90%	69.10%		
Target	72%	72%	72%	72%	72%

How Are We Doing

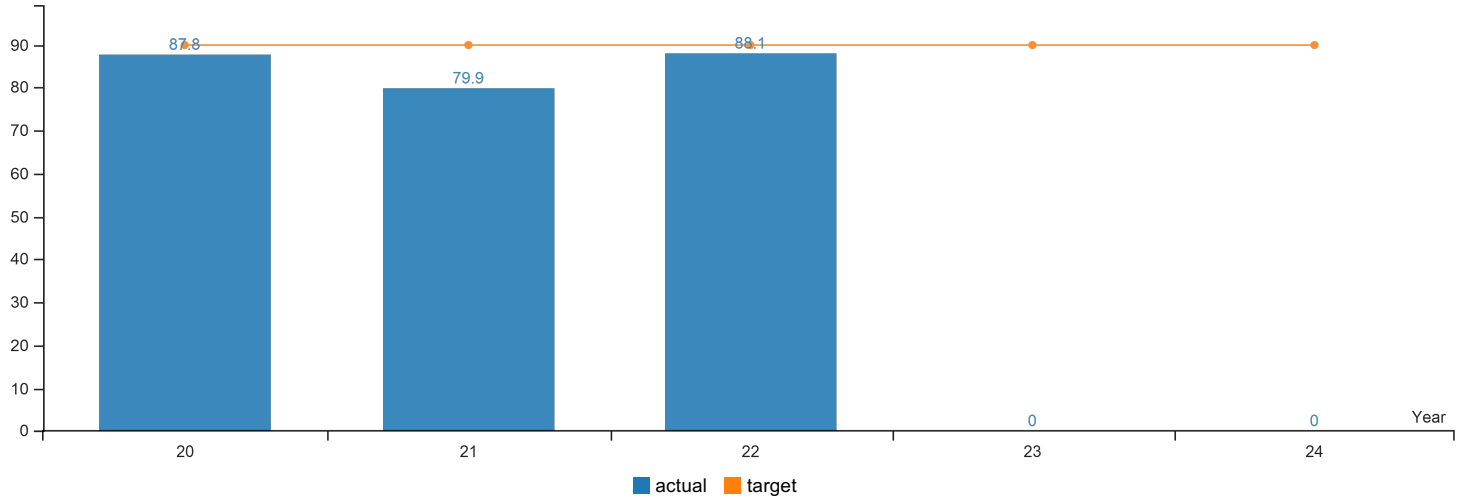
Performance on this measure continued to decline from 2020 to 2021. This is the fourth year in which performance has declined.

Factors Affecting Results

After rising steadily while included in the CCO Quality Incentive Program, performance on this measure has continued to decline since it was retired from the program in 2018. The decline continued through the COVID-19 pandemic.

KPM #4	MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with DHS (foster care).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
MENTAL, PHYSICAL, AND DENTAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY					
Actual	87.80%	79.90%	88.10%		
Target	90%	90%	90%	90%	90%

How Are We Doing

The percentage of children in foster care who received mental, physical, and dental health assessments increased from 79.9% in 2020 to 88.1% in 2021. Previously, 2020 was the first year in which this measure decreased since 2014. The 2021 rate of 88.1% marks a return back to the year over year increases seen in 2014 - 2019.

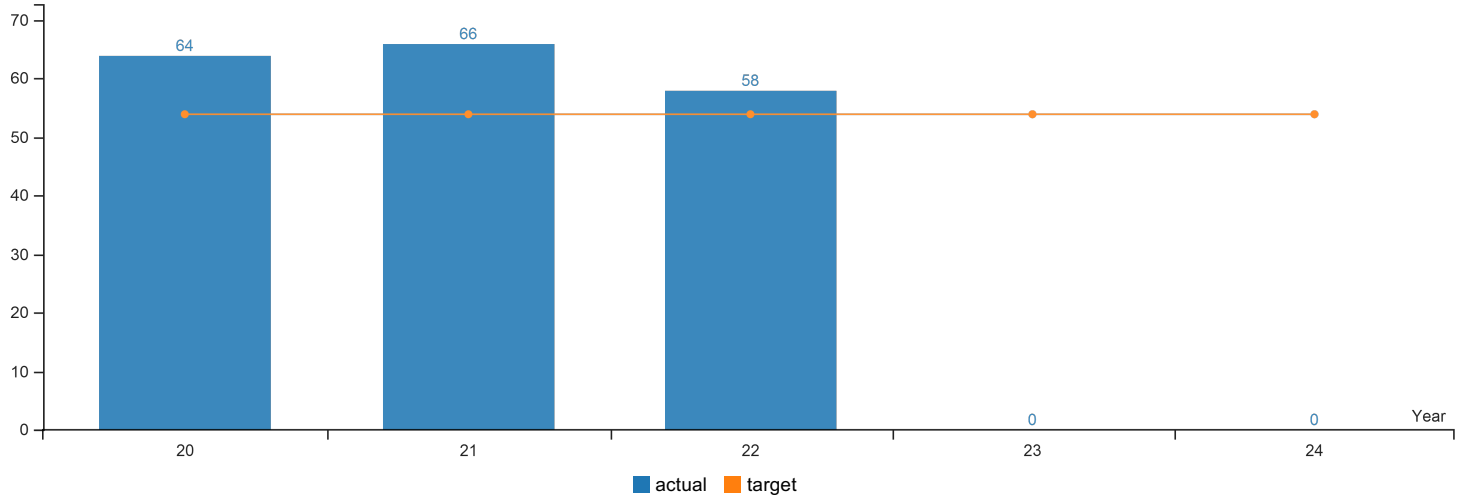
Factors Affecting Results

The COVID-19 pandemic negatively impacted this measure in 2020.

NOTE: 2013 not comparable to later years due to methodology change. In addition, dental assessments added in 2014.

KPM #5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Follow-up care for children prescribed with ADHD medication (initiation)					
Actual	64%	66%	58%		
Target	54%	54%	54%	54%	54%

How Are We Doing

The rate of children ages 6-12 who had at least one follow-up visit with a health care provider during the 30 days after receiving a new prescription for ADHD medication improved through 2018 (65.9%), declined in 2019 (64.0%), and improved to slightly above the 2018 rate in 2020 (66.0%). In 2021, the rate dropped to 58.0%, which is the lowest performance since 2014. NOTE: This measure was included in the CCO Quality Incentive Program, for which CCOs can earn incentive payments based upon performance improvements, in 2013 and 2014.

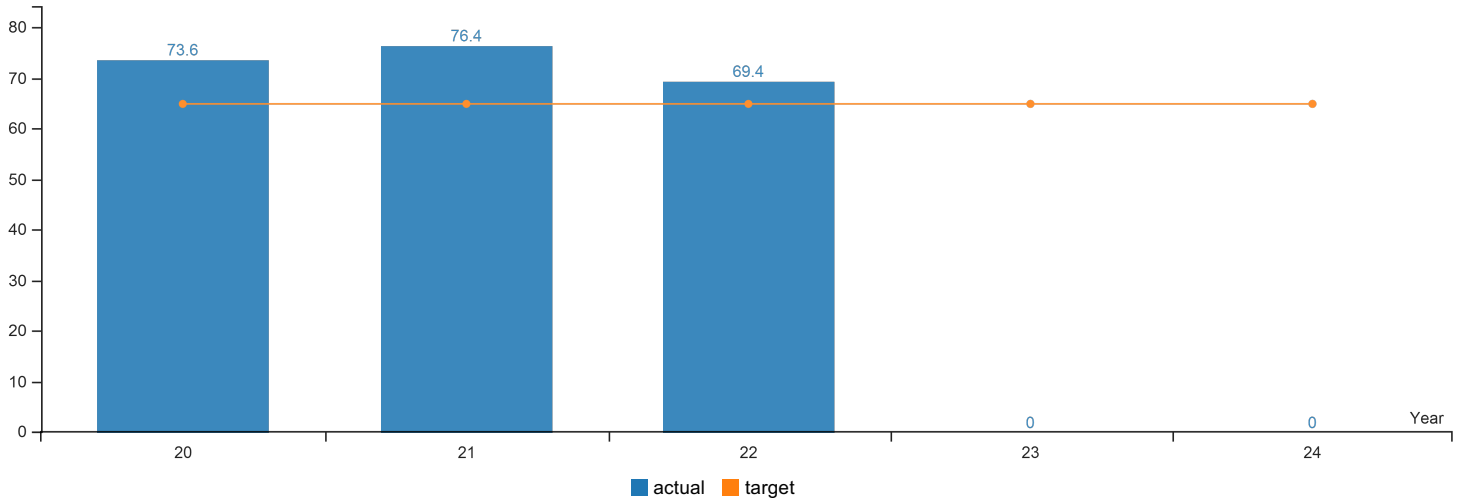
Factors Affecting Results

We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer initial prescriptions would fall outside of the 30 day window for this measure. The COVID-19 pandemic may have affected most recent performance.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Follow-up care for children prescribed with ADHD medication (continuation and maintenance)					
Actual	73.60%	76.40%	69.40%		
Target	65%	65%	65%	65%	65%

How Are We Doing

Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. This rate remained fairly steady in 2013 and 2014, and increased notably in 2015, with 68.9% of children receiving continued follow-up with a provider. The rate declined from 2018 (74.4%) to 2019 (73.6%). In 2020 the rate increased to 76.4%. The rate dropped in 2021 to 69.4%.

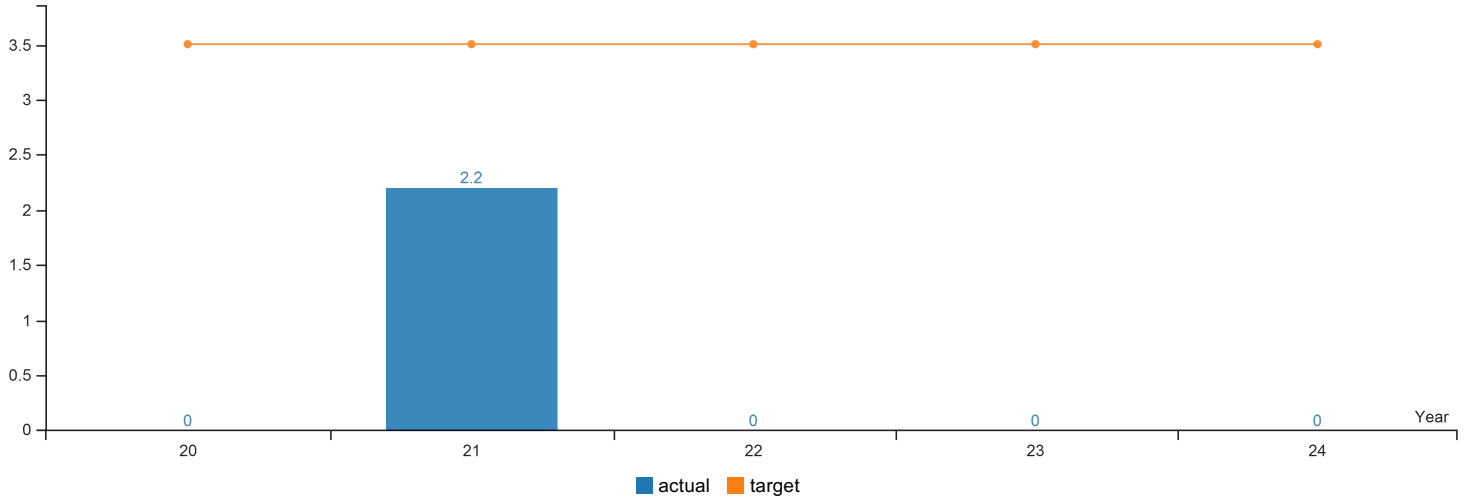
Factors Affecting Results

A number of CCO incentive measures as well as initiatives including the patient-centered primary care home model put greater emphasis on preventive care and well child visits. These efforts may result in children being more likely to engage with their primary care providers, leading to greater follow-up care for children prescribed medications for their ADHD. This measure is also notable for small denominators across the CCOs (with some having fewer than 30 children that meet these criteria); data shifts are more likely given these small numbers. The COVID-19 pandemic may have affected most recent performance.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 6th graders					
Actual		2.20%			
Target	3.50%	3.50%	3.50%	3.50%	3.50%

How Are We Doing

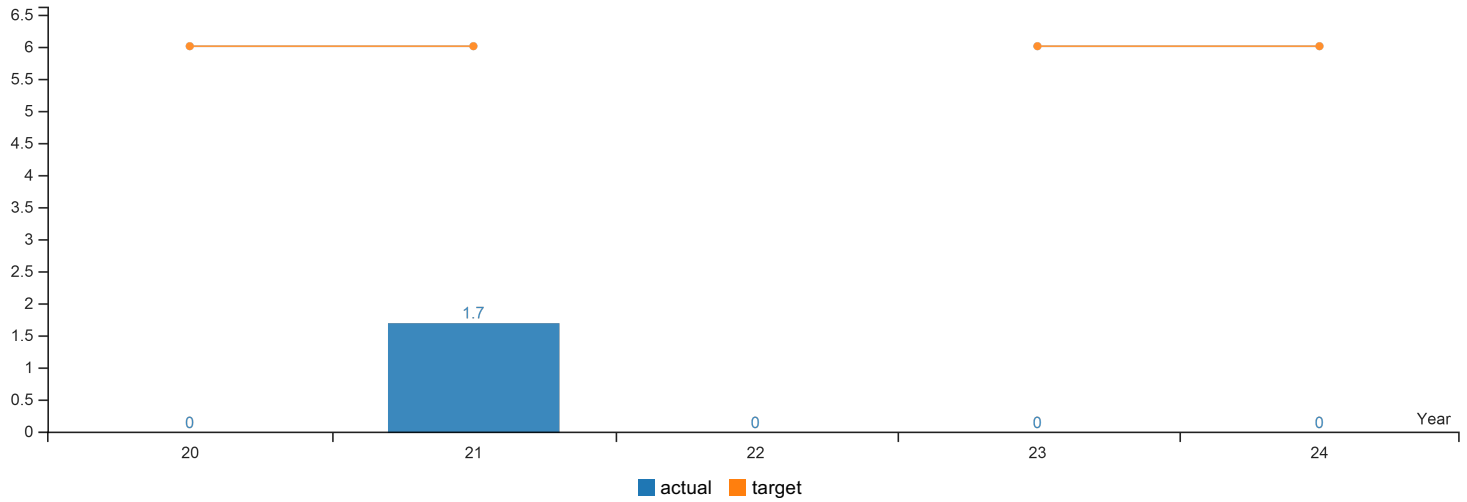
Data only collected in even numbered years. No update available.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day illicit drug use among 8th graders					
Actual		1.70%			
Target	6%	6%		6%	6%

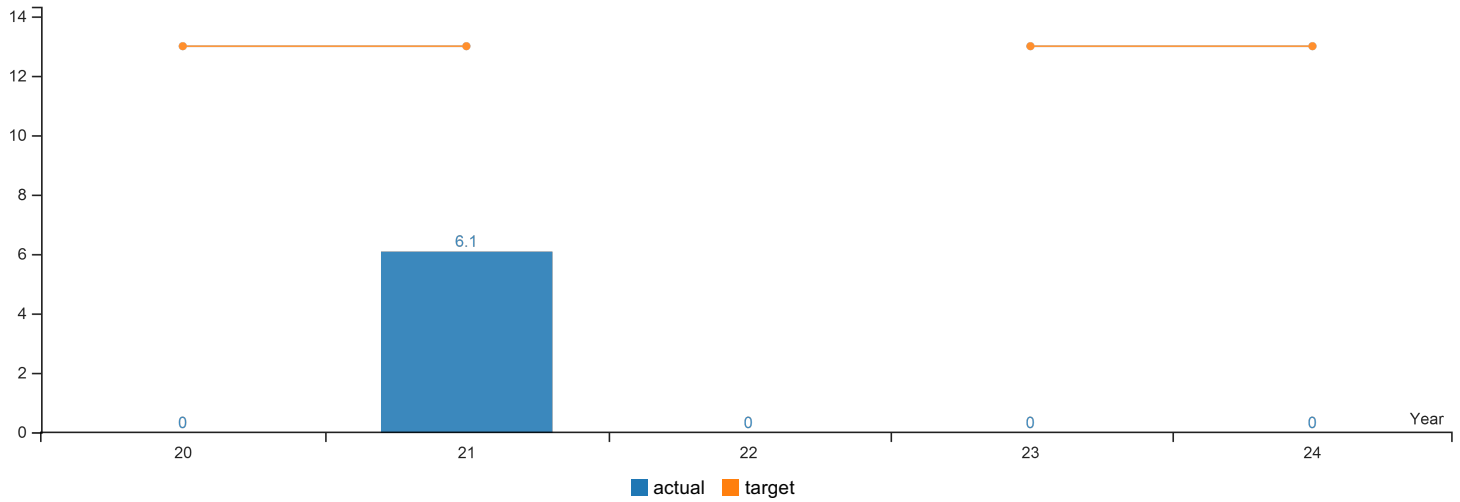
How Are We Doing

Data currently being collected in even numbered years and reported in odd numbered years. No update available.

Factors Affecting Results

KPM #10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 8th graders					
Actual		6.10%			
Target	13%	13%		13%	13%

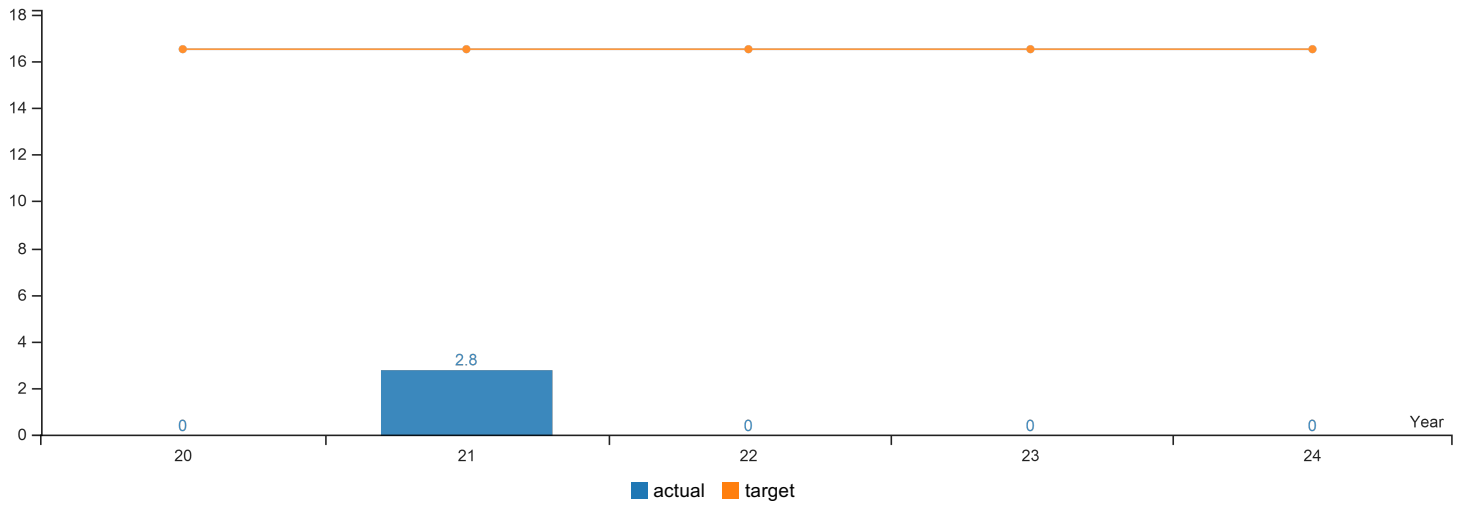
How Are We Doing

Data currently being collected in even numbered years and reported in odd numbered years. No update available.

Factors Affecting Results

KPM #11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day illicit drug use among 11th graders					
Actual		2.80%			
Target	16.50%	16.50%	16.50%	16.50%	16.50%

How Are We Doing

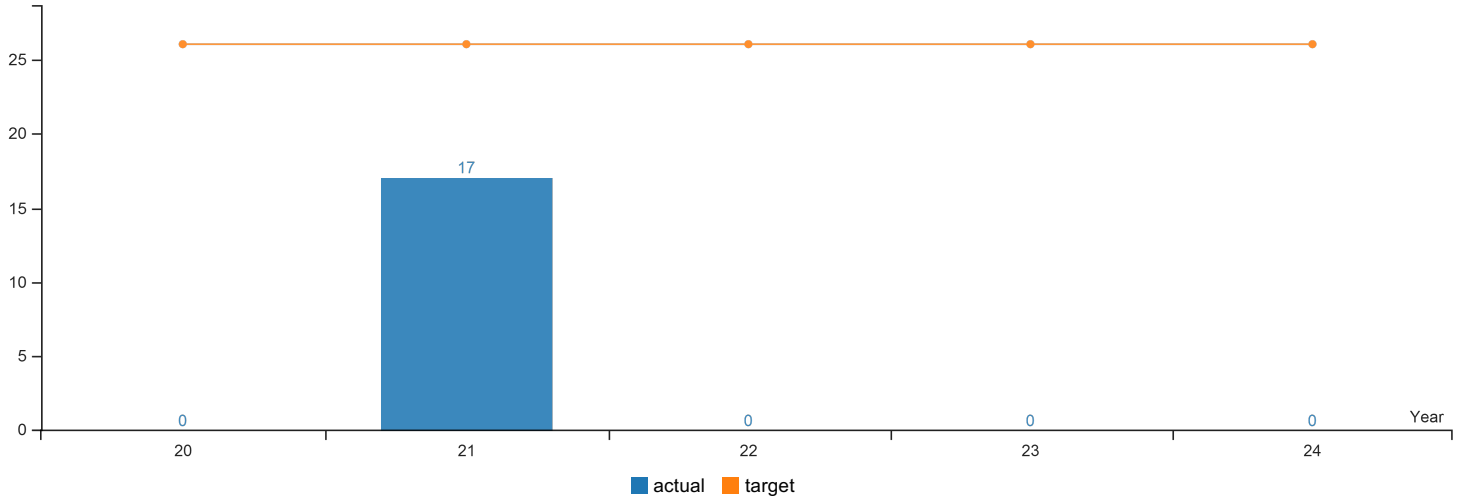
Data only collected in even numbered years. No update available.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 11th graders					
Actual		17%			
Target	26%	26%	26%	26%	26%

How Are We Doing

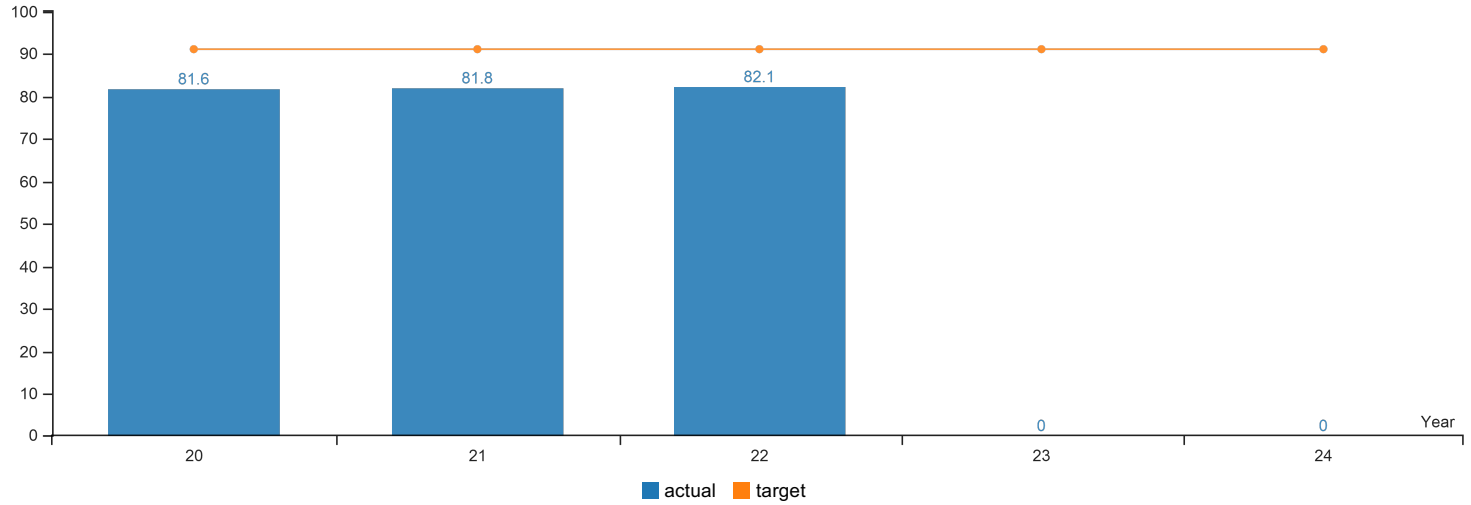
Data only collected in even numbered years. No update available.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Prenatal care - population					
Actual	81.60%	81.80%	82.10%		
Target	91%	91%	91%	91%	91%

How Are We Doing

The percentage of women initiating prenatal care during the first trimester is a marker for access to maternal health care services. This percentage has been slowly but steadily increasing in Oregon from 2015 to 2021. Early prenatal care is important to identify and treat babies or mothers at risk for health conditions that can affect the pregnancy, such as hypertension and diabetes. It is also important because health care providers can educate and assist mothers with health issues related to pregnancy including nutrition, alcohol use, smoking, exercise, and preparing for childbirth and infant care. Prenatal care is an important screening point for behavioral and social risks such as perinatal depression, intimate partner violence, and food insecurity. Babies born to women who receive prenatal care early and throughout the pregnancy are less likely to have low birth weight or to be born prematurely. Psychosocial, financial, logistical, health care provider, and many other issues can create barriers for women in obtaining early prenatal care. This indicator is used by states and at the national level, as the data is from vital statistics (birth certificates), therefore making it widely available and representative of the population. While this indicator has been traditionally used, and is widely understood, it is also valuable to examine the Adequacy of Prenatal Care Utilization Index (https://www.mchlibrary.org/databases/HSNRCPDFs/Overview_APCUIndex.pdf), which examines the number of prenatal care visits a woman has received throughout pregnancy in addition to the timing of initiation. This allows for a more thorough examination of woman's access to care. It is worth noting that the data for prenatal care used in both indicators is only available for live births, and therefore does not include information on the prenatal care of women who had a miscarriage or a still birth. The data on first trimester initiation of prenatal care is publicly released by the Oregon Center for Health Statistics in their Annual Vital Statistic Report. These reports can be found at https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/ANNUALREPORTS/VOLUME1/Pages/index.aspx. Data entered is preliminary for 2021.

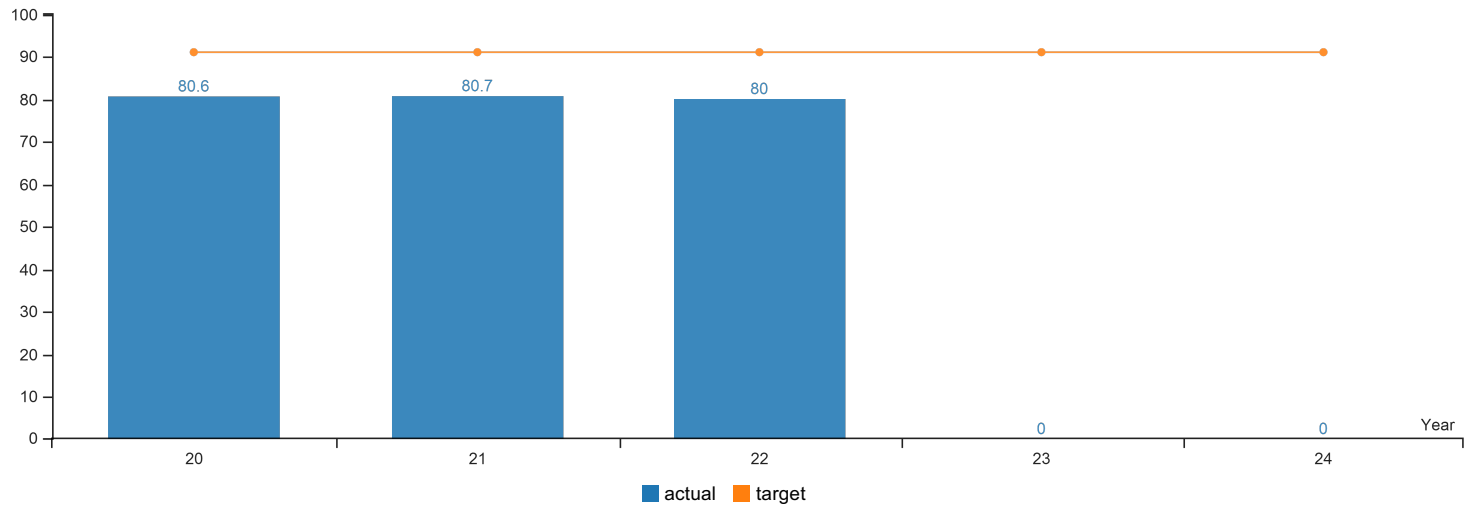
Factors Affecting Results

Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Prenatal care - Medicaid					
Actual	80.60%	80.70%	80%		
Target	91%	91%	91%	91%	91%

How Are We Doing

Performance on timeliness of prenatal care slightly decreased from 80.7% in 2020 to 80.0% in 2021.

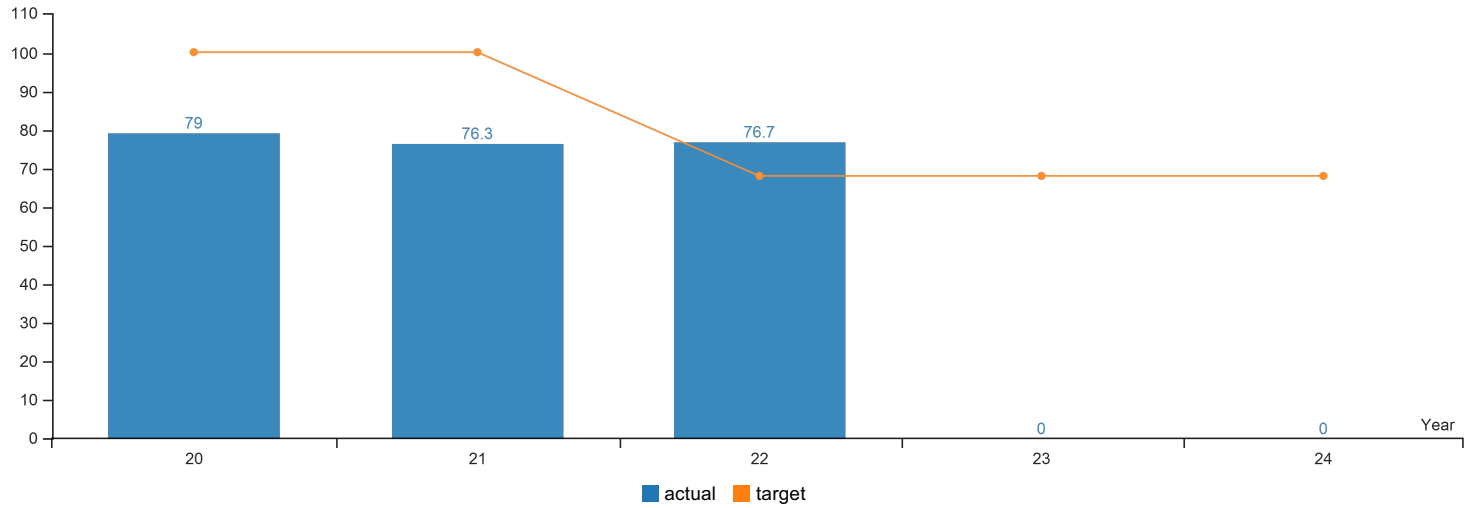
Factors Affecting Results

This measure was an incentive measure through 2018, but not incentivized for 2019 onwards. NOTE: Results prior to 2014 are not directly comparable to later years due to change in methodology.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Patient centered primary care home (PCPCH) enrollment					
Actual	79%	76.30%	76.70%		
Target	100%	100%	68%	68%	68%

How Are We Doing

This measure uses a weighted methodology to ensure members are not just enrolled in a Patient-Centered Primary Care Home (PCPCH), but are enrolled in the higher PCPCH tiers. Statewide in 2019, 96 percent of CCO members were enrolled in a PCPCH, resulting in a weighted score of 79. This weighted score dropped in 2020 to 76.3, with 92 percent of CCO members enrolled in a PCPCH. The weighed score increased slightly in 2021 to 76.7. Beginning in 2017, the PCPCH program launched 5 STAR recognition. This new level of recognition was incorporated into the weighting formula for PCPCH score. Thus, scores are not comparable to previous years.

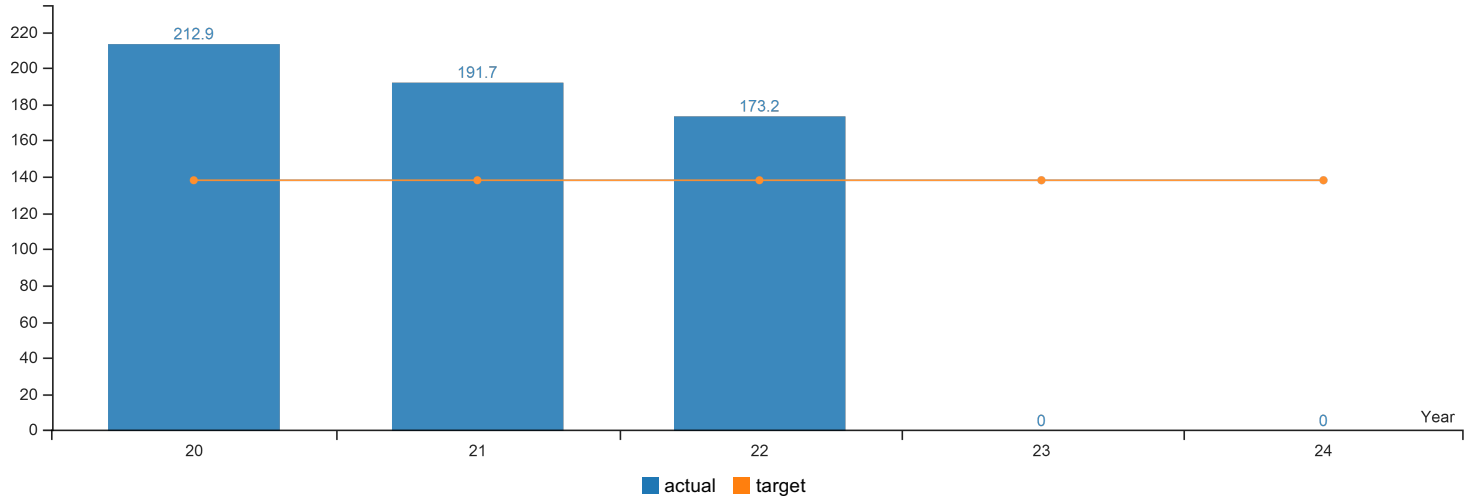
Factors Affecting Results

Coordinated care organizations are driving improvement on this measure through two main efforts: (1) working with contracted providers to go through the PCPCH recognition process, and (2) preferentially assigning members to certified PCPCHs.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #16	PQI 01: Diabetes Short-Term Complication Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 01: Diabetes Short-Term Complication Admission Rate					
Actual	212.90	191.70	173.20		
Target	138	138	138	138	138

How Are We Doing

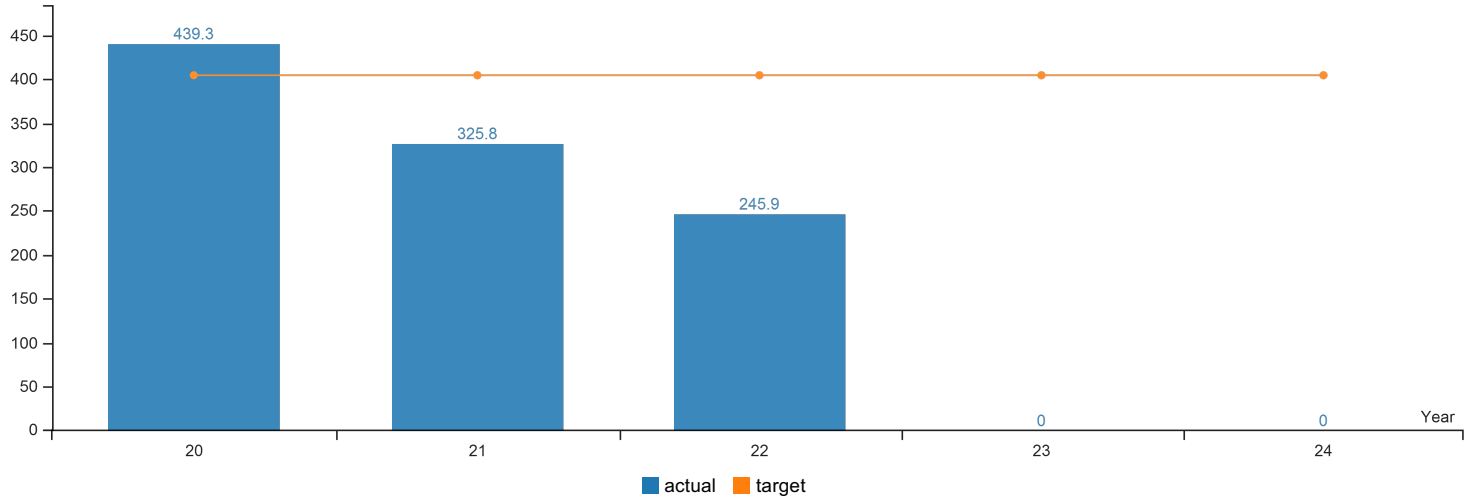
The rate of adult members with diabetes who had a hospital stay because of a short-term problem from their disease improved from 191.7 in 2020 to 173.2 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #17	PQI 05: COPD or Asthma in Older Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 05: COPD or Asthma in Older Adults Admission Rate					
Actual	439.30	325.80	245.90		
Target	404	404	404	404	404

How Are We Doing

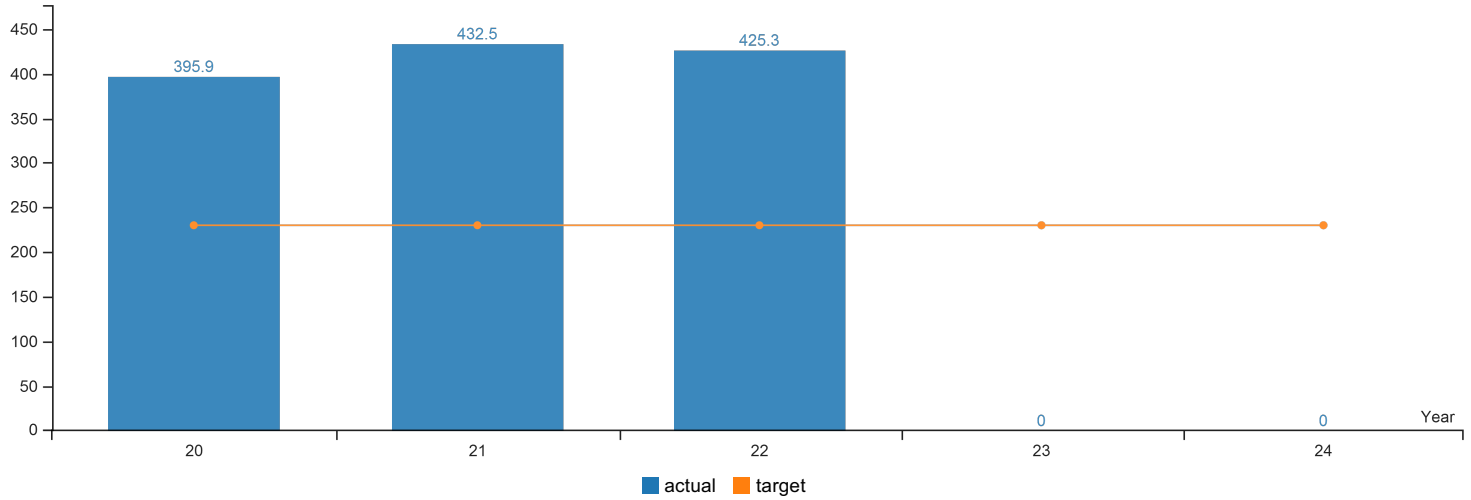
The rate of adult members (ages 40 and older) who had a hospital stay because of chronic obstructive respiratory disease or asthma improved from 325.8 in 2020 to 245.9 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #18	PQI 08: Congestive Heart Failure Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 08: Congestive Heart Failure Admission Rate					
Actual	395.90	432.50	425.30		
Target	230	230	230	230	230

How Are We Doing

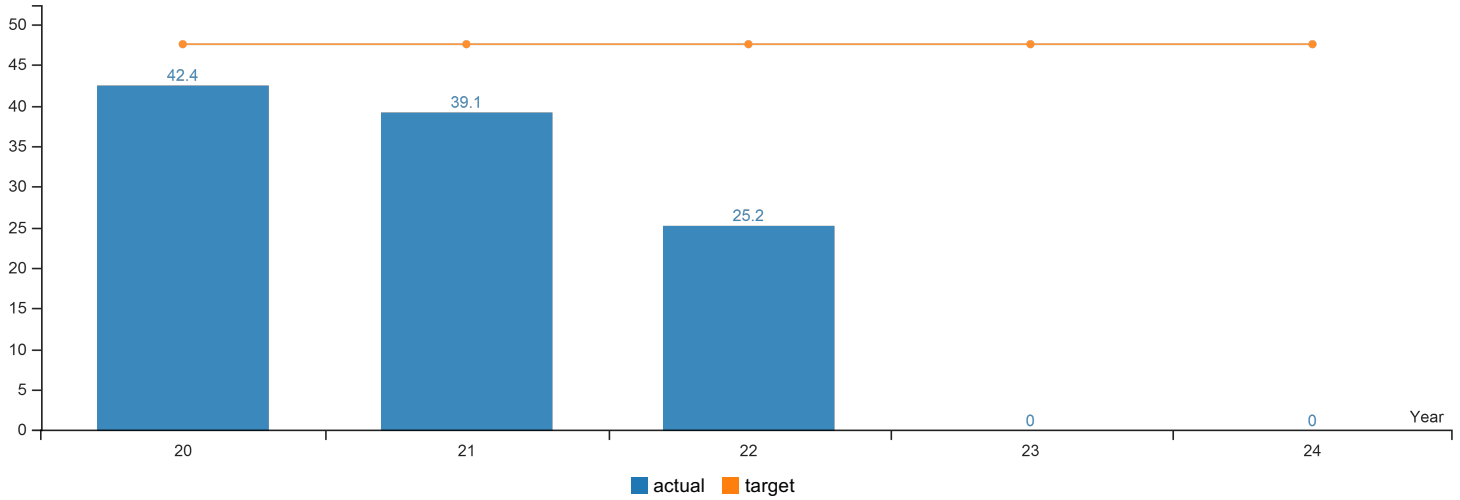
The rate of adult members who had a hospital stay because of congestive heart failure improved from 432.5 in 2020 to 425.3 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #19	PQI 15: Asthma in Younger Adults Admission Rate -
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
PQI 15: Asthma in Younger Adults Admission Rate					
Actual	42.40	39.10	25.20		
Target	47.50	47.50	47.50	47.50	47.50

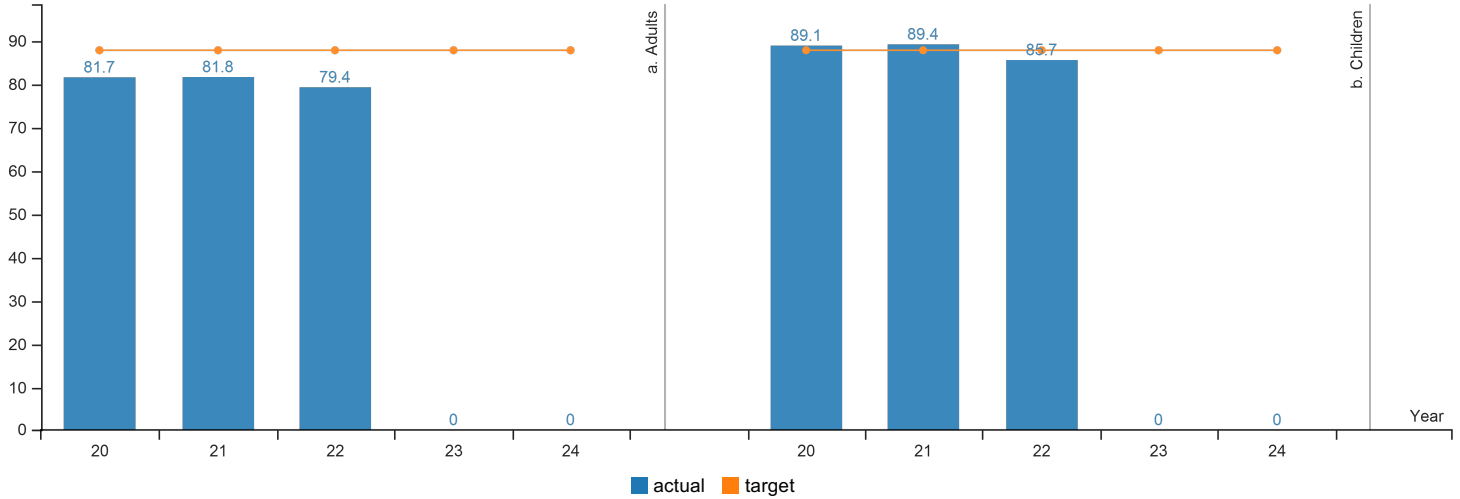
How Are We Doing

The rate of younger adult members (ages 18-39) who had a hospital stay because of asthma improved from 39.1 in 2020 to 25.2 in 2021. Lower is better on this measure. This measure is calculated using proprietary software from AHRQ, which was updated in 2018. Because of the changes that AHRQ made to the way this measure is calculated, data prior to 2018 are not directly comparable to later years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #20	ACCESS TO CARE - Percentage of members who responded "always" or "usually" to getting care quickly.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
a. Adults					
Actual	81.70%	81.80%	79.40%		
Target	88%	88%	88%	88%	88%
b. Children					
Actual	89.10%	89.40%	85.70%		
Target	88%	88%	88%	88%	88%

How Are We Doing

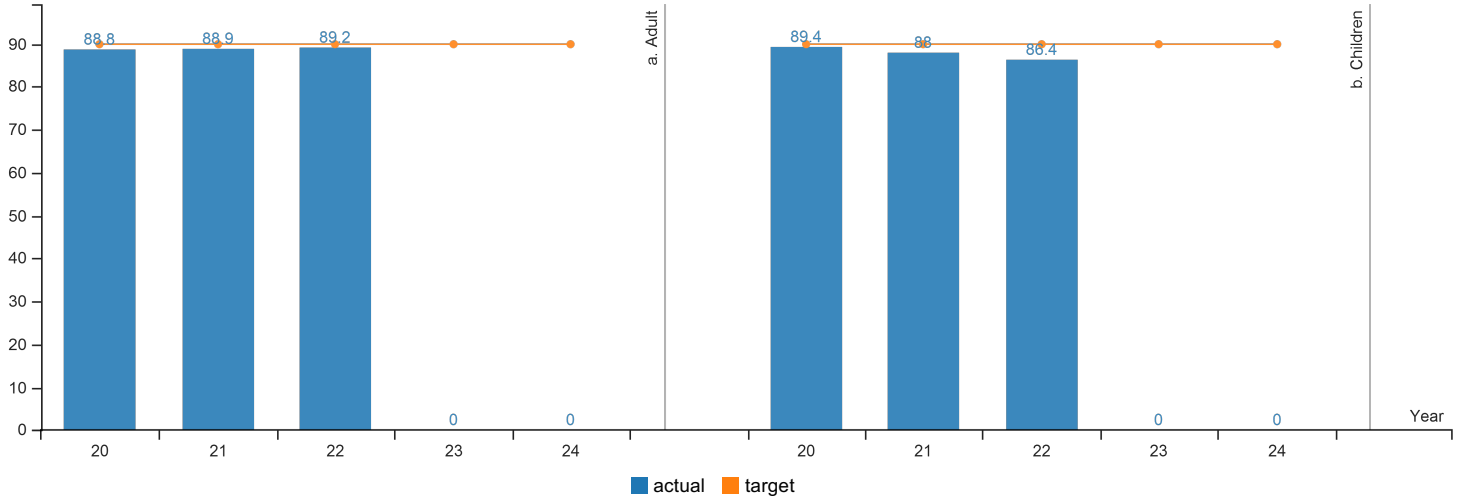
The percentage of adult members who thought they received appointments and care when needed was 79.4%. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to the 2021, making them not directly comparable to previous years.

The percentage of child members who received appointments and care when needed was 85.7% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to 2021, making them not directly comparable to previous years.

Factors Affecting Results

The COVID-19 pandemic may have affected most recent performance. This measure is included in the state's Medicaid demonstration agreement with CMS.

KPM #21	MEMBER SATISFACTION OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
a. Adult					
Actual	88.80%	88.90%	89.20%		
Target	90%	90%	90%	90%	90%
b. Children					
Actual	89.40%	88%	86.40%		
Target	90%	90%	90%	90%	90%

How Are We Doing

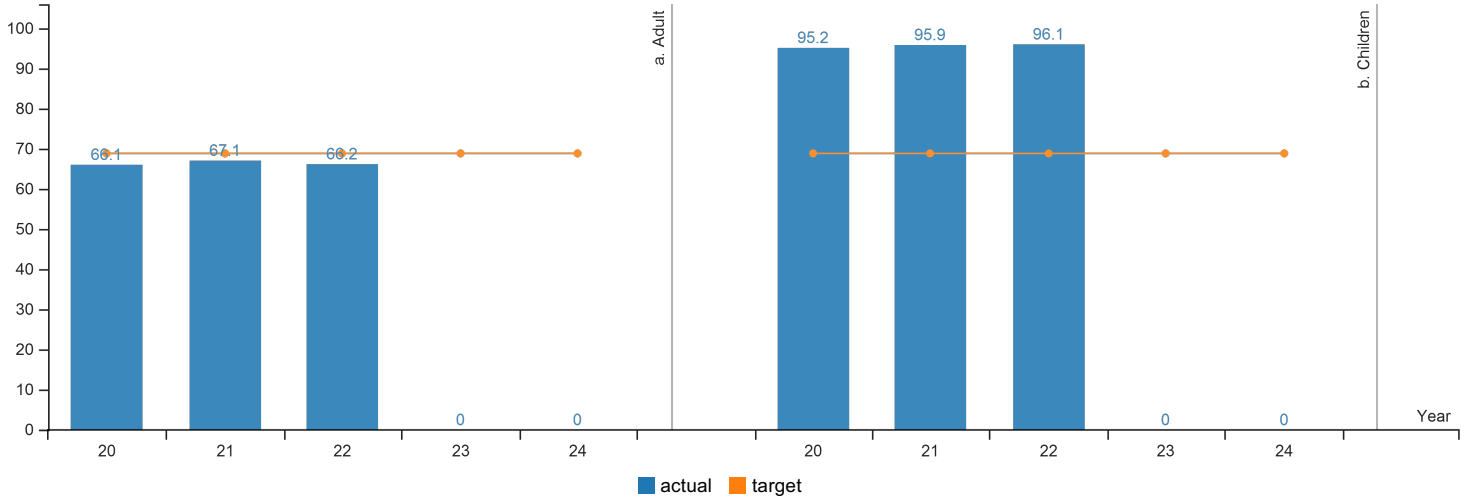
The rate of adults who were satisfied with their experience of care was 89.2% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to 2021 results, making them not directly comparable to previous years.

The percentage of adults who were satisfied with their child's experience of care was 86.4% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to 2021 results, making them not directly comparable to prior years.

Factors Affecting Results

NOTE: This was retired from the incentive measure set in 2017.

KPM #22	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, or good).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
a. Adult					
Actual	66.10%	67.10%	66.20%		
Target	68.90%	68.90%	68.90%	68.90%	68.90%
b. Children					
Actual	95.20%	95.90%	96.10%		
Target	68.90%	68.90%	68.90%	68.90%	68.90%

How Are We Doing

The percentage of adult members who rated their overall health as good, very good, or excellent was 66.2% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. The 2021 rate is not directly comparable to previous years due to adding an oversample of race/ethnicity groups.

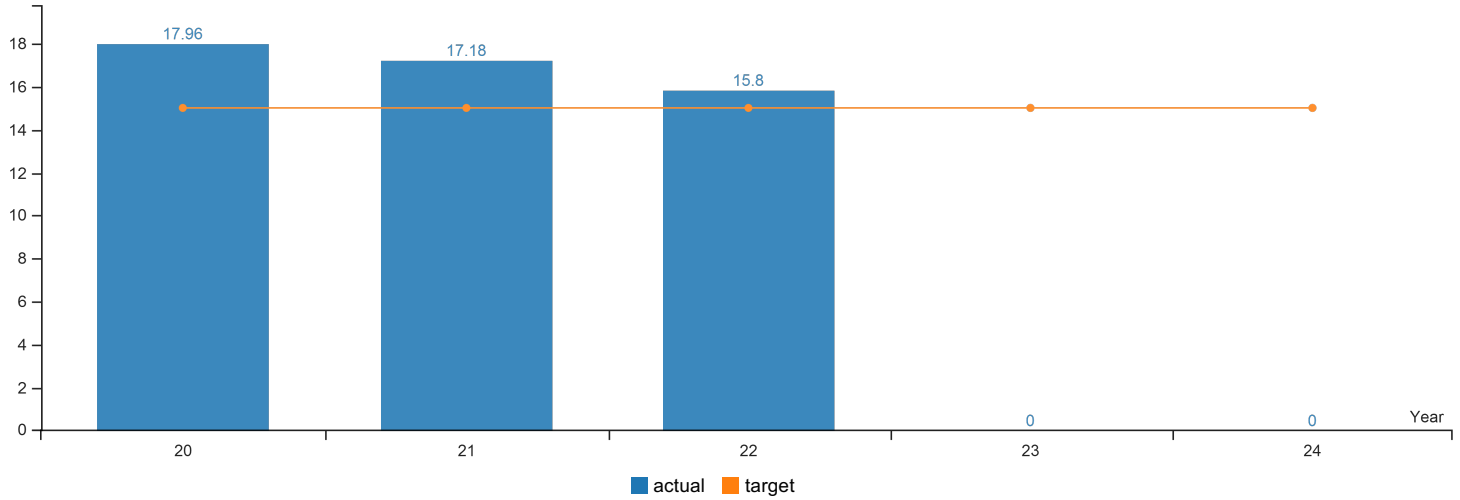
The percentage of children whose parents rated their overall health as good, very good, or excellent was 96.1% in 2021. Prior to 2018, this measure was a weighted score across children and adults. From 2018 on, however, these data are now disaggregated and reported separately for children and adults. This ensures that performance across the different age groups can be monitored appropriately and is based upon a decision from the Metrics and Scoring Committee. OHA added an oversample of race/ethnicity groups to the 2021 results, meaning that the rate is not directly comparable to previous years.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Rate of tobacco use - adult population					
Actual	17.96%	17.18%	15.80%		
Target	15%	15%	15%	15%	15%

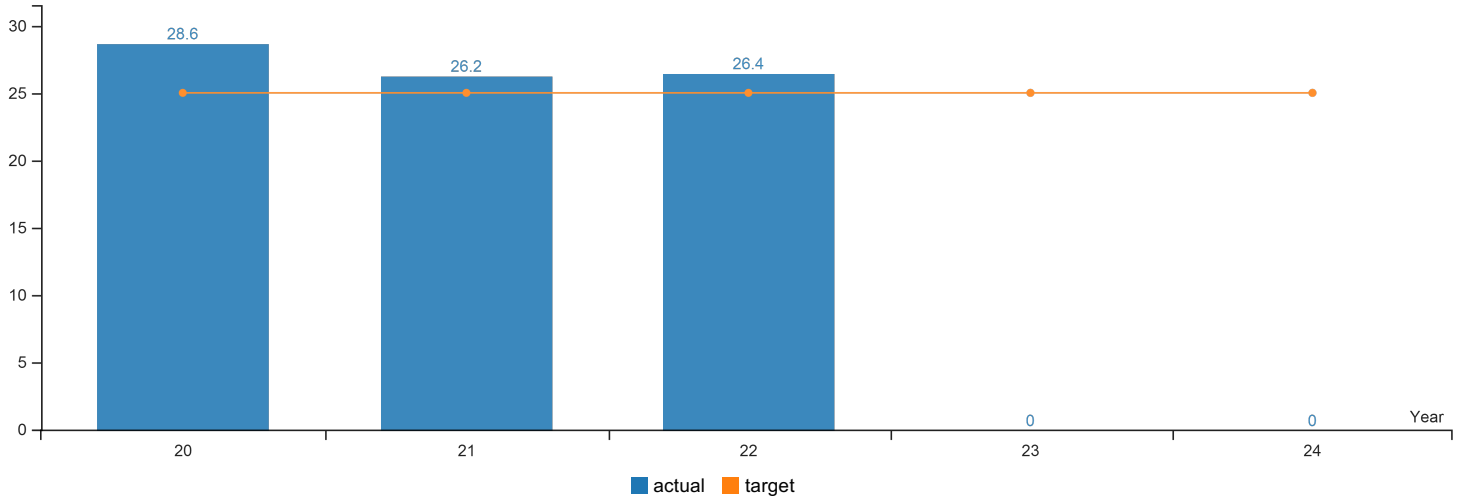
How Are We Doing

Oregon has reached less than 16% of Oregon adults using tobacco (cigarette and smokeless tobacco).

Factors Affecting Results

KPM #24	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Rate of tobacco use - Medicaid population					
Actual	28.60%	26.20%	26.40%		
Target	25%	25%	25%	25%	25%

How Are We Doing

The percentage of members who self-reported smoking cigarettes or using tobacco every day or some days was 26.4% in 2021. Lower is better on this measure. Results in 2021 are not directly comparable to previous years due to adding an oversample of race/ethnicity groups.

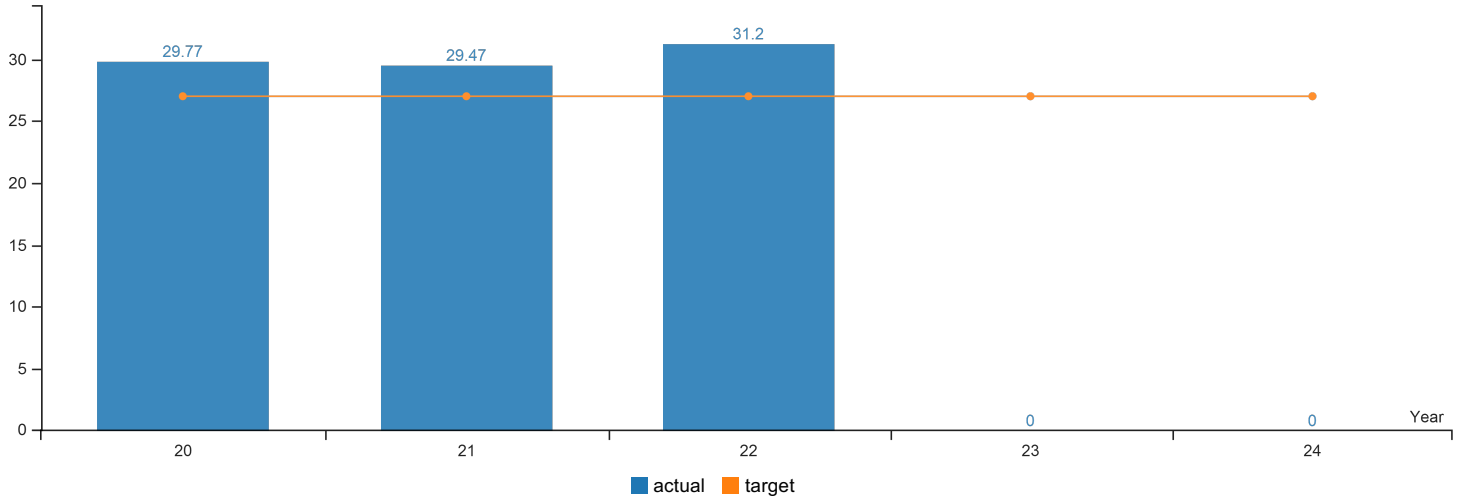
Factors Affecting Results

Note: This self-reported, survey-based measure was included in our previous CMS waiver, but was not included as a metric in the current 2017-2022 waiver; instead the current Medicaid waiver includes a different measure focused specifically on cigarette smoking prevalence, and sourced from electronic health records.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Rate of obesity - adult population					
Actual	29.77%	29.47%	31.20%		
Target	27%	27%	27%	27%	27%

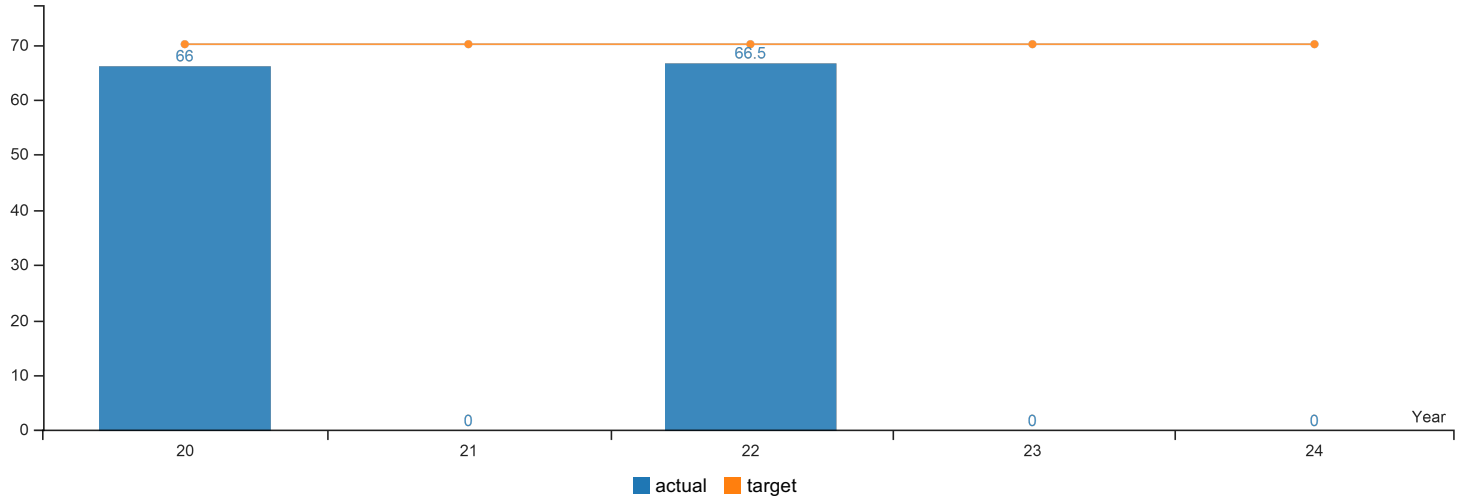
How Are We Doing

The obesity rate continues to increase (worsen) in Oregon. The main factor affecting Oregonian's results is limited funds for statewide initiatives that promote healthy environments where access to physical activity is improved and barriers to nutrition security are reduced.

Factors Affecting Results

KPM #26	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Effective contraceptive use - population					
Actual	66%		66.50%		
Target	70%	70%	70%	70%	70%

How Are We Doing

The 2020 data was not available to report on in 2021 due to delays caused by COVID19. The data collection cadence has changed on this metric as well, such that the survey is only being completed in even numbered years. As such, there is no 2021 survey data for us to report on in 2022. The 2020 data is available now and are reporting that number - 66.5%. The proportion of women at risk of unintended pregnancy who are using effective contraceptive methods has remained steady for the past several years.

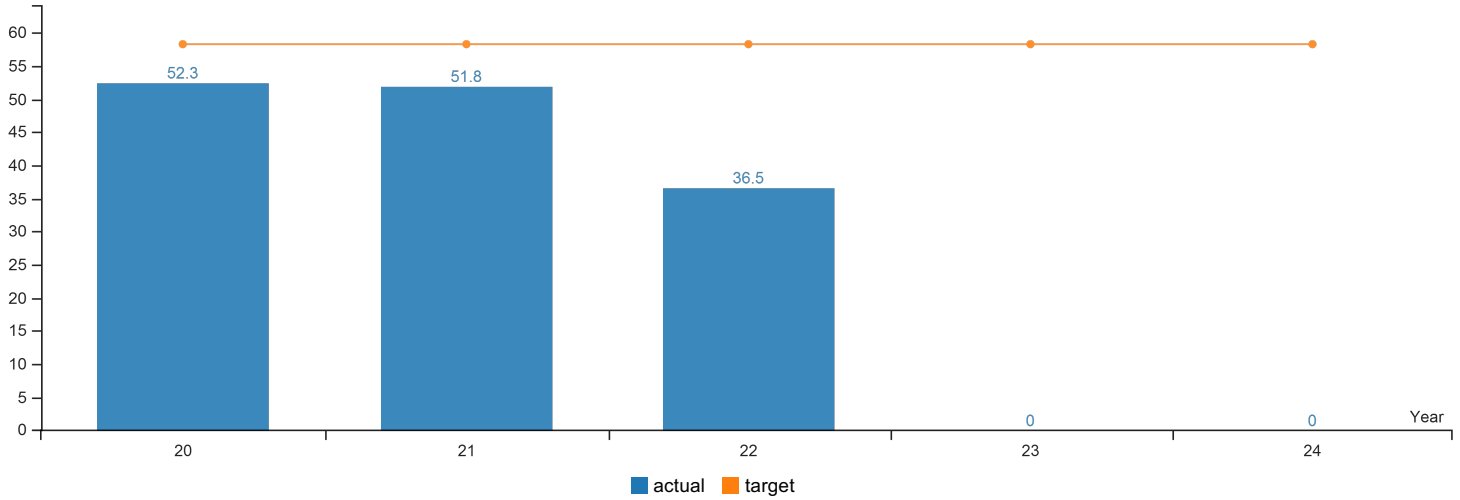
Factors Affecting Results

Access to contraception services was greatly impacted during the acute phase of the COVID-19 pandemic. Family planning clinics demonstrated innovations in service delivery to maintain access during this time.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #27	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Effective contraceptive use - Medicaid population					
Actual	52.30%	51.80%	36.50%		
Target	58.20%	58.20%	58.20%	58.20%	58.20%

How Are We Doing

The rate of effective contraceptive use increased since while the measure was included in the CCO Quality Incentive Program from 2015-2019; this means CCOs could earn incentive payments for improving performance during this time period. The Metrics & Scoring Committee retired this measure from the incentive program in 2020 due to equity concerns about the measure. Subsequently, the rate decreased from 52.3% in 2019 to 51.8% in 2020. The rate continued to decrease in 2021 to 36.5%.

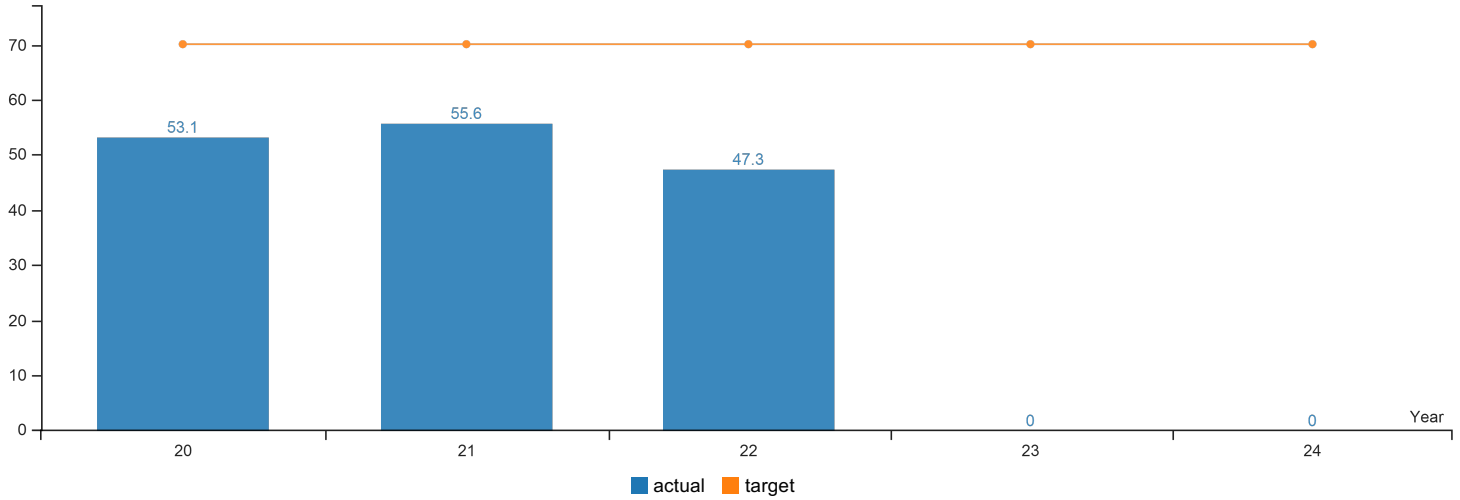
Factors Affecting Results

This was a CCO incentive measure from 2015 - 2019 (the incentive measure also included young women ages 15-17 in 2018 & 2019). The 2020 rate of 51.8% includes women ages 18-50, while the 2021 rate includes women ages 15-50, which may have affected the decreased rate. Due to the change in ages included in this measure, 2021 results are not directly comparable to 2020.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #28	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Flu shots - population					
Actual	53.10%	55.60%	47.30%		
Target	70%	70%	70%	70%	70%

How Are We Doing

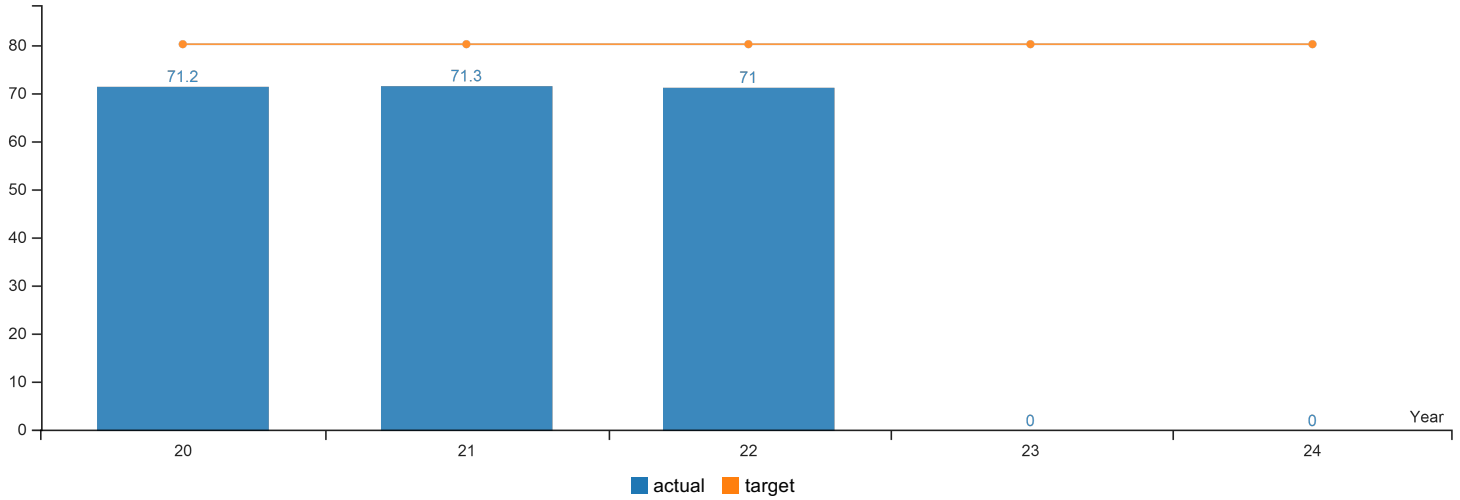
Adult influenza immunization in the Fall of 2021 was reduced to the overlap in time with the recommendation for COVID-19 booster doses.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #29	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Child immunization rates - population					
Actual	71.20%	71.30%	71%		
Target	80%	80%	80%	80%	80%

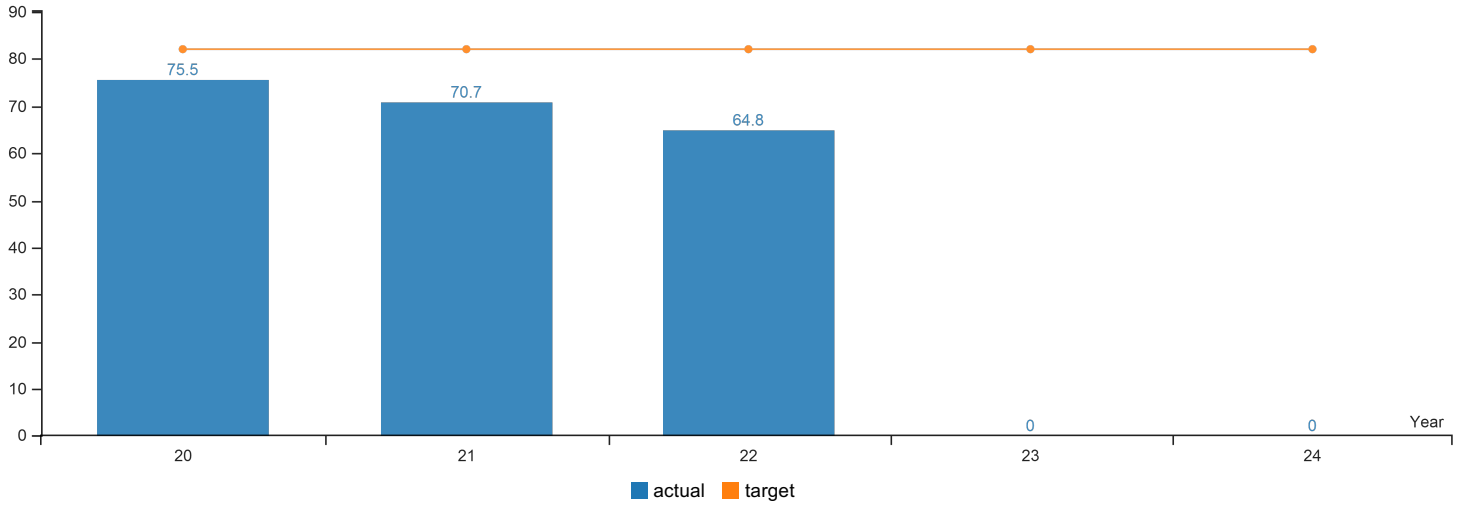
How Are We Doing

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #30	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Child immunization rates - Medicaid population					
Actual	75.50%	70.70%	64.80%		
Target	82%	82%	82%	82%	82%

How Are We Doing

In 2015, 68.2% of CCO members received recommended vaccines before their second birthday. This increased to 73.2% in 2017, and continued to increase to 74.5% in 2018 and 75.5% in 2019. In 2020 this measure decreased to 70.7%. The measure continued to decrease to 64.8% in 2021.

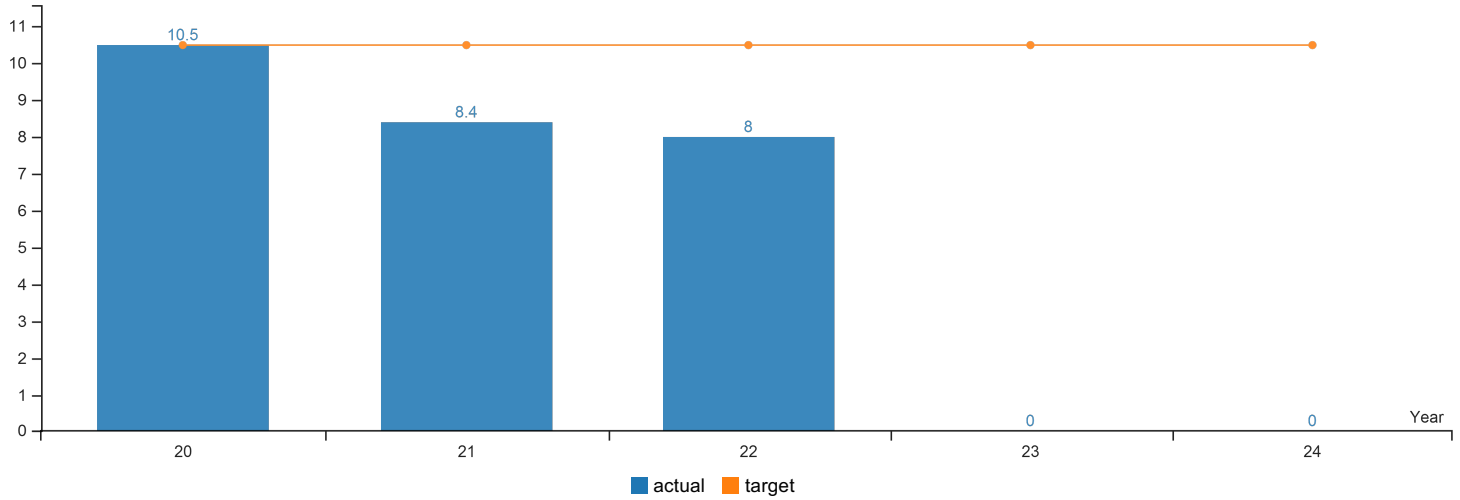
Factors Affecting Results

The COVID-19 pandemic negatively impacted this measure in recent years. Beginning 2016, childhood immunization status was added to the Quality Incentive Program, which means CCOs could earn incentives for improving performance, and which likely drove improved outreach and workflows. This measure is limited to children who turn two during the measurement year and who have been continuously enrolled in an Oregon Health Plan CCO for at least the 12 months preceding their second birthday, and may not be comparable to immunization rates for the general population.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #31	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = negative result*



Report Year	2020	2021	2022	2023	2024
Plan all cause readmissions					
Actual	10.50%	8.40%	8%		
Target	10.50%	10.50%	10.50%	10.50%	10.50%

How Are We Doing

Hospital readmissions continue to decline in Oregon (lower is better), decreasing from 8.4% in 2020 to 8.0% in 2021. However, 2020 and 2021 data for this measure are not directly comparable to previous years due to a methodology change.

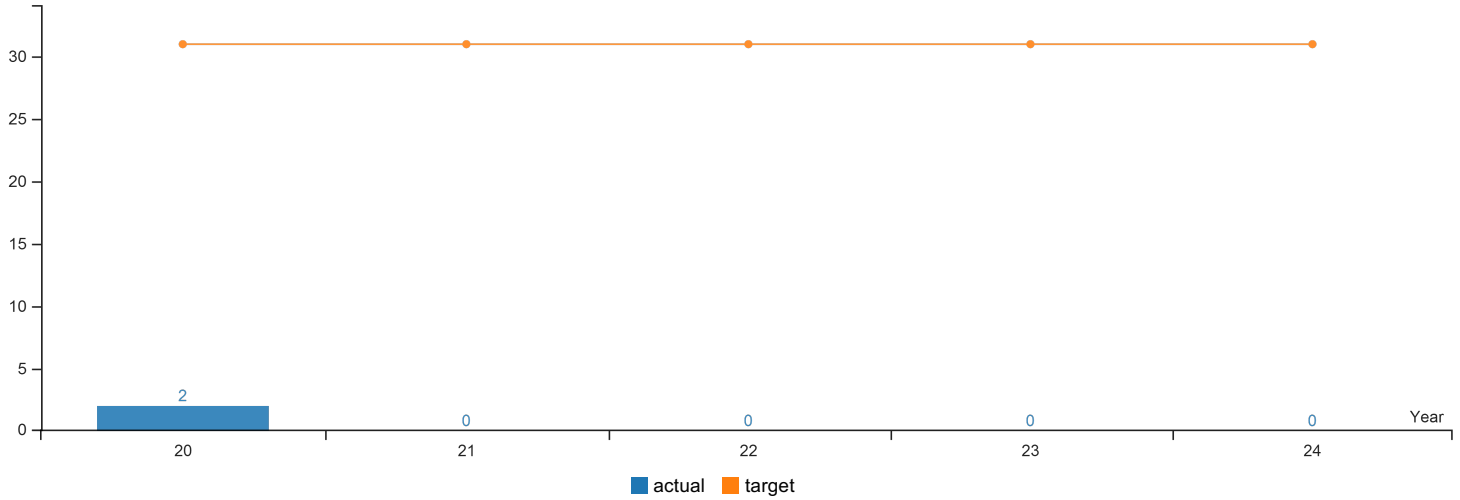
Factors Affecting Results

As CCOs continue to focus on ensuring their members receive the appropriate care at the appropriate time in the appropriate place, many performance indicators are affected. As providers continue to emphasize the importance of coordinated, preventive care, post-discharge care is likely to be more appropriately addressed, resulting in a reduction in this readmission rate.

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #32	ELIGIBILITY PROCESSING TIME - Median number of days processing time from date of request to eligibility determination.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
ELIGIBILITY PROCESSING TIME					
Actual	2	0	0		
Target	31	31	31	31	31

How Are We Doing

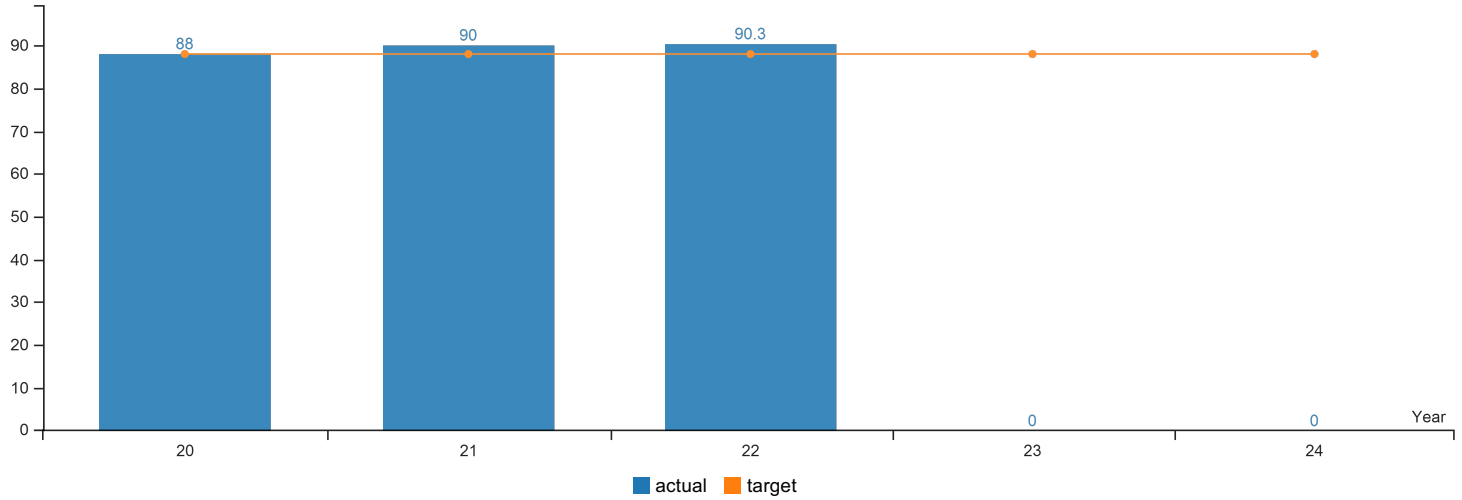
The processing time remains low because Oregon uses an automated eligibility process.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #33	OHP MEMBERS IN CCOs - Percent of Oregon Health Plan members enrolled in Coordinated Care Organizations.
	Data Collection Period: Jan 01 - Dec 31

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
OHP MEMBERS IN CCOs					
Actual	88%	90%	90.30%		
Target	88%	88%	88%	88%	88%

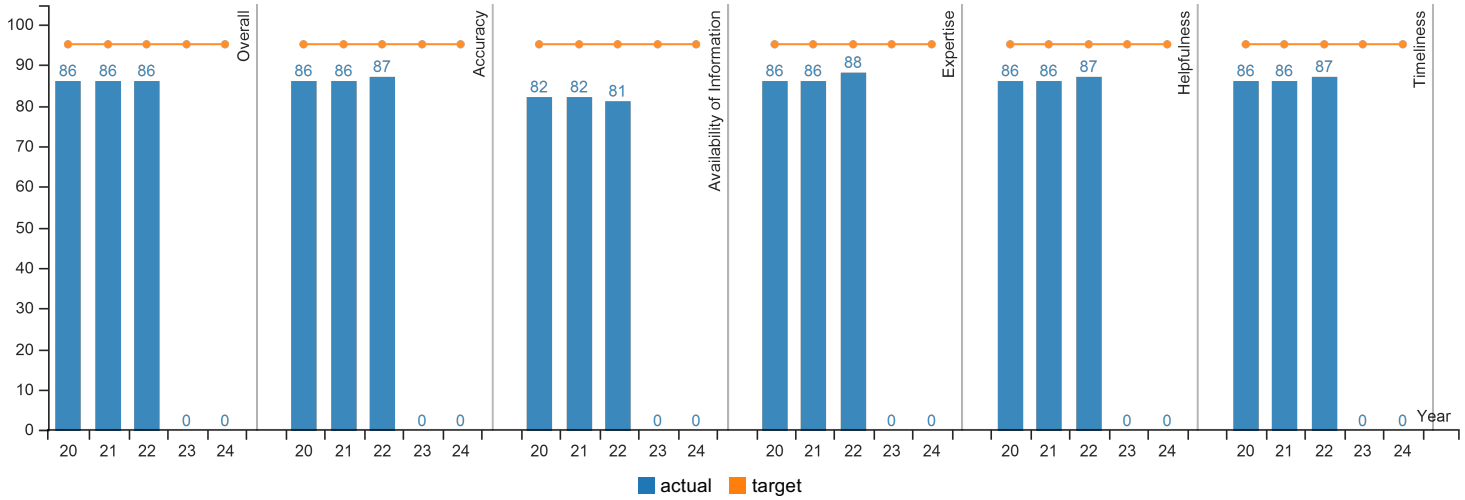
How Are We Doing

In 2021, OHA continued automatic re-enrollment of members into their current CCO. OHA also continued the automatic enrollment of dual eligible members into CCOs for their physical health care. These processes make enrollment in CCOs easier and quicker. As a result, 2021 has the highest rate of CCO enrollment ever.

Factors Affecting Results

OHA is proposing deletion of this KPM as part of our realignment of our legislatively reported key performance measures to those most reflective of our strategic goal of eliminating health inequities by 2030.

KPM #34	CUSTOMER SERVICE - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2020	2021	2022	2023	2024
Overall					
Actual	86%	86%	86%		
Target	95%	95%	95%	95%	95%
Accuracy					
Actual	86%	86%	87%		
Target	95%	95%	95%	95%	95%
Availability of Information					
Actual	82%	82%	81%		
Target	95%	95%	95%	95%	95%
Expertise					
Actual	86%	86%	88%		
Target	95%	95%	95%	95%	95%
Helpfulness					
Actual	86%	86%	87%		
Target	95%	95%	95%	95%	95%
Timeliness					
Actual	86%	86%	87%		
Target	95%	95%	95%	95%	95%

How Are We Doing

Overall: Results are about the same as we continue to provide services fully remote. Percent of members rating quality of service excellent increased quite a bit since last reporting period.

Accuracy: Excellent - 51.86% Good - 35.01%; Results have improved even with continuing to provide services in a fully remote work environment. More members have reported service accuracy as excellent than in the prior reporting period.

Availability of information: Excellent -46.30% Good - 35.03%; Staff continue to work fully remote. We just starting implementing some new communication strategies that should reflect with improved results in the upcoming year. Members who rated availability of information as excellent increased from the last year.

Expertise: Excellent - 54.62% Good - 33.69%; Results have improved since the last reporting period. Especially those rating staff expertise as excellent.

Helpfulness: Excellent - 55.86% Good - 31.42%; More members rated staff helpfulness as excellent over the last reporting period, while overall results stayed about the same.

Timeliness: Excellent - 50.34% Good - 36.98% Overall timeliness results have improved as well as the percent rating it excellent.

Factors Affecting Results

ODHS–OHA
EITGC Project Prioritization | 2023–25

CRITERIA	WEIGHT	SCORING GUIDE	OEBB-PEBB BMS (Benefits Management System) Replacement (OHA)	MMIS Infrastructure Replacement (OHA)	MMIS Program Integrity (OHA)	CM - MOTS Replacement (OHA)	TWIST to Web (OHA)	RPICT Resource Parent Inquiry, Certification, Training (ODHS)	Provider Time Capture (PTC) (ODHS)	HIV-E (OHA)	OVERS ICR (OHA)	Provider Enrollment and Maintenance System (ODHS)	Case Management System (ODHS)	All Hazards Pandemic System (OHA-PH)	Data Governance (OHA)	REALD/SOGI System (OHA - OEI)	State Based Marketplace (OHA-HPA)	1115 Waiver (OHA-HPA)	Mainframe Migration Provider Client Payments (ODHS-Enterprise)	Medicaid Enterprise System (Enterprise)
TOTAL PROJECT SCORE (0-100)			**88**	**88**	**79**	**97**	**79**	**97**	**91**	**91**	**77**	**90**	**87**	**79**	**90**	**93**	**94**	**73**	**90**	**90**
Technology and Strategic Alignment	**35%**	**WEIGHTED SUBTOTAL**	**35**	**35**	**23**	**35**	**23**	**35**	**35**	**29**	**23**	**35**	**35**	**29**	**35**	**35**	**35**	**23**	**35**	**35**
Alignment to Strategic Plans • Does this investment adhere to the Governor's Strategic Plan (Action Plan: User Friendly, Reliable and Secure: Modernizing State Information Technology Systems and Oversight) • Does this investment align with and support the vision, goals, and guiding principles outlined in the EIS Strategic Framework, Cloud Forward: A Framework for Embracing the Cloud in Oregon, Oregon's Data Strategy: Unlocking Oregon's Potential, and the *Modernization Playbook*? • Does this investment align with and support the State of Oregon, Diversity, Equity, and Inclusion (DEI) Action Plan: A Roadmap to Racial Equity and Belonging, the sponsor's agency-specific Racial Equity Plan, and ethical use of data—investing in data justice and representation, visibility, and ethics to serve all Oregonians? • Does this investment optimize service delivery to the public and/or internally by modernizing agency-specific and cross-agency systems? • Does this investment align with and support the agency's IT and business strategic plans, including strategies for modernizing legacy systems? • Does this investment fulfill a legislative mandate, enable compliance with current State or Federal law, or address specific audit findings?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	3	3	2	3	2	3	3	2	2	3	3	3	3	3	3	2	3	3
Technology Best Practices and Priorities • Does this investment align with and support the following enterprise information technology priorities? - ***Information Security***. Improving the security and resilience of the state's systems - ***Modernization***. Optimizing service delivery through resilient, adaptive, secure, and customer-centered digital transformation - ***A Better Oregon Through Better Data***. Leveraging data as a strategic asset—improving data analysis, data quality, information-sharing, decision-making, and ethical use. - ***Cloud Forward***. Enabling Oregon to conduct 75% of its business via cloud-based services and infrastructure • Does this investment align with IT best practices (e.g., cloud-first, modular implementation, agile practices, configuration over customization, open systems, transparency and privacy by design, security principles, and other modern hosting technologies)? • For system modernizations that include data or data systems, has the agency evaluated the current data being collected, its overall quality, and a migration approach if relevant? • Has there been evaluation of the data contained within the system to see if changes need to be made to the data collection itself?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	3	3	2	3	2	3	3	3	2	3	3	2	3	3	3	2	3	3
Business and People-Centered Approach	**25%**	**WEIGHTED SUBTOTAL**	**17**	**17**	**19**	**22**	**19**	**22**	**19**	**22**	**17**	**22**	**22**	**19**	**22**	**25**	**22**	**19**	**22**	**25**
People-Centered Approach • Does this investment put people first—the people who rely on essential services and those working to provide those services? • Does this investment help to eradicate racial and other forms of disparities in state government? • Does this investment improve equitable access to services, programs, and resources, or make the agency's overall service portfolio more accessible or usable for diverse populations? • Does the agency intend to strengthen public involvement through transformational community engagement, access to information, and decision-making opportunities? • Does this investment reduce or eliminate administrative burdens* that have created barriers to access or reinforced existing inequalities for historically underserved and underrepresented communities? • Has the agency utilized the Racial Equity Toolkit within the DEI Action Plan in assessing and planning the project? • If the investment is for agency use, does it improve the agency users' experience?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	2	2	1	2	2	3	2	2	2	2	3	3	3	3	3	3	2	3
Business Process Transformation • Does this investment contribute to business process improvement/transformation? • Does this investment improve service delivery to customers, partners, or other stakeholders? • Has the agency done public engagement, outreach, or an internal evaluation to identify which populations are most highly impacted (positively and negatively) by these business process changes (e.g., considering populations without home internet in creating a digital application process)? • Have measurable business outcomes and benefits been established, including the return on investment if applicable?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	2	1	3	3	2	2	3	3	2	3	3	2	3	3	2	3	3	3
Investment Risk • Would inaction impact systems or solutions that support critical business functions? • Would inaction increase risk to continuity of services to customers, particularly vulnerable or underserved populations? • Are there community impacts of not undertaking this project? • Has the agency identified an inequity or imbalance in service provision that this initiative would resolve? • Is there increased risk if investment is not addressed during this budget cycle (e.g., security, safety, legal, funding source, or any other related risk)? • Does the investment address non-compliance of federal or state requirement, audit finding, or mandate? • Does this investment address an identified and documented highly probable agency risk?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	2	3	3	3	3	3	2	3	2	3	2	2	3	3	2	2	3	3
Agency Readiness and Solution Appropriateness	**40%**	**WEIGHTED SUBTOTAL**	**37**	**37**	**37**	**40**	**37**	**40**	**37**	**40**	**37**	**33**	**30**	**30**	**33**	**33**	**37**	**30**	**33**	**30**
Organizational Change Management (OCM) • Does the investment significantly impact operations throughout the organization? • Does the agency have, or intend to acquire, OCM resources with the skillsets and experience for the size and complexity of the project? • Does the agency plan to address and mitigate impact or adoption risks through a change management plan or intend to follow a formal OCM methodology? • Has the agency identified community engagement or community involvement as a component of the change management process? • Is external outreach or training planned to implement this change with constituents?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	3	2	2	3	3	3	3	3	3	3	2	2	3	**3**	3	**2**	**3**	2
Solution Scale and Approach • Has the agency engaged customers, partners, and communities to understand and structure the business problem, benefits, and outcomes? • Does the investment fully address the agency's business problem, benefits and outcomes? • Is the solution of the appropriate size and scale? • Does this investment adhere to principles in *EIS Cloud Forward* (p.4) or *Modernization Playbook* (p.4), etc.? • Will the agency continue to engage customers and communities to inform design, approach, and usability of the solution?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	2	3	3	3	2	3	3	3	2	2	2	2	2	2	3	2	2	2
Capacity • Has the agency considered skillsets and capacity requirements needed to effectively resource this initiative? • Does the agency have resources with the necessary skillsets and knowledge, or can the agency acquire the resources? • Will this investment impact the agency's ability to deliver on its core business functions? • Has the agency considered capacity for various non-technical resources, including organizational change management, project management, business analysis, testing, communication and community engagement activities? • Does the agency or project environment foster an inclusive workplace culture and promote equitable hiring, retention, and promotion practices?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	3	3	3	3	3	3	2	3	3	2	2	2	2	2	2	2	2	2
Governance and Project Management Processes • Does the agency have formal IT governance in place that will oversee this investment? • Does the investment have executive sponsorship and steering committee in place? • Does the agency employ adequate project governance structure and practices to oversee vendor/contract management, change control, quality control and quality assurance, and data management and usage? • For projects that impact data or data systems, is there a data governance body or other body responsible for data management that is engaged in the process? Is there an agency data lead who is engaged as part of the project? • Are agency DEI staff involved in the IT Governance and prioritization process? • Does the agency intend to involve customer or partner representation on project forums (i.e. steering committees, advisory boards, etc.)? • Has the agency established processes for community outreach, feedback, engagement, or advice in accordance with the Racial Equity Framework and DEI Action Plan? • Does the agency have, or intend to acquire, project management resources with the skillsets and experience for the size and complexity of the project? • Does the agency use mature project management practices (PMBOK)?		**3 - Fully Aligned** (all applicable criteria addressed) **2 - Mostly Aligned** (most applicable criteria addressed) **1 - Partially Aligned** (some applicable criteria addressed) **0 - Not Aligned** (no or very few applicable criteria addressed)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3

References:

*Administrative burdens include learning costs, such as finding out whether one is eligible for a program; compliance costs, such as burdensome paperwork and documentation; and psychological costs, such as the stress and stigma that people feel when interacting with government programs. Health Affairs, Herd, P., Moynihan, D. (2020, October 2). *How Administrative Burdens Can Harm Health*. www.HealthAffairs.Org. Retrieved February 9, 2022, from

Scores
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2
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0

Oregon Health Authority
Audit Response Report

1. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2019, audit #2020-14 (dated March 2020)

- Recommend management ensure year-end accrual methodologies are complete and include consideration of all relevant expenditures.

  During FY21, the SFR unit has reviewed/updated every year-end procedure, including accruals, by going through them as a team so everyone understands the process and what to review.

  The Office of Financial Services has also put together a group from multiple financial units to document the financial processes of each program within the sub-systems, so everyone understands the impacts and needs for accruals. This document includes the financial transactions throughout each step of the process and the year-end financial process.

  We expect to continue this until all programs are completed. Lastly, we have created an accrual template for the program areas that provide the accrual estimates to use in order to clarify our needs.

- Recommend authority management implement procedures to monitor user access and potential unauthorized changes to the application, as well as continue to implement processes to verify the effectiveness and completeness of the claims edits and audits function.

  1. Rewrote the deliverable from Gainwell so that testing results are easier to read and understand.

2. The steps involved in creating and implementing an edit into the MMIS require the interaction of at least three managers: including Medicaid Policy and MMIS Business Support Unit manager approval, and approval from the EDI/Claims manager.

3. Since January 2021, OHA conducts monthly meetings involving managers from Provider Services, Claims, EDI, and BSU to review any claims/EDI issues, including new edits being proposed or developed. This meeting is a checkpoint to be sure that all units impacted by claims edit and audit changes are aware of proposed & pending changes, and to create accountability before implementing a new edit or audit in MMIS.

4. Staff with access to MMIS Edits & Audits is 4.

5. Weekly audit activity reports on the four analysts who can update edits and audits in the MMIS are generated and reviewed by HSD Leadership & Management to monitor activity by the analyst in MMIS to determine if any incorrect actions have occurred.

6. MMIS contains audit tables detailing the activities of users – HSD Management monitors for suspicious activity.

7. The MMIS Business Support Unit is automated or enhanced solutions monitoring of edits.

8. OHA maintains system documentation in the Oregon Project Workbook site, secure for access by management, which serves as project site for MMIS and houses system documentation including details on edits.

9. Documentation from Gainwell shows that between July 1, 2019, and June 30, 2020, that 94 of 116 identified edits were tested. Of the 116 edits, those tested had active paid status. OHA is committed to a clearer presentation of testing results.

10. OHA reviews, on a weekly basis, the claims edits & audits, in MMIS.

- Recommend authority management continue their analysis and correct all incorrect provider payments. It is also recommended that authority management ensure tables are updated timely and accurately when CMS provides updates.

  A correction was made in MMIS to change the incorrect table rate and rule so that future claims will be processed at the proper rate. A total of six System Mass Adjustment Processes (SMAP's) were conducted to pay at the lower rate. The final total amount to be recovered or recouped by the state would be $348,079.

  Decision was made on February 24, 2021, by Medicaid Policy not to reprocess these claims as originally pursued, but instead to let them remain because they will be corrected when they go through the settlement process.

  The programmed rates in MMIS were corrected in alignment with the fee schedule to correct future payments on January 1, 2020. The State assigned a backup to monitor emails from CMS that contain conversion factors to prevent future issues. Having more than one person in BSU subscribed to receive CMS transmittals/updates and watching out for rate changes should reduce/ prevent future errors. The State is not planning on adjusting the 2019 past claims because of a detrimental effect it would have on providers based on the lack of a State Plan requirement that specifies which conversion factors the state must utilize for outpatient claims.

- Recommend authority management strengthen controls to ensure documentation supporting a provider's eligibility determination is retained.

  Starting with the 2020 revalidation cycle, October 2020, the state requires new Provider Enrollment Agreements (PEAs) for all revalidating individuals and organizations. Revalidation is required every five years for all Medicaid providers. This requirement ensures all newly enrolling and revalidating organizations and individual providers will have new or updated

PEA's at the time of enrollment or revalidation. Enrollment and revalidation applications without attached PEA's are no longer accepted. Providers failing to revalidate with a new PEA will be inactivated as a Medicaid provider.

Provider validations may be missed due to the manual nature of the processes. Currently, the state is reviewing missed validation reports no less frequently than monthly to ensure missed validations are corrected at the earliest opportunity. The state continues to check all providers against OIG, SAM and Death Master databases monthly as required. Waiting for a response from CMS in order to update projected implementation to December 31, 2022.

- Recommend department and authority management strengthen controls to perform timely eligibility redeterminations and verification of client income and ensure eligible clients are appropriately enrolled in both Medicare and Medicaid. Additionally, we recommend management provide periodic training to caseworkers to reduce the risk of administrative errors. We also recommend management correct all identified issues and reimburse the federal agency for unallowable costs.

  OHA and ODHS have confirmed with CMS that the requirement to pursue Medicare as a condition of eligibility was not submitted as a requirement of SPA 10-011 filed in 2011 by previous leaders no longer with either agency, however our rules and processes had not been updated. APD is in process of filing Temp rules immediately and permanent rules in October 2022. We anticipate having all gaps tied up by the end of December 2022.

- Recommend authority management comply with subrecipient monitoring requirements, develop and implement internal controls to ensure risk assessments are performed and documented for each subrecipient, and monitoring activities are completed and documented in conformance with risk assessment results.

The Health Systems Division (HSD) has assigned a project manager to assist program area to develop and implement a sustainable process, documentation and grant administrator training package and creating corrective action for remediating the issue and ensuring it does not reoccur.

There is now a documented process and standardized tools to perform risk assessments of subrecipients to determine appropriate monitoring policies. There is also a documented formal process to ensure subrecipients comply with federal regulations, terms, and conditions of the subrecipient performance. However, we are currently piloting this process and tools within a small workgroup, the Grant Management Process Improvement Team, in anticipation of conducting division wide training and implementation by May of 2023.

- Recommend authority management develop and implement controls to ensure performance progress report are complete and accurate prior to report submission.

  There is now a documented process and internal control tool to ensure that performance reports are accurate and complete. Tools are in the final phase of testing and this recommendation will be implemented by January 31, 2023.

2. OHA: Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis audit #2020-32 (dated September 2020)

- Recommend develop and document a comprehensive strategic plan for the agency and Behavioral Health Division. A process to update and report plan progress to governing bodies should be created in tandem. Once established, the plan should be communicated to the public, agency staff, and governing entities.

  Management Response*: OHA agrees with a primary theme of this audit about the importance of aligning agency values, principles, and strategic vision with agency operations. This audit*

illustrates the complexities and gaps that have resulted from lack of a documented and well-communicated strategic plan. We agree with all of the elements of this recommendation, including the need to develop and document plans; conduct regular performance reviews against the plans; report performance to governing bodies; and to broadly communicate all aspects of planning to stakeholders including consumers, providers, staff, the public and governing bodies. Prior to the pandemic, OHA was nearing completion of a strategic plan whose conclusion was that OHA must eliminate health inequities. Our work during the COVID-19 pandemic has confirmed that direction as we have observed inequity in the rate of infection among communities of color, more acute illnesses for those who are infected, and higher rates of hospitalization.

Inequity issues: *As this audit acknowledges, COVID-19 has disrupted OHA operations since early 2020. While that is an important backdrop to some of our responses, the pandemic has also helped OHA staff and partners learn and adapt. Much of that learning, focus and adaptation will inform future strategic planning efforts.*

In addition, the Legislature allocated $25.6 million from the Coronavirus Relief Fund to focus on culturally appropriate behavioral health services during the crisis. OHA is working with Community Based Organizations and stakeholders to better understand how to provide outreach and improve access to meaningful behavioral health services for historically underserved people. Much of our effort involves engaging with stakeholders we have not previously known. These new connections will carry forward after the pandemic to inform our strategic planning.

Consumer voice: *Any strategic plans created for the behavioral health system must center consumers and be trauma informed. OHA must devote time and resources to ensure that consumers can express needs and co-create solutions. We will include people with lived experience in planning from the beginning and embed their participation in processes and procedures.*

As this audit stressed, we must take a trauma-informed approach to all of our work and planning as we create a more culturally and linguistically responsive system of behavioral health services.

Work underway: *The Behavioral Health Director was appointed in April 2019. His initial vision is included in this audit report: Behavioral health services must be simple, responsive, and meaningful. For children and families, the guiding vision is that children can be at home, in school and in their community because they receive the right services, at the right time and for the right duration.*

The behavioral health system does not exist in isolation from other public systems. Decisions made by OHA can affect other systems and, conversely, things happen in other systems that can affect the behavioral health system. We are embarking on strategic planning that is fully inclusive to help all systems function better.

After articulating our initial vision, OHA and the Behavioral Health Director have been working with stakeholder groups, the Governor, the Legislature and various workgroups and committees over the past year to gather input and map a direction for the behavioral health system and its components.

While the audit pointed out that the myriad groups and advisors can be overwhelming, OHA receives important input from people representing diverse interests and perspectives. That input is critical to understanding the implications of the decisions being made in the behavioral health system and in setting effective strategies for system improvement.

Other planning efforts include the strategic plan developed by Oregon's Alcohol and Drug Policy Commission (ADPC). The purpose of the ADPC is to improve the effectiveness and efficiency of state and local substance use disorder prevention, treatment, and recovery services for all

Oregonians. The ADPC and its state agency partners adopted a comprehensive strategic plan. The plan seeks to identify processes and resources to create, track, fund and report on strategies for systems integration, innovation, and policy development; strategies to reduce Oregon's substance use disorder (SUD) rate, including preventing SUD and promoting recovery; and strategies to reduce morbidity and mortality related to SUD. This work intersects with services to children and their families and adults, as people who have SUD often have mental health issues as well.

OHA is committed to the work that is needed to synthesize the results of all these efforts into a comprehensive strategic plan for behavioral health services.

Internally, after the audit was completed, OHA reorganized the Office of Behavioral Health Services. The new structure will allow the office to better focus on strategic planning and data analytics. The structure adds a Child and Family Behavioral Health Director, an Adult Mental Health and Addictions Director, and a Behavioral Health Operations Director, all of whom report to the Behavioral Health Director.

OHA is also integrating performance management into the expected duties and work of all staff.

***Challenges:** As this audit recognizes, the financial picture changed rapidly and unexpectedly upon the arrival of COVID-19. OHA and the behavioral health system started the 2019-2021 biennium with momentum and expectations of new funding after several years of a strong Oregon economy. The Governor and the Legislature established multiple workgroups to begin addressing chronic system underfunding, much of which is called out in this audit report.*

Once the impacts of COVID-19 are fully known, we expect the funding situation to be significantly worse, and we anticipate the need to imagine a system with different financial constraints than we had been planning. We also expect that administrative resources will be

constrained and that we will have to make difficult decisions about what work our staff can support and what will be deferred.

That being the case, it is more important than ever that we plan for, implement and monitor a behavioral health system that is responsive to consumers, children and families when the services are needed and that results in the best outcomes possible.

This audit recognizes the complications faced by people who receive services in a system with multiple funders, multiple stakeholder groups and multiple levels and systems of government, all with differing objectives and requirements. These realities cannot be ignored and must be synthesized during strategic planning to ensure a system that meets the vision of being simple, responsive and meaningful.

***Agency needs:** As this audit report stresses, our current data and analysis capacity is severely limited. Our Agency Requested Budget for 2021-23 includes funding to support data improvement work that is underway. If that effort is not funded, challenges will continue. Without the data improvement, we will not be able to monitor, analyze and track performance and outcomes, as the audit recommends throughout.*

***Update:** OHA has adopted the bold vision to Eliminate Health Inequities in Oregon by 2030. This essential work seeks to recognize the systemic racism and discrimination experienced by communities of color in our in our state and to achieve health equality within 10 years.*

The Behavioral Health director has developed a strategic plan for the Behavioral Health Division of Health Systems Division in line with this larger vision. Over the past year, he has met with community groups and partners across Oregon and has engaged consumers in feedback sessions to build a comprehensive vision for behavioral health. In recent months, the Director has presented

this vision to legislators and interested community members in multiple sessions and is implementing this vision across behavioral health programs.

While OHA has taken steps to address this recommendation and even expanded upon it, it is not yet complete. Next steps include public communication of this information and updates to OHA's website for full transparency.

- Recommend Oregon Health Authority define necessary terms, such as "health" and "mental health," and integrate those terms into all plans and contracts and propose integration into Oregon Administrative Rule and ORS in order to be institutionalized.

  Management Response: *We agree that defining key terms and integrating them into our work and guiding documents will better define the relationship between behavioral health and the broader agency goal of "better health." OHA agrees that we need to revisit our Performance Outcome system and strengthen the behavioral health linkages to the high-level goal of "Better Health." We will engage consumers and other stakeholders in the development of the definitions. With the vetted definitions, we will review our contractual instruments to incorporate the definitions. We will also identify OARs where these definitions need to be clarified and begin rulemaking to incorporate these changes. Finally, we will review Oregon Revised Statutes (ORS) and create legislative concepts that include these definitions as well as other needed changes identified during the strategic planning processes. We will engage a broad array of stakeholders and partners to integrate the definitions into the governance and delivery systems. OHA will craft legislative concepts, rule revisions and contract changes to ensure consistency of terms and definitions used across all ORSs, OARs, procedures and contract instruments.*

  Inequity issues: *We must articulate the most basic element of our strategic vision for behavioral health, or the concept of mental health will remain invisible. Without that common*

understanding, consumers won't be able to find connections to the services they need, and stakeholders won't be able to effectively advocate for needed changes to the system.

Consumer voice: *Acknowledging that mental health is an integral part of health is a trauma-informed action that will support co-creation of solutions with consumers. Definitions should center on the consumers and their experiences and emphasize that each individual defines what constitutes mental well-being. Co-creating definitions will support a responsive and meaningful system.*

Work underway: *OHA staff are familiar with consolidating and synthesizing definitions. During the recent development of Oregon Health Plan coordinated care organization contracts (CCO 2.0), we focused on using consistent definitions in the CCO contracts and OARs. This process has been completed for OAR Chapter 410, and additional work is needed on Chapter 309. OHA is also aiming to provide consistent definitions in its work on County Financial Assistance Agreements.*

Challenges: *Clear definitions will provide the foundation for all of OHA's behavioral health work. Incorporating these definitions into all statutory references, Oregon Administrative Rules (OAR) and contracts will help to prevent the fragmentation that can result from decentralized administration. If everyone is working from the same definitions, expectations will be clearer, and accountability will be easier to institute. That said, it will be complex and time-consuming.*

Agency needs: *OHA will need support and agreement from stakeholders as we develop definitions. Additionally, each governance document or protocol requires specific procedural actions that may require additional champions. Statutory change may be necessary. The support of legislative leadership will be key.*

***Timeline**: Development of the definitions can begin during the next strategic planning phase, as envisioned in Recommendation #1. Implementing changes to governance documents will require calendaring and coordination with contracting, rulemaking and legislative cycles. Target completion of this recommendation is December 31, 2021.*

***Update:** In his 2019 message on Health Equity, The OHA Director defined health as "a positive state of physical, mental, and social well-being and not merely the absence of disease." Additionally, HB 3046 (2021) provided a definition of mental health treatment and services as "the treatment or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the mental health disorders section of the current edition of the a) International Classification of Disease; or b) Diagnostic and Statistical Manual of Mental Disorders."*

In updates to Oregon Administrative Rule and ORS, terms are being addressed and edited over time. Efforts to achieve this goal have been slowed by the COVID-19 pandemic, which stretched resources across OHA. These efforts are ongoing and staff within OHA are monitoring for this issue as any rule changes are considered.

- Recommend Oregon Health Authority Work with the Oregon Health Policy Board and Legislature to review effectiveness and role of councils, commissions, and other advisory boards. Bodies identified as not essential should be considered for dissolution or revised in function.

  ***Management Response:** As the audit report demonstrates, many councils, commissions and advisory boards provide guidance for the delivery of behavioral health services in Oregon. OHA and the behavioral health system have a long tradition of seeking broad-based input and advocacy.*

  Additionally, various system funders, including the federal Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration, and the Oregon

Legislature, have mandated many of the formal advisory bodies. Currently, there are at least 42 of these types of groups established to advise OHA about the behavioral health system. This is an unwieldly number of councils to support, and the important input provided by each group often gets overwhelmed and difficult to hear or extract. OHA agrees with the recommendation that the functions, overlaps and effectiveness of these advisory bodies should be evaluated and addressed.

When the Behavioral Health Director was appointed in April 2019, he quickly realized that he would be unable to devote the hours needed to actively engage with every advisory board within his purview. To prepare for the Governor's Behavioral Health Advisory Council, OHA staff began to identify all the formal and informal boards, commissions and groups advising the Behavioral Health Director. Most of that work is complete. To ensure that consumers and underserved communities are centered, the Office of Consumer Activities Director has taken lead in analyzing the information. Conversations have also been started with several of the advisory groups regarding the question raised in this recommendation.

Inequity issues: *Membership and representation on these advisory groups is often pre-defined by statute and other processes. The groups typically include medical professionals, business executives and other professional-level staff, sometimes combined with other representatives such as family members or consumers. Meetings are generally conducted in English and take place on weekdays in state office buildings. This systematically excludes the voices of unserved and underserved people. In addition, some of the same people fill roles in several groups, which creates less diverse representation. The sheer volume of advisory groups also means that the individual issues identified by any one advisory group or group member may not receive full and meaningful attention from OHA leadership.*

Consumer voice: *OHA will evaluate how each group prioritizes consumer voices and ensure that we are providing the proper, trauma-informed spaces to co-create solutions that are simple, responsive and meaningful as we consider next steps with each council.*

Work underway: *Instead of identifying groups as nonessential, the Behavioral Health Director is taking a holistic look at the groups, their makeup and their missions and how they relate to one another. He is evaluating methods to engage behavioral health stakeholders as a whole and gather information and feedback from them. The goal is to find more efficient ways to synthesize the information and make it available for multiple purposes, including strategic planning, budgeting, troubleshooting, advocacy, and service delivery system improvements. Along the way, OHA is also asking who does not currently have a seat at the table and how to engage those voices.*

Challenges: *Deciding whether to disband or disengage with an advisory body is a difficult one. Understanding the history and needs of each advisory body is critical to deciding how to make it function better or whether to incorporate it into another advisory body or disband it altogether. All these advisors have been convened for legitimate purposes, so it's imperative to understand the implications of changes to the function of those groups.*

Because of the decentralized and fragmented system that currently exists, this multitude of advisory councils is duplicated on every level. Community Mental Health Programs and CCOs and providers all have requirements for advisors at the local level. Often those requirements are prescribed by funders and the legislature. At any level of the system, when advisors convene with the primary goal of meeting a contract or funder requirement, we do not see engagement at the levels intended when those advisory boards were imagined and required.

Agency needs: *OHA needs the groups' membership and stakeholders to understand the goal of the work: to have a better coordinated slate of advisory groups whose voices are heard. We will prioritize this work with a focus on culturally responsive, consumer-centered input.*

Timeline: *This work has already begun and will continue throughout the current and next biennium. Initially, work will focus on providing a trauma-informed avenue for effective input from consumers and underserved communities and be completed by July 1, 2021.*

Update*: Since the publishing of the audit report, OHA has created a new unit within Health Services Division titled the Office of Recovery and Resilience. This unit is charged with coordination of community feedback and participation in OHA councils, policy work, and strategic planning. As OHA embraces the strategic goal to eliminated health inequity in our state by 2030, community voice is seen as more important than ever. The Office of Recovery and Resilience is working to streamline meetings where possible, but also to broaden community input and empower individuals with lived experience to be part of discussions and decision-making.*

A comprehensive list of councils, commissions, and advisory boards has been compiled. Many of these are legislatively required and OHA is not able to make independent changes to these committees and councils. However, the Office of Recovery and Resilience is working to expand the communities involved, and to educate a broader group in ways to participate in these meetings. This work will continue as OHA continues to embrace health equity and the value of lived experience.

- Recommend using the existing stakeholder map presented to Legislature on November 18, 2019, to develop and document a process for maintaining regular stakeholder input. Once the plan for receiving input has been established, it should be communicated across the stakeholder spectrum to ensure coordination.

  Management Response: *As this recommendation points out, OHA has a starting point for compiling information about the formal advisory channels in place. We are building on that list of stakeholder partners. We have significant work left to do to create input channels for the list of stakeholder partners – and partners who may not yet be on the list.*

Inequity issues: *The November 18, 2019, stakeholder map is the compilation of formal stakeholder input channels as of that date. OHA continues to identify and implement new methods for reaching unserved and underserved populations. The COVID-19 emergency has helped OHA better understand and improve communications with key stakeholders who have been historically and systematically underserved. Developing and documenting a process for regular stakeholder input will require flexibility and adaptation as we become more skilled at hearing and centering the voices of those who need or receive service.*

Consumer voice: *OHA must create trauma-informed avenues that support consumer input to OHA and throughout the service delivery system so that we are able to co-create solutions to complex system issues.*

Work underway: *Since that initial list was created, OHA and the behavioral health system have shifted focus to the COVID-19 response. In that shift, we have developed more insight into the needs of stakeholders, including those who currently receive services, those who need service, providers of service, funders, and system managers. We have been forced to get creative about stakeholder engagement, which has introduced us to new ways to engage with the community and put us in touch with new people.*

Challenges*: Stakeholder input is critical at all levels of the system, and different groups need to be engaged with in different ways. Additionally, processes are evolving as we learn and implement trauma-informed approaches to working with various stakeholders and groups. The volume, complexity and ever-changing needs have made documenting and communicating across the spectrum challenging.*

Also, because the system is locally driven and delivered, stakeholder input from all levels of the system and at all levels of the system is critical. This creates the need for a well-functioning web of interrelated communication channels.

Agency needs: *The more we learn from each stakeholder group about the most responsive ways to engage with them, the more effective our communications will be. Communicating across the stakeholder spectrum will require attention, interest and patience from each stakeholder group.*

Timeline: *This work has begun. Anticipated completion is July 1, 2021.*

Update: *Since the publishing of the audit report, OHA has created a new unit within Health Services Division titled the Office of Recovery and Resilience. This unit is charged with coordination of community feedback and participation in OHA councils, policy work, and strategic planning. As OHA embraces the strategic goal to eliminated health inequity in our state by 2030, community voice is seen as more important than ever. The Office of Recovery and Resilience is working to streamline meetings where possible, but also to broaden community input and empower individuals with lived experience to be part of discussions and decision-making.*

A comprehensive list of councils, commissions, and advisory boards has been compiled. Many of these are legislatively required and OHA is not able to make independent changes to these committees and councils. However, the Office of Recovery and Resilience is working to expand the communities involved, and to educate a broader group in ways to participate in these meetings. This work will continue as OHA continues to embrace health equity and the value of lived experience.

- Recommend Oregon Health Authority update outdated policies and procedures that refer to divisions that no longer exist within the agency, such as Addictions and Mental Health, and update all outdated policies, (s)procedures, and evidence-based practice guidelines.

  Management Response: *OHA agrees that imprecise information in the regulatory documents creates confusion at all levels and must be updated. OHA sees a need for a comprehensive*

review of definitions and consistencies across policies and procedures, contractual instruments, OARs and ORS. We have been working to align terminology across OARs, CCO contracts and County Financial Assistance Agreements. As opportunities arise, staff are poised to update other documentation for consistency.

Inequity issues: *Consistency in regulatory information is needed so that people can trust and understand how the various systems work and can be accessed. The system needs to be free of unwritten rules and informal processes, otherwise people who don't know how to navigate these informal channels cannot get access.*

Consumer voice: *Updating and cleaning up regulatory documents is a basic starting point to the process of simplifying the behavioral health service system. With access to accurate and up-to-date information on policies, procedures, and other guidelines, service users will be better positioned to make informed decisions about their care and advocate for their own needs.*

Work underway: *The Office of Behavioral Health Services was recently reorganized. In that restructure, a Behavioral Health Operations Division has been created that has assumed responsibility for this work.*

Challenges: *OHA is a large agency with multiple programs and rules supported by a biennial budget exceeding $23 billion. Statutes, rules, procedures, and contractual instruments change frequently, and the processes that support those changes often have long lead times. Keeping all governance documents aligned requires constant attention, with staff particularly focused on that alignment. OHA is working to improve internal processes to better recognize opportunities to include consistency updates across governance documents. Inconsistencies in policies and procedures and evidence-based practice guidelines make it difficult to establish transparency and accountability in a decentralized system.*

Agency needs: *Changes to statutes and rules require open, public process, so OHA would need participation from stakeholders to ensure that changes fully reflect the needs of stakeholders.*

Timeline: *This work will begin immediately, and initial work will be completed by the end of the biennium, June 30, 2021.*

Update: *This work was delayed due to staffing resource assignment to pandemic response. However, OHA has assigned staff within the Health Services Division to search policies, procedures, and rules for outdated terms in need of update. A list will be compiled and addressed as a comprehensive process over upcoming months. Rules Coordinators are aware of this need and are monitoring for any language updates needed as part of the standard rule updates.*

- Recommend Oregon Health Authority identify data gaps that prevent the tracking of behavioral health performance measures and:

    1. Once identified, develop a plan for addressing the gaps, and communicate the plan and its results to appropriate bodies.

    2. Define benchmarks for children's mental health service performance measures tied to goals and document the methodology used to track the measures with appropriate data.

Management Response: *OHA appreciates that this audit highlights the need we have for a defined set of outcomes and goals. Outcomes are best defined as part of a comprehensive strategic plan, which is currently underway. Once the strategic plan is in place. This in turn will help us better define the needs we have in data collection and administrative data sets used to collect data. But to fully achieve this and several other recommendations, we must secure funding to continue the COMPASS Modernization Project.*

Inequity issues: *We will continue to work to implement data systems that match REAL-D (race, ethnicity, language and disability) data requirements, which are comprehensive. As we work to achieve this goal, it will allow us to better understand and identify inequities and differences associated with underserved populations in Oregon.*

Consumer voice: *Historically, OHA has selected performance measures based on the availability of data from legacy systems. As noted above, this is a poor approach and will be corrected by defining and comprehensive strategic approach to services and using that to define need outcomes to measure progress. For this to be a success, we must engage with consumers and other advocates.*

Work underway: *While OHA does need to define an overall strategy to attach outcomes, we have consulted with national children's System of Care expert Liz Manley. Manley was the chief architect behind the New Jersey System of Care mentioned in this audit report. She will help us define targeted outcomes so we can begin to create meaningful outcome reports. Additionally, as a result of 2019's Senate Bill 1, OHA, Oregon Youth Authority, and Oregon's Department of Human Services are teaming up to create a children's focused data dashboard.*

OHA will incorporate this work into an overarching data collection and outcome process that is inclusive of all the populations served and integrates the work overseen by OHA in the behavioral health system.

At the foundation of our work to improve our data capabilities is the COMPASS Modernization Project.As we reported in our response to our internal audit in December 2019, the behavioral health system has long struggled with data issues. In 2014, the primary legacy system for tracking community behavioral health systems was replaced by the system now in use, Measures and Outcomes Tracking System (MOTS). Due to budget constraints, the MOTS system that was implemented was a truncated version of what was actually needed. Implementation and data

quality issues have plagued the system. As a result, OHA submitted a Policy Option Package for the 2019-2021 budget to replace MOTS. The Legislature approved funding sufficient for the planning phase of the COMPASS Modernization Project. Additional phases will require coordination across all OHA and DHS data initiatives and legislative approval and funding. In the meantime, behavioral health managers have deployed various desktop tools or relied on contracted studies and data collection to assist in managing data for key components of the behavioral health system.

Behavioral health and substance use disorder data is currently underreported by providers due to the outdated, fragmented processes and systems; under-analysis and utilization of the data by the agency is due in part to underreporting and in part to system age and fragmentation. The agency cannot adequately utilize data for required reporting or for analytical purposes that would better promote the Triple Aim.

The COMPASS redesign provides OHA with an opportunity to examine and update business processes and better align to the agency's vision and the continuity of care model. Part of this business process alignment will include the standardization of data fields, validation of business data needs, an evaluation of partner needs, and an analysis of desired inputs and outputs. OHA has the chance to reduce silos and begin integrating data from Managed Care Entities (Coordinated Care Organizations or CCOs) into the behavioral health service delivery model.

The objectives of Compass modernization:

1. *A data collection system to evaluate more timely, appropriate, cost-effective services for Oregonians.*
2. *Reduce the administrative burden on providers and improve care coordination.*
3. *Streamline and update business processes for collection, analysis, and reporting of information.*

4. *Improve the standardization of behavioral health data.*
5. *Collect data to increase the agency's ability to measure and report on behavioral health outcomes.*
6. *Implement a solution that includes data elements necessary for tracking outcomes and providing data for a 360-degree view of the client.*
7. *Establish a platform that can be easily modifiable and expanded to meet evolving needs.*
8. *Provide more accurate and robust data for SAMHSA and Block Grant reporting.*
9. *Reduce use of Excel and paper surveys and improve the data collection efficiency.*
10. *Enable analysis of program approaches and resource allocation efficacy.*

In addition, the resulting system will conform to all standard Privacy and Security requirements.

In addition to work on the underlying data infrastructure, in 2018, OHA implemented the Performance System. This system is about organizational alignment across all agency divisions. The agency identified outcome measures that are quantifiable indicators of the agency's overall performance. Process measures were then created to assess the progress of the work that supports our customers and functions in the organization. Cross-functional collaboration and engagement allows teams with different functions to move toward the same goals. The performance system is data-driven, telling us how our processes are doing. Health Systems Division units are creating metrics for their work, measuring their processes to understand current conditions and setting goals for short and long-term continuous improvement. All units are creating dashboards for essential and priority work. At the quarterly performance reviews, measure owners share the current condition of their unit dashboard, process measures, improvements, and quarterly goals. The agency-wide quarterly performance reviews focus on shared goals and outcomes. Strategic planning recommendations influence the measures highlighted at the agency-wide reviews.

Challenges: *OHA relies on what is currently a decentralized and fragmented system to provide quality data inputs. Providers and subcontractors have varying capabilities and challenges when it comes to synthesizing local data and feeding it into the state-level collection systems. OHA will need to simplify and focus its data-gathering efforts to allow for a comprehensive view of the system envisioned by its strategic plan while keeping the administrative burden on the providers to a minimum. This will be a difficult but important task.*

Agency needs: *To implement the data system development needed to support this recommendation, OHA and OHA/DHS Shared Services will require ongoing state and federal funding support. Additionally, OHA's data needs require staffing and prioritization within Shared Services.*

Timeline: *Work is underway and will continue for at least the following two biennia. Planning and benchmarking to be completed by June 30, 2023.*

Update: *The Child and Family Behavioral Health Unit worked extensively with community partners to identify key indicators of youth mental health and coordinated with Health Policy and Analytics to compile data and create a Unit dashboard for inclusion on the CFBH internet page for internal and public use. Some concerns are ongoing related to reporting from counties and CCO's, and CFBH leadership is coordinating with other parts of the HSD team to address these issues through contracting, CFAA updates, and CCO accountability. However, even though these efforts, many reporting requirements have been suspended during the Covid-19 pandemic to help alleviate administrative burden on counties and provider agencies. The CFBH Unit will provide information as it becomes increasingly available and is committed to being data driven as access to data improves.*

- Recommend Oregon Health Authority develop and deliver a proposal to request additional resources for a data analyst within the Child and Family Behavioral Health Unit.

Management Response: *OHA appreciates how this audit highlights the critical need for quality data and meaningful analysis. The audit further highlights the challenges OHA faces when attempting to identify and support staff skilled in the multiple areas needed to do this work well. While this recommendation is one way to achieve the goal, OHA may need to explore* alternative *solutions.*

Inequity issues: *As this audit report points out, OHA's current analytic capabilities are limited. As such, we often lack information about unserved and underserved populations, systemic racism, and outcomes related to service delivery or lack of service.*

Consumer voice: *OHA must have staff who are able to engage with children and families and direct the analytical questions posed to the data systems. Those staff must also be well-versed in the underlying data that supports needed analyses and have the technology skills to be able to extract and interpret data appropriately.*

Work underway: *Regardless of whether OHA can pursue additional resources, we are determining how to integrate analytical functions into the functions of multiple positions in the Office of Behavioral Health. Recent reorganization of the office creates a specific unit with focus on Medicaid, Policy and Analytics.*

Longer term, through the COMPASS initiative, we are also looking at newer types of technology and platforms such as Behavioral Health Data Warehousing and the cloud to identify methods to get more accessibility to system data.

Challenges: *OHA and other state agencies now face significant budget challenges. Considering those constraints, it is not prudent to expect to receive funding for additional administrative staff. We will likely need to develop an alternative method to meet the goals of this recommendation.*

This audit reveals that the decentralized and fragmented system creates real challenges when it comes to understanding all the complex program and data interrelationships. These issues are further exacerbated by confidentiality and identification issues that create real barriers to data sharing.

Recruiting, training, supporting and supervising staff who have information technology skills coupled with multi-system program understanding would be difficult regardless of where staff sit in the organizational structure.

***Timeline**: The work of enhancing the analytic functions within the Office of Behavioral Health Services has begun and will include submission of a proposal for an analyst position by June 30, 2021.*

***Update:** A proposal for an additional data analyst was delivered, and funding for an additional dedicated position for the CFBH Unit was authorized through HB 2086 (2021). The position was posted in November 2021 and interviews were held in December; it is hoped that this position will be hired early in 2022.*

- Recommend OHA leverage data analysts in the Health Policy and Analytics Division and resources in the Child and Family Behavioral Health Unit to determine the extent to which Medicaid claims data can be used to accurately identify and track the number of children receiving mental health services statewide and outcomes.

  ***Management Response:** Even considering the data and analytical challenges described in this audit, OHA does have a wealth of information available through the Medicaid Management Information System (MMIS). OHA agrees that we can do more to extract and analyze data from the Medicaid system to make assessments about how many children are receiving services and their health outcomes. In consultation with national children System of*

Care experts Liz Manley and Shelia Pires, OHA staff are working on a project to determine what Medicaid claims data can be used to identify and track children receiving mental health services statewide and define targeted outcomes. This project work will overlap with the Senate Bill 1 data dashboard project team (DHS/OHA/OYA) and the work that is currently underway.

Inequity issues: *Through regular review of information about service delivery, we can begin identifying patterns in service utilization. These patterns can serve as proxies that will bring us closer to understanding inequities faced by certain children and families in Oregon.*

Consumer voice: *As we identify service patterns and outcomes, children and families will be equippedwith information to help us co-create system solutions and identify trauma indicators.*

Challenges: *We will continue to face challenges with the massive scale of the data that is submitted through a centralized and fragmented system. All conclusions must be considered carefully as there are many nuances to the data. Developing careful understandings about how the data was extracted and for what purpose is significant to interpreting results. Also, the sheer size of MMIS, coupled with the data submission rules that must allow adequate time for service providers to submit and time for correction mean that the data system is fluid and subject to change well after the dates of service.*

Update: *This work is ongoing but is being delayed due to reporting pauses as part of the Covid-19 support for CMHP's. Additional data analysis support within HPA will help make this work possible when reporting resumes.*

- Recommend OHA formalize agreements with DHS to help assess the ongoing needs for intensive mental health treatment services statewide and track performance measures of mental healthservices for children by foster care status.

Management Response: *This audit report appropriately highlights the critical relationships between OHA and DHS in supporting the needs of children in foster care. Oregon's System of Care partners are guided by the vision that children can be at home, in school and in their community because they receive the right services, at the right time and for the right duration.*

OHA and DHS are working together on a project that will identify and prioritize cross-system interventions to better serve children in foster care and children and families in Oregon. This project will address access, Medicaid services, eligibility, and capacity-building.

Inequity issues: *OHA agrees with the audit report's conclusions that without behavioral health performance measures for children in foster care, we risk perpetuating programs and levels of care that are not culturally and linguistically responsive, may be of low quality and may not meet the needs of the children who receive treatment.*

Additionally, as the audit report highlights, OHA's mechanism for tracking children's intensive service capacity has not worked as intended, and data resulting from it is incomplete. This limits our ability to see inequity in access and identify the barriers children and families are experiencing.

Consumer voice: *In collaboration with youth and families, OHA and DHS must together support a system that meets the behavioral health service needs of children in foster care. Too many times, children and their families, especially children being served in foster care, have struggled to access services in a system that is difficult to navigate, non-responsive to their needs, that forces them to endure long waitlists for intensive services, and that too often results in inappropriate placements and emergency room use for behavioral health intervention. OHA and DHS must work with system users to co-create solutions to these and other challenges.*

Work underway: *OHA and DHS have a combined Psychiatric Residential Treatment Services (PRTS) Capacity Building Project that will create a needs assessment and develop strategies to build and monitor this intensive level of behavioral health capacity. OHA has drafted a POP for the 2021 Legislative Session requesting funds to expand this capacity. To date OHA has developed seven new PRTS beds and continues to work with existing and new providers to increase capacity at this level of care.*

OHA and DHS have committed to:

- *Engage PRTS providers, CCOs and commercial insurance carriers to identify future state options for Oregon recognizing collective resources and knowledge.*
- *Identify start-up funds needed to help offset one-time costs for developing additional capacity.*
- *Develop programmatic and policy change recommendations that would encourage and support capacity development and operational sustainability.*
- *Track provider outcomes and ongoing system capacity needs.*
- *Review current services with an equity lens and make recommendations to ensure culturally specific service delivery is occurring.*
- *Explore funding models to ensure capacity is available when needed*
- *Coordinate with the System of Care Advisory Council with an analysis of the current continuum of care and develop long-term recommendations for the appropriate settings needed in Oregon.*

DHS and OHA are developing recommendations by December 31, 2020, for capacity, policy changes and budget to adequately build a service array for children specifically served by the child welfare system.

In addition, OHA, DHS, and the Oregon Youth Authority (OYA) are building a Children's System of Care Data Dashboard that will show the continuums of care in OYA, Child Welfare and Behavioral Health and how they overlap for children. Dashboard elements will include utilization, youth involved with multiple systems, and much more to inform policy and program development moving forward.

OHA and DHS will be working together with the System of Care Advisory Council and national experts to define performance and outcome measures to be tracked to support and monitor the children's continuum of care.

Rates were increased for PRTS and Subacute Service on July 1, 2019. The intent of the rate increases was to support the current provider network and potentially attract new providers to the system.

***Challenges:** As this audit highlights, OHA and DHS have faced many challenges in getting to this point. Some of the barriers to success include:*

- *Crises and lawsuits driving system and policy focus rather than data and outcomes;*
- *Inadequate staffing and financial resources to support and focus on this work;*
- *We have not yet identified the specific outcomes to measure;*
- *As the audit points out, the capacity tracking system has not worked as envisioned;*
- *Development of inpatient care can be expensive and takes time;*
- *Need for additional financial investment into the Children's System of Care;*
- *Lack of funding appropriated to capacity retention and expansion (especially for inpatient levels of care;*
- *Children's service capacity development has been reactive and happening separately (Behavioral Health, Foster Care, Behavioral Rehabilitation Services);*
- *CCOs are responsible to ensure the provision of children's behavioral health services.*

This has led to confusion about which organizations maintain lead responsibility for capacity management and expansion, especially for statewide services such as Psychiatric Residential Treatment Services;

- *Minimal demographic data in the MMIS system to support racial equity evaluation.*

The children's behavioral health system is decentralized and locally managed through the CCO model. While OARs give some structure to the services, the infrastructure does not support the notion of "no wrong door" for children and families needing to access care. This is especially challenging for children in foster care who are supported by case workers and system partners throughout the state, navigating 15 different continuums of care with different access points.

***Agency needs**: To successfully and systematically monitor performance measures of mental health services by foster care status, OHA and ODHS would benefit from support from the Oregon Enterprise Data Analytics (OEDA) unit. The 2015 Oregon Legislature created the OEDA unit to conduct inter-agency research. The legislation encouraged the expansion of data-informed decisions throughout state government. The research analysts, economists, and information technology positions work among agencies to translate data into information; that information promotes data-informed decisions and improves outcomes for children and families. OEDA uses advanced analytics with human service organizations, health organizations, public health organizations, corrections, the courts, employment, housing, and education. The current projects include use of predictive analytics for health risk, identifying nongraduates during elementary school, differentiating Self-Sufficiency client groups to better serve the highest risk families, developing staff engagement surveys to recognize staff most likely to leave ODHS, algorithms identifying children at risk for temporary lodging and out-of-state placement, and developing data sharing agreements among agencies.*

OHA staff from the Child and Family Behavioral Health Unit will reach out to OEDA to determine what support may be available to help implement this audit recommendation.

***Timeline**: Work is underway and will continue through 2021.*

***Update:** Intra-Agency meetings have been held to review the direction for this formalized agreement, and an agreement has been drafted. It is anticipated that the agreement will be finalized by March 2022.*

- Recommend OHA develop and document shared guidance on the methodology that will be used to track performance measures and communicate that to all stakeholders, including CCOs and providers.

  ***Management response:** OHA agrees that clear communications and guidance are critical as we seek to improve transparency about the methods that support our performance measures. We will continue to move forward with the CCO Compliance Project described below and refine our measures in the OHA Performance System.*

  ***Inequity issues:** Shared understandings about how systems will be evaluated improve transparency and accountability. This frees us to ask probing questions about the meaning of performance results. Understanding and communicating underlying methodologies allows advocates to highlight systemic barriers and racism inherent in those methodologies. Without the option to evaluate those methods, stakeholders and decision makers may have differing interpretations of the results.*

  ***Consumer voice:** OHA believes that this recommended guidance will provide consumers, children and families with helpful information about how well our measures reveal whether the system is simple, responsive and meaningful. Understanding exactly what is being tracked*

and why, and knowing that key stakeholders have the same understanding, provides consumers and families with tools needed to ensure transparency and accountability. Also, to the extent the guidance reveals inadequate measures, consumers and families will be in a stronger position to advocate for system improvements.

Work underway: *OHA has been working on several initiatives that relate to this audit recommendation. We are working on what we call the CCO Compliance Project, which addresses this recommendation across all CCO requirements. We developed a standard process for submission of CCO deliverables. We have a framework to track each deliverable for each CCO based on a variety of factors, including timely submission, level of completion and an evaluation of quality. We still have work to do to refine and finalize this work, and ultimately work is needed to effectively communicate it with stakeholders.*

This audit report also alludes to the OHA Performance System that we have been building for the department. This has been a multi-phase, cross-departmental effort and is described in a previous response. We continue to refine the measures and reporting. For the programs within Health Systems Division, including Medicaid and Behavioral Health, managers meet quarterly to review progress in establishing measures and evaluating performance. We still have work to do to finalize the performance measures and to communicate to stakeholders.

Challenges: *To make a meaningful assessment of whether people are receiving services that are timely, meaningful, and responsive performance and outcomes must be measured from various vantage points. Data-sharing across agencies is often useful in helping determine the performance of our system. At the same time, some data, if used incorrectly, can be incriminating. Much of that data is managed by other agencies that are governed by strict data confidentiality rules. Also, there are technical challenges inherent in matching disparate data sets. Some service systems collect data for different purposes than OHA does, so matching information is structurally complicated. Oregon does not have a Master Client Index that*

allows us to follow the services people and families receive, and there are ethical considerations when evaluating outcomes across systems.

The current decentralized, fragmented system means that there will be multiple areas for which performance measure guidance will need to be developed, documented and shared. OHA is currentlyresponsible to administer multiple performance measure systems. Communicating the underlying methodologies to key stakeholders can be confusing without adequate synthesis and interpretation.

***Agency needs:** To best implement this recommendation, OHA would need data-sharing agreements with other agencies, plus the underlying technical support from their staffs to extract and share information with us. Additionally, the COMPASS Modernization Project described earlier in this response is key to success with this recommendation. If that project is not funded, OHA will continue to struggle with the most basic data issues. Even if it is funded, OHA and our system partners will have a great deal of work to do to resolve deeply rooted, systemic data challenges.*

***Timeline:** Work has been underway and continues to be refined by OHA staff. Anticipated completion date is December 31, 2021.*

***Update:** HB 2086 (2021) provided direction for a Behavioral Health Metrics Committee, which has been formed with a diverse group of community partners and individuals with lived experience. This group is completing recommendations for appropriate metrics for behavioral health services. While much of this work is aimed at adult services, the CFBH team is coordinating efforts to align efforts across the lifespan.*

A team within HSD has been assigned to this body of work, and several staff have been hired to lead the efforts. Performance measures are written into the CCO 2.0 contracts, and accountability

for CCO entities includes reporting, grievance monitoring, coordination within HSD to determine CCO compliance with contracted requirements. Health equity is an essential part of this work, and OHA is closely monitoring CCO actions to address health equity in their regions, including equitable distribution of resources, tracking of REAL-D information for members, community input into services, and maintaining a robust system of care.

- Recommend OHA clarify expectations for reporting through a robust set of instructions, similar to the technical manual provided by Washington's Health Care Authority.

  ***Management Response**: OHA respects that clear expectations are important. While on its face, this recommendation would seem straightforward, there are differences between how the Oregon Health Plan is structured and how Washington State's Medicaid Program operates. OHA does not believe that this recommendation can be implemented as written. However, OHA does agree that we must continue to improve and clarify our written guidance, contract language, reporting requirements, and data submission instructions throughout the system.*

  The Oregon Health Plan Behavioral Health covered benefit is detailed on a prioritized list of conditions paired with effective treatments. Oregon's CCO model requires CCOs to understand the communities they serve and to tailor delivery of the benefit for the community. This model means that the fine details of rates and billing code requirements are not set statewide. Details for the state's Fee-for-Service (FFS) program are in OARs and on the published FFS fee schedule. CCOs are held to account through a capitation model (encounter claims history is factored in) and metrics. The state monitors complaints of all types and follows up. There is also an audit process that monitors patterns in services and can serve as a means of accountability and quality improvement when issues are discovered.

Operationalizing the CCO 2.0 contracts will also help clarify reporting requirements inside the framework of our more flexible system.

Inequity issues: *A statewide billing code standard would reinforce the inequitable status quo, which doesn't align with stated goals of our waiver with the federal Centers for Medicare and Medicaid. The state's current flexible model is necessary to address inequities in services unique to each community across the state. But much more work is needed in this area. The state must maintain sustained focus on identifying and eliminating differences to ensure that services as needed are available across the state. OHA must also make sure CCOs use the flexibility we give them to achieve this essential outcome.*

Consumer voice: *Consumers are one step removed from this issue, but they are impacted by it. This issue is about the details of billing between providers and payers (FFS and CCOs). Consumers' interest would not be best served by a statewide billing guide. Consumer interests are best served when the state ensures their voices influence CCO policies including billing details, the policies guiding those services, and the outcomes achieved through the services and policies.*

Work underway: *OHA revised the CCO contracts (CCO 2.0) to require much stronger oversight. OHA is building the team and defining the deliverables to operationalize these requirements. This work that will ensure OHP members receive quality well-coordinated behavioral health care. Some of the billing code detail is defined in the metrics. Additional details may be included as each CCO deliverable is defined with an initial focus on access to services across all populations.*

Challenges: *Oregon's transformation model works to reduce fragmentation at the community and CCO level. A statewide billing code standard could interfere with this work. OHA needs to continue consolidating and creating a cohesive framework associated with Behavioral Health services. This will create direction for the system and reduce current fragmentation.*

Agency needs: *OHA needs sustained direction and focused resources to achieve the goals outlined.*

Update: *OHA does not feel that the Washington system is similar enough to Oregon's system to use the manual as a template for Oregon. However, this work is being addressed through CFAA innovation and revision, and contracted organizations will be provided with clear instructions for reporting.*

- Recommend OHA develop and document a process for verifying that data submissions used to track performance measures are timely, complete, and accurate. Once documented, establish a policy for the process to hold stakeholders, including CCOs, accountable fortimely, complete, and accurate data submissions and communicate the policy to all parties.

  Management Response*: OHA agrees with a primary theme of this audit about the importance of high- quality data to support decision-making. This audit recognizes a long-standing challenge within the behavioral health system, which is lack of timely, complete and accurate data. There are legitimate systemic reasons why this is the situation, and OHA continues to work on developing the ability to find cost-effective levers that result in improvements.*

  Inequity issues: *As so many of our responses have indicated, lack of timely, complete and accuratedata means we struggle to identify indicators of systemic inequity and, thus, struggle to eliminate these inequities.*

  Consumer voice: *Similarly, working without reliable data makes it extremely difficult to be adequatelyinformed to co-create trauma-informed system solutions with consumers and families.*

Work underway: *OHA has several efforts to support behavioral health agencies' ability to collect and share client-level information, which is an important part of data quality and accountability. OHA conducted an in-depth Health Information Technology (HIT) scan focusing on behavioral health needs and convenes a Behavioral Health HIT Workgroup to recommend strategies and oversee OHA's work. In particular, OHA supports adoption of certified electronic health records through federal Promoting Interoperability incentive payments and technical assistance to providers. OHA supports health information exchange efforts that have significantly increased behavioral health providers' ability to coordinate care and access information about their clients' hospitalizations and use of emergency departments. These data are critical for behavioral health providers' ability to meet OHA's expectations for performance, manage their clients proactively, and improve the quality of their care.*

OHA also holds CCOs accountable through the CCO quality incentive program to address disparate use of emergency department visits for their members with serious mental illness. OHA supports CCO and behavioral health agencies in this metric by providing a flag for CCO members with serious mental illness. The goal is to let CCOs and behavioral health agencies to know, in real time, when these individuals are in the emergency department, which will help inform care management and coordination efforts. Providing this simple yet critical data enables CCOs and behavioral health agencies to act quickly to address the needs of members with mental illness – and ultimately drives outcomes that positively impact CCO metric performance.

OHA is in the midst of a substantial redesign of the underlying data systems and warehouses that support performance measures. OHA is also currently working with CCOs on the CCO Compliance Project across all CCO deliverables.

Challenges: *This issue is driven by the decentralized and fragmented system. Providers regularly struggle with data-reporting requirements. Much of that struggle is the result of conflicts between local electronic systems and OHA's complex information technology requirements. Some of it is driven by needs for various data elements to meet billing requirements versus licensing requirements versus clinical requirements. Some is driven by accounting requirements.*

Timeline: *OHA has begun this work and will continue to make improvements in data monitoring processes. Improved technology will be an essential in making data collection, analysis and reporting feasible in ways it isn't currently. Anticipated completion of June 20, 2023, but dependent on anticipated technology enhancements.*

Update: *Efforts to address data submission have been delayed due to the Covid-19 pandemic due to workforce shortages across the sector. Reporting has been paused for most entities to reduce administrative burden for providers. However, OHA remains committed to accountability across the system, and is working to revise and expand data expectations across the system.*

A CFAA Revision framework is underway, including discussions with county representatives, community input, and streamlining CCO and County contracting. These revisions will include accountability standards for data submissions and sustainably maintaining data submission requirements over time.

- Recommend OHA collaborate with System of Care stakeholders to perform a systemwide needs assessment for the children and family continuum of care, including: Wraparound, secure inpatient, residential, and intensive support.

  Management Response: *A 2017 OHA/DHA Continuum of Care Project explored recommendations to support the child serving systems. The recommendations were*

supported by extensive stakeholder engagement and feedback. The three selected projects included: State System of Care Infrastructure Implementation, Trauma Informed State Agencies and Intellectual and Developmental Disabilities- Mental Health (IDD/MH) Improvements and Capacity. Many objectives have been completed, including the work through Senate Bill 1 and both OHA and DHS developing Trauma Policies. This work continues.

In March 2019, the Child and Family Behavioral Health Unit developed a vision that will be used to launch the statewide needs assessment recommended here. Staff have reviewed and summarized previous needs assessments, audits and reports and are incorporating that work into the ongoing vision and policy direction.

***Inequity issues:** Oregon lacks a full spectrum of mental health supports that meet youth and family's needs in a culturally responsive manner across Oregon's Black, Indigenous and People of Color (BIPOC) communities. Many of Oregon's nine federally recognized tribal members remain on Open Card OHP benefit that provides them less access to providers and services, including Wraparound for children and families. This inequity impacts Latinx and immigrant communities getting access to a continuum of care that meets their cultural and linguistic needs. When conducting the needs assessment, it will be essential to engage with individuals from these communities to identify needs and challenges and co- create culturally responsive solutions.*

Oregon also struggles to provide a continuum of care in rural, frontier and urban areas of the state. Mental health promotion and prevention efforts have historically been limited statewide. Higher-level care options are mostly in urban areas, while rural and frontier communities do not have access to needed services and supports. A more specific inquiry into how social determinants of health is impacting children's behavioral health supports, and how that can be alleviated, is warranted.

Consumer voice: *To adequately and accurately conduct a needs assessment across the continuum of care, it is essential to center the voices and experiences of youth and families. This approach is especially critical when identifying the needs of historically marginalized or underserved communities, including those who are Black, Indigenous, or other people of color, and Oregon's rural and frontier communities. Meaningful consumer participation will be prioritized throughout the needs assessment process.*

Work underway: *The outcome of the work outlined above will guide the work of the Child and Family Behavioral Health Unit's five-year plan.*

In the 2019 session, funds were allocated to support the development of Intensive In-Home Behavioral Health Treatment (IIBHT) services. These critical services help alleviate many of the concerns addressed in this audit, including bridging the gap between emergency room use and the need for intensive services that do not require a psychiatric residential treatment level of care. IIBHT offers support in the home to children/youth and their families. A framework for the implementation of these services has been created: OARs have been filed, stakeholder engagement has been sought, a series of webinars for potential providers have been conducted, funding mechanisms are established.

Much of the related work has been outlined in other responses, and in addition, OHA and DHS are working with the Governor's Children's Cabinet and participating in a subcommittee with members of the Statewide Child Welfare Oversight Board to develop and manage a workplan to ensure the integration of new service development with an efficient and comprehensive system of care for children. Also, OHA is supporting DHS's Family First Prevention Services Act by implementing new requirements for Qualified Residential Treatment Programs (QRTPs) and prevention models.

Challenges: *Child-serving systems, service providers, and families and youth recognize that Oregon lacks a fully coordinated, effective network of services to support Oregon's more than 2 million children. More than 20,000 of these children are being served by multiple systems. The Governor and Legislature have established several initiatives to address this system challenge, including the Children and Youth with Specialized Needs Workgroup (2018), the Governor's Behavioral Health Advisory Council (2019–2020) and the statewide System of Care Advisory Council (Senate Bill 1, 2019).*

National best practice for System of Care shows early intervention for children's behavioral health crises is a cornerstone of a strong, effective System of Care. Oregon's current service array does not support early intervention, nor does it adequately serve young people and families when they are in crisis or after they have stabilized. Additionally, there is a lack of cross-system collaboration, flexibility and responsiveness, which results in avoidable crises and inappropriate placements, including for children involved with child welfare. The current system lacks a clear delineation of roles, responsibilities and accountability around emerging and urgent issues for children and families experiencing intensive behavioral health needs and has neither the capacity nor a sustainable funding structure, to keep them in a family setting and in school.

The services and supports for youth that are involved in child-serving systems span a broad range dependent upon CCO and local county capacity. For youth with complex mental health needs involved in child-serving systems, CCOs provide Wraparound and Intensive Care Coordination; however, these coordination models do not provide direct access and coordination to other child-serving systems. Thus, barriers still exist for children and youth with complex needs. This often means that the system is reactive to children and families rather than proactive and responsive.

Oregon lacks sufficient community-based services and placements, and emergency rooms may be boarding youth with mental health issues who do not have access to treatment, or for some, a

place to live. Families are navigating a service array that is inconsistently available, with waitlists for psychiatric residential treatment services, medication management and outpatient services. It often does not consistently include respite, peer delivered services, or child-focused mobile crisis response and stabilization. Mobile crisis response is extremely limited in Oregon and could alleviate cross-system barriers by providing timely identification and contributing to co-created solutions in a manner similar to that accomplished by New Jersey.

Agency needs: *OHA needs:*

- *Increased opportunities for meaningful youth and family involvement and consumer co-creation.*
- *Partnership with the other child-serving agencies to complete a full system wide needs assessment to ensure impact and feedback includes school, juvenile justice, child welfare and intellectual and developmental disabilities.*
- *Continued national consultation to determine the right questions to ask our communities to get at system level structure and policy changes needed. A targeted look at racial equity across the current mental health continuum of care needs to be conducted and documented.*
- *Support from CCOs and outpatient providers statewide to ensure that prevention and proactive levels of care are represented.*
- *Collaboration and support from related advisory councils to participate in a robust needs assessment.*
- *A significant investment into data systems and development of measures/performance indicators needs to occur led by OHA but developed with extensive stakeholder input and direction.*
- *Legislative investment for OHA to be responsive to the children's continuum of care.*

Timeline: *Systemwide Assessment to be completed October 2020-October 2021*

Update*: The CFBH Unit met with family and youth community groups, tribal representatives, providers, and other community groups to develop a policy vision paper. This plan was finalized with OHA leadership and approval of the Children's System Advisory Council in 2020. The Unit has developed a five-year plan to implement this vision, including the full continuum of youth and young adult care in Oregon. Final communication of this plan through the CFBH Unit website and presentations is upcoming in early 2022.*

- Recommend OHA utilize stakeholder input to develop and determine the methodology used to assess statewide emergency department boarding, with separate reporting for children and youth boarding and frequency, and pursue measures needed for consistent implementation. The methodology should be documented and maintained by the Behavioral Health Division.

  Management Response: *OHA has long been concerned about inappropriate or excessive use of Emergency Departments (ED) for children and adults who need behavioral health services. Additionally, we recognize that it is crucial to engage people into appropriate services upon discharge from EDs. In an agreement with the U.S. Department of Justice, we have prioritized ongoing study, evaluation and improvement of this issue for adults with serious and persistent mental illness. For children, we have made and will continue to increase investments in services to help reduce overall ED utilization. We recognize that we still have work to continue to address this issue.*

  Inequity issues: *National data shows 1 in 5 young people experience diagnosable mental health conditions in any given year. In the last three years on average, 8,250 Oregonians on the Oregon Health Plan ages 0 to 25 with behavioral health diagnoses were treated in EDs. In 2018, there were over 7,600 young people in foster care, and of these young people, 60 percent experienced a disruption in their foster home that led to the need for a new foster home,*

placement in a shelter or going to an ED. An emergency department's primary role is to address physical and not behavioral health needs, and they are adult oriented. This lack of specialized expertise to respond to and successfully stabilize children and youth experiencing a behavioral health crisis often leads to an extended stay in an ED or discharge without effective safety planning. Children in foster care are overrepresented by our BIPOC communities.

With the increased potential for trauma response in the wake of the COVID-19 pandemic, all young people are at risk for added stress. Safety and health are a top priority during this unique time of physical distancing, and this need poses significant interruption in daily routines that impact access to support and care. Physical distancing is also disruptive to normal growth and development, particularly for older children and teens who are learning about appropriate relationships and need interpersonal support. Children and teens will be disproportionately impacted for months and years to come, even after a vaccine is found and particularly with the prospect of future outbreaks. This will heighten existing mental health symptoms and create additional symptoms, including post-traumatic stress disorder.

These additional stressors will contribute to increased risk of abuse and neglect as people experience overwhelm and isolation. This has been previously measured and documented in areas experiencing natural disasters. Among the top concerns are Oregon's most vulnerable youth, who are at risk, or already living in a foster home.

***Consumer voice:** The development and implementation of this methodology will be informed by input from consumers, including youth and families. Consumers can provide guidance on collection and assessment of data. Consumers can also provide insight into any trends in data, give context for the information gathered and advise on actions to be taken based on the data collected.*

Oregon's current service array does not support early intervention, noted elsewhere as a national best practice, nor does it adequately serve young people and families when they are in crisis or after they have stabilized. Additionally, there is a lack of cross-system collaboration, flexibility and responsiveness that results in avoidable crises and inappropriate placements, including for children involved with child welfare. The current system lacks a clear delineation of roles, responsibilities and accountability around emerging and urgent issues for children and families experiencing intensive behavioral health needs and has neither the capacity nor a sustainable funding structure, to keep them in a family setting and in school.

***Work underway**: OHA's 2021-23 Agency Requested Budget includes a policy option package (POP) to implement Children's Mobile Response and Stabilization Services (MRSS). MRSS is a prevention program specifically designed to support children and their families and/or caregivers before situations turn into a crisis. This trauma-informed program will also provide support to children and their families in their home, their schools and in the communities.*

Evidence from other states shows that MRSS services and supports dramatically increase the stability of youth residing in foster homes. Further evidence shows MRSS can successfully decrease police involvement and emergency room use, while providing treatment to youth and their families in their home and community.

Other programs OHA has implemented and expanded to support ED diversion and accessing appropriate levels of care:

- ***Crisis and Acute Transition Services (CATS)** are designed to provide a community-based alternative to emergency department "boarding" for children, youth and young adults in need of acute psychiatric treatment who are awaiting inpatient psychiatric hospitalization. The program includes and requires brief crisis services, stabilization, and transition to community- based supports and services when individuals from birth through age 18 present to emergency*

departments or crisis center and are at risk of admission for psychiatric or behavioral crises. Programs must serve all individuals presenting in the settings indicated above, including those with public, private, or no insurance. The CATS program has served over 1,300 youth and their families in nine counties in 2019. Approximately 78 percent of youth are discharged from the emergency department within 24 hours, and 92 percent within 48 hours.

- ***Fidelity Wraparound*** *is an intensive care coordination model and a fidelity process that supports young people and their families with complex behavioral health needs who are multi- system involved. Wraparound is a voluntary process, guided by youth and their families, that connects them to the supports and services needed to improve health and wellbeing. Wraparound reduces the use of emergency rooms, higher levels of care, reduces episodes of psychiatric hospitalization, improves school attendance, and provides significant support to youth involved in child welfare and juvenile justice. Most counties and all regions have access to Wraparound care coordinators and peer-delivered service providers with specialized training in supporting youth and their families.*

- ***Interdisciplinary Assessment centers (IATs).*** *The 2019 Legislature passed Senate Bill 1 and established a special purpose appropriation for OHA, DHS and OYA to coordinate efforts and establish regional interdisciplinary assessment centers. The teams in the centers would conduct thorough assessments and make treatment recommendations for long-term wellness. As of July 2020, IATs are in statute but the special appropriation is no longer available to finance the initiative.*

OHA's 2019-2021 Legislatively Approved Budget did include funding to support the Children's System of Care data dashboard as established in Senate Bill 1. Emergency Department utilization will be incorporated with separate reporting for children and youth boarding and frequency, and the Council will pursue recommended measures needed for consistent implementation.

***Challenges**: With the current wait list for residential treatment beds, we need more innovative services and resources in Oregon. These waitlists create a gap in services that causes families to wait more than 6 weeks for assessment appointments, resulting in increased likelihood of a crisis emergency department visit and worsening health of the family. Utilizing MRSS, fully implementing the 2019 investments (including IATs) and expanding other current programming (CATS, IIBHT, Wraparound) would provide supports that would prevent disruptions, interactions with emergency departments, law enforcement, foster care and higher levels of mental health care.*

***Agency Needs**: Oregon's System of Care aims to improve the effectiveness of state agencies serving Oregon's children and improve the continuum of care that provides services to youth, ages 0 to 25 so that mental health care is community based, family driven, effective, and culturally and linguistically responsive. Achieving this will require changes to the current systems and the filling of gaps in the continuum of services available to children and young adults. Filling the early intervention gap with MRSS and the current programming would decrease demand for higher levels of service and preserve foster placements for young people involved with DHS Child Welfare.*

*Coordination of services and network is critical, particularly during the pandemic. Oregon must prepare to meet this need to support children, young people and families and provide resources and support at the right time. Adequate response to COVID-19 issues requires the creation a*nd *utilization of early intervention strategies and trauma-informed mobile response and stabilization services, and an increase in the coordination of the service network.*

***Timeline:** The work described above to reduce ED boarding for children and adults will continue over the next several years. The monitoring and reporting of ED boarding through dashboards is expected to be completed by December 31, 2021.*

Update: *Staff within the CFBH team worked with HPA analysts and hospital representatives to obtain and study Emergency Department data for children and young adults. This information has been compiled into a report and presented to community groups, CSAC, parent groups, and internal partners. The information has been communicated through the CFBH website and will be updated and reported quarterly to the CSAC group.*

- Recommend OHA develop an intermediate proposal to Legislature for addressing issues with statutory language requiring the call center contract up to discontinuing OHA's portion of the contract.

  Management Response: *In 2017, the Governor signed SB 944 into law. The intentions of this bill were to establish a call center to help children get access to the right service at the right time and so that OHA and the community would be able to track the need for different levels of care. The call center focus is on children in emergency departments and inpatient care (Subacute and PRTS). The bill also intended that we would improve our ability to understand and track system capacity in real time.*

  OHA and the System of Care have learned valuable lessons, as execution of the bill did not result in the intended outcomes. OHA and the System of Care will need to reevaluate how to improve the effectiveness of the referral system and capacity management tools. While it may help to change the statute, the underlying work that needs to be done is to identify more effective methods to achieve the outcomes envisioned by the legislation.

  As with other responses, the lessons and work that OHA has done through COVID-19 response may allow us to break through some of the stumbling blocks that occurred as we initially attempted to create this capacity management system for this singular level of service. Instead of abandoning the entire concept, consumers will be better served if OHA, providers and funders revisit the mechanics of how to make this work and commit to the goals of SB 944.

Once a solution is crafted that works, OHA will review the statutes and rules and update if needed.

Inequity issues: *As the crafters of SB 944 recognized, having a service delivery system dependent on existing knowledge and relationships between providers resulted in a delivery system that would often exclude people from easily accessing needed services. This is one more instance of systemic barriers that are especially difficult for those from nondominant cultures to overcome.*

Consumer voice: *While this is a very specific recommendation related to one section of the statutes, the underlying work is germane through the entire lifespan for behavioral health services. Having an easy to access, systematized capacity management system for every level and type of behavioral health service will allow consumers, families, and referring providers to identify appropriate and timely service options.*

Work underway: *On June 5, 2020, the Legislative Emergency Board approved allocation of $6 million to develop an Oregon Behavioral Health Access System. Within this initiative, OHA will be utilizing nationally recognized capacity management tools and techniques to create a one-stop shopping experience for consumers who seek behavioral health services. The system will build from lessons learned in SB 944 implementation, be sophisticated and will also support connections for providers who seek real-time information about capacity so that we can streamline referrals to appropriate levels of care.*

As noted in the audit, OHA did work with the PRTS and Subacute providers in 2018-2019 to gather important data, outside of the call center, for a calendar year to specifically look at the capacity need, utilization, wait times and access barriers. OHA recognizes that this is valuable data.

Challenges: *The current design of the children's continuum of care mental health provider participation is required to have a call center to assess system needs and access. When capacity is consistently full, the ability to consider capacity management is limited. The children's system is in crisis so there is a focus on getting urgent services to children and families rather than data gathering to make more informed decisions.*

Creating a one-stop experience will be complex as providers operate under multiple governance systems and payor structures. For example, the children's behavioral health system is primarily managed through the CCO model in Oregon. CCOs contract for their provider network directly. For the inpatient levels of care there are only five providers, but CCOs are not required to contract with any or all of them. In addition, access to these levels of care can look different depending on the CCO of the member. OHA does not contract with these providers directly so although we oversee them through certification and OARs, access and management are not directly overseen.

Agency Needs: *To be successful, OHA will need to determine an effective method for providers to keep capacity reports up-to-date and current.*

Update: *HB 2086 (2021) amended statutory language related to the call center contract and allowed for increased flexibility for the collection of access data across the system, and the Lines for Life contract has been amended.*

The CFBH Unit has worked extensively with the System of Care Advisory Council to review system needs, differentiating between data needs for different levels of care. A centralized bed capacity tracker is under development for SUD and mental health residential capacity to provide a robust communication tool for these high levels of care. Following implementation, the Unit will work to determine broader applicability for program access.

- Recommend OHA work with the newly created Senate Bill 1 System of Care Advisory Council and Legislature to better optimize the statute guiding mental health treatment services. Specifically, the collaborative effort should:

    - Expand statutes to consider CCO framework and evaluate disconnected mental health statutes for potential revision.
    - Clarify statutory roles and responsibilities of stakeholders.
    - Develop alternative language for “subject to the availability of funds” in order to establish priority of mental health services.
    - Define the requirement of integrated physical, mental, and oral health.
    - Deliver a report on planned optimizations.

    Management Response: *OHA appreciates the importance of aligning and optimizing foundational statutes that support the behavioral health system. Because this is needed for the behavioral health statutes covering the lifespan, we would suggest expanding the advisory process through which we accomplish this. In addition to utilizing the System of Care Advisory Council, which focuses primarily on children and families, we would also work through other advisory groups including, potentially, the Governor’s Behavioral Health Advisory Council, the Alcohol and Drug Policy Advisory Council, the Alcohol and Drug and Mental Health Planning and Advisory Council, the Oregon Consumer Advisory Council, and many others. We would also need input from a vast array of stakeholder groups. Additionally, we would engage regularly with legislative committees on behavioral health as we proceed, to ensure we are addressing issues that constituents bring forth.*

Inequity issues: *Conflicts in statutes, as well as optional financing and poorly articulated roles and responsibilities, leave room for service gaps and lack of accountability and perpetuate long-standing systemic barriers to service, particularly for persons of color.*

Consumer voice: *Consumers, including youth and families, will be leaders in the process and will co-create the recommendations for changes needed to the behavioral health statutory framework. As OHA does the difficult work of clarifying and aligning statutes, consumers will benefit from a system that becomes more simple, responsive, and meaningful.*

Challenges: *This work will be challenging. The current system is built from the local level. Each county and region has unique operational challenges and needs flexibility to ensure the needs of consumers can be met. Additionally, while CCOs represent a majority of the financial investment in Oregon's behavioral health system, there remains a need for safety net capacity for services that are not covered through the Oregon Health Plan or for people who are not eligible for services. Also, many people access services through private health insurance, and it will be important to factor that into the statutory work. For children and families, intersections with the other child-serving systems will influence how this work moves. For adults, it will be critical to factor intersections with justice systems, law enforcement, housing, disability services, older adults, veterans and other systems.*

Agency Needs: *OHA will need stakeholder consensus for this to succeed.*

Timeline: *This work has started and will continue through 2023.*

Update: *The System of Care Advisory Council has developed a vision and plan and is currently hiring for an Executive Director of the Council. This newly created role will be charged with evaluating statutes for potential revision and clarifying language and requirements for integrated health care. The System of Care Advisory Council is intended to operate as an independent body,*

and CFBH will continue to provide technical assistance and support for this group during the transition to the Executive Director, when hired.

- Recommend OHA collaborate with system stakeholders, such as providers and other agencies, to develop and document a comprehensive workforce retention and recruitment strategy and communicate it to all stakeholders. Reporting on strategic implementation should be delivered annually to the Oregon Health Policy Board.

  Introduction: *As referenced in the audit, the Behavioral Health Collaborative made recommendations regarding the behavioral health workforce, namely, to complete an assessment. OHA contracted with the Eugene Farley Health Policy Center to assess the current behavioral health workforce and develop a recruitment and retention plan. This work was completed in 2019 and was presented to the Oregon Health Policy Board. OHA's Behavioral Health Medicaid, Policy and Analytics unit work works closely with OHA's Primary Care Office and OHPB's Health Care Workforce Committee on all behavioral health workforce recommendations, including the Farley Center recommendations.*

  Since the publication of the Farley reports, OHA staff has conducted an analysis of Oregon-specific workforce recommendations in the past decade. These were presented to a workgroup of the Governor's Behavioral Health Advisory Council. OHA is incorporating the council's policy recommendations into requests for the 2021 legislative session.

  Inequity issues: *The behavioral health workforce in Oregon is predominantly white. BIPOC consumers are not able to receive treatment from BIPOC providers. Low wages result in individuals not entering the workforce. Some cultures don't see traditional counseling as acceptable, and this results in many people not seeking behavioral health care or being distrustful of the care they receive. Black communities experience bias from providers, which often results in misdiagnosis and poorer quality of care. This continues the cycle of mistrust*

and a tendency not to seek behavioral health care. Culturally competent providers have long waitlists and accept limited insurance. Lastly, systemic racism has created deep distrust.

Consumer voice: *Consumers, including youth and families, have critical insight into this issue. Oregon must develop and retain a behavioral health workforce that is responsive to the needs of the people who rely on these services. As such, consumers will inform the development of this plan and will guide OHA in determining goals for workforce composition and training. The workforce issues, such as high turnover, results in consumers having to start over with new providers. This is not a trauma-informed system as consumers are required to retell their stories and develop a therapeutic relationship with a new provider. Our most qualified workforce tends to work in lower acuity settings, whereas our least experienced workforce is working with the most acute patients. This is a disservice to consumers as they are not able to receive care from a highly trained and senior workforce. Consumers are not able to receive treatment from providers that share their culture, language, or background. These issues result in consumers not receiving meaningful services and overall poor outcomes.*

Challenges: *As the audit itself recognizes, Oregon's turnover rates within the children's behavioral health system are within the national averages, indicating that this is not only an Oregon issue, but also a national one. Efforts to integrate behavioral health into the healthcare system are underway, but behavioral health staff is not paid in parity with physical or oral healthcare with parallel education, training, and certification. OHA can raise rates, work with the Transformation Center to convene learning collaboratives, and work with partners, higher education and licensing boards to implement recommendations. But until behavioral health is fully integrated and in parity with physical and oral healthcare, we will continue to face significant workforce turnover and shortages.*

The audit asserts that "while OHA is aware of the turnover problem, its efforts to reduce it have been ineffective." OHA does not have staff dedicated to work on this area. OHA has a Primary

Care Office that is responsible for workforce, including loan repayment and incentive programs, workforce development issues, and the Oregon Health Policy Board's Health Care Workforce Committee; however, their primary focus is physical health. The former Addictions and Mental Health Division had a behavioral health workforce unit of approximately four FTE; those positions were lost in a reorganization.

Agency Needs: *Behavioral Health does not have staff to implement the recommendations. Adding behavioral health staff to the Primary Care Office (which oversees much of the workforce related efforts for OHA and staffs Oregon Health Policy Board's Health Care Workforce Committee) would place the staff in the right place to effectively do this work. Bringing higher education and licensing boards together with OHA and other stakeholders could require a mandate.*

Timeline: *This work is underway and was prioritized by the Governor's Behavioral Health Advisory Council. It will continue through 2023.*

Update: *While the behavioral health workforce was under strain during the Secretary of State's audit process in 2019, the Covid-19 pandemic has created unprecedented shortages over the past two years across the healthcare system. Extensive funding has been routed to behavioral health providers to support efforts to recruit and retain staff, and HB 2086 (2021) provided funds for a comprehensive workforce study.*

HSD representatives have brought system partners together for ongoing conversations on how best to recruit and build a robust workforce, including student loan forgiveness, mentoring and career ladders, credentialing, supervision, rate increases, and development of educational pipelines particularly to bring staff of color into the behavioral health field. Additional legislation is being considered for further efforts in the upcoming legislative session.

- Recommend OHA develop and deliver a public information campaign for mental health, including challenges faced by individuals in the system, as well as direct care workers, similar to campaigns delivered by the Public Health Division.

  Management response: *This audit report highlights how statutory provisions with no reliable source of funding have undermined OHA's ability to focus on mental health prevention and promotion. Also, OHA recognizes the serious challenges faced every day by the direct care staff.*

  In response to COVID-19, OHA contracted with Brink Communications to develop the Safe + Strong campaign. OHA received funding from the federal CARES Act to support current work with Brink for a behavioral health specific campaign. A key feature of that campaign will address stigma. Priority populations identified include health care workers, BIPOC, and those with behavioral health concerns.

  Inequity issues: *As mentioned in previous responses to the recommendations, the COVID-19 pandemic has had significant impact on and disruptions to OHA operations since early 2020. While that is an important backdrop to some of our responses, it is important to note that during the months of operating under the pandemic, OHA has realized some opportunities for system improvements. We received funding to support a broad-based public information campaign to help people understand mental health and to provide information about resources that can be helpful if they are experiencing mental health service needs.*

  Brink Communications conducted research and found high health disparity scores near Salem-Keizer, the Willamette Valley and agricultural counties. BIPOC seek support from personal networks rather than behavioral health care professionals. Income level and refugee of immigration status have a large impact on behavioral health of BIPOC. Reducing stigma in Latinx communities may help normalize help-seeking behavior.

Consumer voice: *This work, in progress, will continue to be centered on the needs of behavioral health consumers, including those who are healthcare workers and members of high-risk or underserved populations. The first round of creative from Brink shows a simple campaign that will be transcreated into 11 languages. The campaign aims to be inclusive for gender and BIPOC. Stigma reduction and normalizing help-seeking behavior will help more people access behavioral health care. The campaign is building upon trauma-informed and supportive messages. To provide the foundation of the work, Brink and OHA staff did extensive community engagement work to speak to Community Based Organizations and other community leaders and learn about the needs of BIPOC communities. Messages and materials are being tailored from the insights gathered from that work.*

Work underway: *OHA has utilized resources from the Federal Mental Health Block Grant and funding from behavioral health investments in 2015 to contract with communities to enhance wellness practices and prevention. Since 2014, OHA has funded local Mental Health Promotion and Prevention projects. Led by community organizations, the projects aim to help everyone improve and sustain their mental health. This means children and adults can:*

- *Achieve developmentally appropriate tasks,*
- *Maintain a positive sense of self-esteem, mastery, well-being, and social inclusion, and*
- *Strengthen their ability to cope with adversity.*

The projects promote evidence-based, community-based interventions and activities.

In 2019, OHA funded Mental Health Promotion and Prevention projects in 20 counties, serving more than 25,000 individuals and reaching thousands more through social media, websites, online learning and other outreach activities. Projects included:

- *Advocacy, stakeholder engagement and interagency collaboration: Train the Trainer,*

Honest Open Proud (HOP), youth groups, peer support, parent support groups, life skills, coping skills and self - regulation, harm reduction.

- *Onsite and School-Based Services: Professional development for staff, Question Persuade Refer, Curve It Forward, Positive Behavior Interventions, Mental Health Tool Box, Applied Suicide Intervention Skills Training, Culturally Responsive Mental Health First Aid (suicide prevention), STEPS to SUCCESS (bullying prevention), Second Step (social and emotional well-being), MindUp (social-emotional awareness to enhance psychosocial well-being), Collaborative Problem Solving, NETSMARTZ (cyberbullying prevention), CONNECT (creating youth leaders).*
- *Summer school programs, food security, tutoring, art classes, after-school sports.*
- *Culturally appropriate refugee and immigrant resources and services.*

Related work: *Also, during the COVID-19 crisis, OHA has enhanced the availability of tools for direct care workers affected by the crisis to include psychological first aid training and a self-assessment tool called PsyStart.*

Challenges: *The Brink Communications media campaign is funded for a limited period of time. There will need to be ongoing funding to continue the campaign.*

Timeline*: Work has been underway for several years and will continue to be expanded and improved. As a result of the COVID-19 work, a targeted campaign will be completed by December 31, 2020.*

Update: *HSD worked with Brink Media and the Public Health Division to implement the Safe and Strong Oregon public health campaign during the Fall of 2020. This program provides information for Covid-19 vaccine resources and safety, as well as mental and emotional health supports and community resources.*

Ongoing collaboration between Behavioral Health and Public Health is planned in order to provide resources and public campaigns for integrated health.

- Recommend OHA work with Trauma Informed Oregon to become a trauma-informed agency, finalize the internal trauma-informed policy, and provide related agency wide training starting at the highest leadership levels. The agency should hold contracted organizations accountable for Trauma Informed Practices.

  OHA's leadership team recommended that the policy be reviewed by the agency-wide Equity Advancement Leadership Team (EALT).

  The EALT reviewed the policy and discussed how the policy could best be moved forward in synchronization with OHA's Strategic Plan and Equity Advancement plan (formerly known as the Affirmative Action plan).
  The EALT recommended that the Equity and Inclusion Division be responsible for policy oversight and governance, including facilitating a workgroup in the implementation of the policy and associated work, and for any revisions necessary to align with OHA's strategic planning and anti-racism framework.

  OHA leadership agreed to the EALT recommendations, and the work has now been passed to the Equity and Inclusion Division.

  Workgroup recruitment completed in June 2021 and a new draft is anticipated August 2021.

  ***Update**: During 2020, the CFBH Unit worked with internal partners, community groups, and Trauma Informed Oregon to develop a draft policy in alignment with Equity, Inclusion, and Diversity efforts. This draft was paused to determine the definition of "trauma informed" as it applies to anti-racism work and OHA's goal to address health inequities.*

Current policy work in this area is focused on the connection between anti-racist actions and trauma-informed policies. The workgroup addressing this policy is working with ODHS to determine if a comprehensive policy can be developed, and work was paused to allow time for all members to attend anti-racist trauma trainings. An updated version of the policy is anticipated in Spring 2022.

- Recommend OHA continue to collaborate with Trauma Informed Oregon to deliver training of trauma-informed practices to direct care providers.

  Management response: *OHA supports a trauma-informed foundation to all services and supports provided for children and families. As noted in the previous response, OHA currently works extensively with Trauma Informed Oregon to shape our understanding of the impacts that trauma has on how people experience services and the importance of addressing that experience so that people can expect successful outcomes. We will continue to do so.*

  Inequity issues: *Trauma manifests in several ways. For people who identify as members of communities of color, systemic racism and microaggressions are recurring traumas that compound their experiences. Direct care providers must be educated to understand the subtle and overt ways that their service delivery can be improved and be trauma informed.*

  Consumer voice: *Consumers, including youth and families and members of communities of color, have consistently expressed the desire for behavioral health providers who are competent in delivering trauma-informed care. Consumers often won't access services because the health care environment feels unsafe. This happens when service providers or the service system is not trauma aware. As a result, existing issues manifest to point of crisis, or illness and symptoms become worse.*

  Work underway: *OHA recently invested additional funds in the Trauma Informed Oregon contract, to address technical assistance and training needs in the areas of social emotional*

learning, and culturally responsive practices in strength-based healing centered engagement, Trauma Informed Care (TIC), and Adverse Childhood Experiences (ACEs). This technical assistance and training will be provided for service providers serving people of color, people with physical and cognitive disabilities, LGBTQIA2S+ individuals, interested consumers, family members, young adults, and individuals across the lifespan with serious mental illness, those in recovery from mental health disorders, substance use disorders, and problem gambling issues; and to support Coordinated Care Organizations (CCOs), Community Mental Health Programs (CMHPs), individual providers of behavioral health services, and health professionals statewide.

Challenges: *The decentralization and fragmentation of systems can cause consumers to be retraumatized, via having to repeat their "story" (need for treatment) to various providers because the system is not contiguous and working well together. People drop out of services when this becomes untenable for them.*

Agency needs: *As with all that OHA does, the successful and ongoing implementation of this recommendation will require sufficient funding to support training contracts and staff focus to implement and schedule.*

Timeline: *This work is underway and will be ongoing with an initial goal of providing training to all OHA regulated providers of children's services by July 1, 2022.*

Update*: OHA's contract with Trauma Informed Oregon has been extended and is managed through the CFBH Unit. Trainings and resources are provided to internal partners across OHA, as well as to CMHP's and provider agencies*

- Recommend OHA work with the Oregon Health Policy Board, System of Care Advisory Council, and Legislature to update the statutory framework to ensure agencies within the System of Care are fully

invested to support the burden costs across the system. A System of Care roadmap should be developed and documented to demonstrate process owners and related costs.

Management response: *OHA agrees with this recommendation. To reiterate from previous responses, Oregon's System of Care partners are guided by the vision that children can be at home, in school and in their community because they receive the right services, at the right time and for the right duration. OHA agrees that a strong, interconnected statutory framework would provide transparency and clarity in describing, defining, and ensuring financial commitment to the children's System of Care.*

Inequity issues: *Oregon's statutory direction for the children's System of Care must be fully informed and designed to break the cycle of systemic and historic racism and inequity. To make* meaningful *inroads in resolving health inequity, all stakeholders must learn to see past "business as usual" thinking and invest in ideas that are trauma informed. As the audit repeatedly mentions, so many of the statutes that support behavioral health services are qualified with "subject to available funds" clauses. A complete System of Care roadmap will identify funding, with proposals for elimination of gaps and barriers to success.*

Consumer voice: *Youth and family voice will be critical in the development of a System of Care roadmap and in determining policy and funding priorities. Well-written statutory framework and a System of Care roadmap will add cohesion so that individual agencies can more effectively work together toward common goals for children and families. If well written and administered, the needs of the children and families will drive service delivery and outcomes should improve.*

Work underway: *This body of work was envisioned, and the 2019 Legislature passed SB 1, which established the System of Care Advisory Council. OHA hired staff to lead this effort and the council began meeting in March 2020. OHA will collaborate with the Oregon Health Policy*

Board, System of Care Advisory Council, consumers and stakeholders to develop the System of Care roadmap and continue developing recommendations to update the statutory framework. This work will also include development of POPs to provide appropriate supporting financial investments and staffing.

***Challenges**: How systems are organized affects focus, alignment and effectiveness. Oregon organizes child-serving agencies along service lines with separate governance over each major service, including education, social service, justice, and medical services. Each of those organizations has evolved differently over multiple generations, and all are now uniquely structured to meet the specialized requirements tied to delivering those services. Underlying funder requirements, particularly federal partners such as Medicaid and U.S. Department of Education, also affect organizational structures and program priorities. Those structural differences are substantial and will be difficult to synthesize and simplify in the roadmap and statutory frameworks without revolutionary adaptations and compromise.*

Historically, Oregon's child-serving agencies have struggled with incompatible requirements and service delivery structures that have made it difficult to work across systems. Oregon has a high rate of child welfare referrals, unacceptable suicide rates for youth ages 10-24, challenges with school completion and graduation, especially for communities of color, high numbers of black, indigenous and people of color youth being incarcerated, and high numbers of children and youth needing intensive level of services. Likely, a robust array of culturally appropriate services that is easily accessible by families could have prevented escalation to that level of need.

***Agency needs:** To implement this recommendation, OHA will need full support from children and families and from all child-serving stakeholders and agencies ranging from the Governor's office to all child serving agencies, including service providers, DHS, OYA and ODE.*

Timeline: *This work has begun with OHA's convening of the System of Care Advisory Council and some preliminary POPs are being advanced through OHA's Agency Recommended Budget for 2021-2023. Full implementation of this recommendation will cross several biennia.*

Update: *The System of Care Advisory Council has developed a vision and plan and is currently hiring for an Executive Director of the Council. This newly created role will be charged with evaluating statutes for potential revision and clarifying language and requirements for integrated health care. The System of Care Advisory Council is intended to operate as an independent body, and CFBH will continue to provide technical assistance and support for this group during the transition to the Executive Director, when hired.*

- Recommend OHA develop and document internal policies and procedures for monitoring behavioral health funding to the counties through ORS 430. The agency should seek to establish a process owner for regularly reconciling and reporting on these funds.

Management response: *OHA values partnerships throughout the behavioral health system. An historic partnership is that which establishes the Community Mental Health Programs (CMHPs) through ORS 430. OHA's current formal relationship with the CMHPs is through negotiated County Financial Assistance Agreements (CFAAs). These CFAAs are the contractual mechanisms OHA uses to distribute state funds, federal grants and other funds to CMHPs. CMHPs, in return, operate community mental health programs and provide a locally developed array of behavioral health services. Funding from the CFAAs is combined with other resources including Medicaid billings, CCO contracted funding, private insurance, and other local resources. OHA plans to conduct an internal audit to identify methods for tightened contracts and compliance. This will help inform next steps and realistic options for ongoing reporting.*

Inequity issues: *By reviewing each county's financial resources for behavioral services, OHA will be in a better position to understand fiscal incentives that may be perpetuating inequities.*

Consumer voice: *To understand financial underpinnings of the behavioral system at the local level, consumers will have information to understand and direct a system that is more responsive and accountable.*

Challenges: *Because behavioral health services are delivered in a decentralized system, and because each of the CMHPs (covering 36 counties and Warm Springs tribe) have unique administrative structures, funding sources, and business models, creating meaningful financial reports and appropriately evaluating the reports will be complex. OHA is not currently staffed to do this work well. Additionally, the CMHPs, who don't currently provide these reports to OHA, may not be staffed to produce the reports in the formats that meet a statewide evaluation need.*

Agency needs: *To implement this recommendation, OHA will need to reach agreement with CMHPs about reporting requirements and CMHPs will need to provide requested information. Additionally, OHA will need staff to review and interpret complex financial information and who can report the results of the reviews back to CMHPs for continued system improvement and feedback.*

Timeline*: Internal audit work described above will be completed by March 31, 2021. OHA will continue to negotiate reporting requirements with CMHPs as County Financial Assistance Agreements are being revised. OARS 430 changes will be ongoing with target completion of December 31, 2021.*

Update: *OHA has hired a consultant to support efforts to innovate and revise county contracting, including a list of recommendations and findings. An HSD Manager has been assigned to this work and is building a team to monitor county compliance with contractual requirements. County representatives are involved in this process and work has begun to align county contracting with CCO requirements. As mentioned previously, reporting requirements have been paused to help*

support staff stresses during the Covid-19 pandemic. During this pause, however, ongoing work is underway to build robust system for monitoring and addressing consistency of standards, and funding will be dependent upon compliance with expectations.

3. OHA: Efforts Have Helped Limit Some Employee Health Care Costs, but PEBB and OEBB Can Do More to Manage Costs and Optimize Benefits, audit #2020-39 (dated November 2020)

- Recommend PEBB and OEBB regularly communicate to members further educational opportunities in addition to open enrollment for members to learn how to better understand the details of their insurance coverage and how to utilize their benefits to make optimal health and cost decisions.

  1. *PEBB has been collaborating with Rise Partnership (now Uplift Oregon) to roll out training and resources for new State of Oregon employees explaining their robust benefits package.*

     - *Uplift Oregon is currently offering Uplift Your Benefits, a weekly two-hour training that includes:*
       - *90 minutes of content on benefits, and*
       - *a 30-minute union orientation for positions represented by SEIU or AFSCME.*
       - *The training was designed with new employees in mind, but any employee is welcome to attend.*
     - *The goal is to have this as a mandatory training within the first 14 days of hire for AFSCME and SEIU represented positions.*
     - *2021 major milestones:*

- *June 2021: DAS will send an email to all State of Oregon employees announcing Uplift Oregon and the process for enrolling in the benefits workshop, Uplift Your Benefits*
- *July 6, 2021: Uplift will begin sending emails directly to all new employees, inviting them to register and attend the Uplift Your Benefits workshop*
- *September 2021: Agency listening session scheduled to adjust and adapt the process for Uplift Your Benefits, and Uplift offers an additional "Benefits Tune-Up" workshop in anticipation of open enrollment, available for any State employee to attend.*

2. *In partnership with Jellyvision, PEBB has expanded program offerings through "Alex Advanced." Updates include:*
    - *Promote use of chronic care/wellness programs by incorporating into the Alex tool*
    - *Continue "Smart Tips" to direct people to care resources like telemedicine, etc.*
    - *Coordinate with Uplift Oregon to support new hire training and the benefits' selection process*
    - *Host a new PEBB specific and fully customizable URL that includes:*
    - *On-demand videos related to medical plan basics, using a nurse advice line, talking to a provider using telehealth, etc.*
    - *Links to wellness pages, carriers, or whatever we want*
    - *FAQs*

3. *We are purchasing "Benefits 101" instructional videos. OEBB and PEBB will post video links prominently in a "member education" section on both websites.*

4. OEBB and PEBB monthly newsletters will include benefit tips each month.

5. PEBB is partnering with Mercer to design a dedicated "on demand" resource page for new hires where they can find information on:

- *Benefits training opportunities*
- *Educational Videos*
- *Enrollment resources*

***Update:** PEBB staff collaborated with Rise Partnership, SEIU, and DAS to develop training and materials for newly hired State employees. Rise Partnership and SEIU began piloting the training with DAS in October 2020. These workshops are now available several days a week. State employees can register to attend a workshop in Workday. In 2019, the PEBB Board directed our consultant, Mercer, to develop a comprehensive communications strategy.*

Staff, in partnership with Mercer, have developed and implemented a dedicated new hire section for the PEBB website, with supporting materials. This section is aimed at guiding new employees through the benefits decision-making process and updated regularly.

PEBB and Mercer have designed a monthly newsletter sharing timely benefits and wellbeing information, carrier resources and webinars. Newsletters include a section on how the Board works to ensure cost-effective and quality benefits for members.

PEBB and OEBB, in collaboration with contracted insurance carriers have created educational resources including webinars, targeted videos, downloadable flyers and

newsletters. These resources continue to expand now that Mercer supports both PEBB and OEBB.

- Recommend PEBB and OEBB periodically communicate to employers, members, and stakeholders about the board's ongoing administration of benefits, cost containment efforts, and the anticipated effects on affordability and accessibility of health care coverage to stakeholders, including employers and members.

  1. Both programs have restarted PEBB Information Exchange (PIE) and Business Information Exchange (BIE) in 2021. We are expanding the board information and feedback agenda topics as described to ensure stakeholders are fully informed of board actions and have an opportunity to provide feedback if desired.

  2. In collaboration with our consultant, Mercer, PEBB has designed a monthly member newsletter, the first of which will be sent in June. Among other informational benefit-related topics, the newsletter will include a regular "Working for You" section in which we will share the highlights of board discussions, decision making, cost-containment efforts, etc.

  3. OEBB is expanding our current Wellness-focused newsletter to include all employee benefit topics. The expanded monthly email will align with PEBB and incorporate board news and highlights.

  4. Mercer is currently performing a review of the PEBB website. The Board section is being expanded to provide detailed information of the topics highlighted in the monthly newsletter. We will also expand the board focus on the OEBB website. Implementation date is December 31, 2021.

Update: *PEBB Information Exchange and OEBB Business Information Exchange meetings have been scheduled quarterly for the 2022 calendar year. Agenda topics have been updated to include a detailed summary of board discussions and decisions. Staff continue to expand the board presence in monthly newsletters web pages.*

- Recommend PEBB and OEBB consistently collect, analyze, and share results of employers' and members' experiences to better inform board decisions; for example, consistently track customer service calls to the programs, ask about benefit and claim experiences on the annual member survey, and obtain information from carriers on claims calls and appeals.

  PEBB currently performs a customer-service focused survey that does not contain benefit utilization questions. PEBB will seek to align with OEBB over the next year and request the carriers collect the same information.

  Update*: Program call tracking solutions: The new OEBB/PEBB benefit system requirements include the ability to track and categorize customer service phone calls. This includes reporting capabilities. This resolution will be complete when the new system is fully implemented estimated in 2024-25.*

  The current benefit systems contain a note section but are administratively cumbersome. Call volume, especially during open enrollment precludes implementing a manual solution with limited staff capacity. Since we are designing a new system that will fill this gap, we don't plan to expend staff and system resources to address it in the current system.

Carrier data collection: Staff are meeting in May to discuss and develop additional carrier reporting criteria for utilization data and member experience data.

Programs currently collected from carriers:

- *claim processing timeliness and accuracy*
- *appeal processing timeliness*
- *call abandonment and average speed of answer*
- *first call resolution*
- *email response timeliness*
- *telephone inquiry response timeliness*

- Recommend PEBB and OEBB promptly enhance clarity and oversight of consultant and carrier contracts, which should include:

  a) Ensuring consultant contracts have clearly defined deliverables that are of value and the related costs.

  Consultant Contracts: OEBB and PEBB have monthly account meetings with its consultants. The meetings include OEBB/PEBB team leads as well as the department leadership. These meetings have set agendas, which include reviewing invoices, having consultants present budget tracking information and confirming work priorities/expectations with the consultants.

  Other Contracts: We have mapped out the full annual renewal process for these contracts, which include the consultant-led public meetings and discussions, as well as the subsequent contract amendment drafting and future monitoring building in internal touchpoints during the course of this process to ensure we review proposed renewal parameters and address any performance issues we may be experiencing with the carriers. This is a challenge due to

claims lag.

Once this process has been vetted and completely approved, the Contracts team will then assign specific contract reports to the team to shore up roles and responsibilities for the touchpoint meetings discussed below.

We reviewed our consultant contracts and worked with staff to develop a more accurate description of the work we need from our consultants. This is critical for the upcoming Consultant RFP. One benefit to this process is that we more specifically defined our communication needs so that our staff will have more flexibility in working with our consultants in the future to develop communications (content and delivery methods).

Current: We expect to have the updated annual renewal process vetted and changes to the process approved soon. Once this occurs, Contracts will determine how specific contract reports will be assigned out or otherwise reviewed and addressed during the touchpoints. Touchpoints will have standing agendas and will be facilitated by the Contracts team. We will review required reporting and other deliverables as well as gather feedback from other area leads on their experiences working with carriers. This information will be shared with leadership and consultants to ensure we not only respond with appropriate contract actions but also consider asking the Board to address the performance in its renewal discussions and decisions.

Future: Program and Contracts staff are currently working with leadership and the Innovation Workgroup (IWG) to establish a comprehensive strategy for assessing contract performance that includes new performance and outcome measures with associated financial risk. This is expected to take a few years to implement, which is why staff initially focused on mapping and improving the annual renewal process. Currently, staff is working to finalize the performance measures for measurement year 2022. Staff will work on creating a

standardized reporting guide for carriers to fill out and send back to staff. Dates have not been set nor has frequency of reporting been established at this time.

b) Identifying deliverables in current contracts and monitoring and enforcing deliverables be contract compliant.

Current: We expect to have the updated annual renewal process vetted and changes to the process approved soon. Once this occurs, Contracts will determine how specific contract reports will be assigned out or otherwise reviewed and addressed during the touchpoints. Touchpoints will have standing agendas and will be facilitated by the Contracts team. We will review required reporting and other deliverables as well as gather feedback from other area leads on their experiences working with carriers. This information will be shared with leadership and consultants to ensure we not only respond with appropriate contract actions but also consider asking the Board to address the performance in its renewal discussions and decisions.

Future: Program and Contracts staff are currently working with leadership and the Innovation Workgroup (IWG) to establish a comprehensive strategy for assessing contract performance that includes new performance and outcome measures with associated financial risk. This is expected to take a few years to implement, which is why staff initially focused on mapping and improving the annual renewal process. Currently, staff is working to finalize the performance measures for measurement year 2022. Staff will work on creating a standardized reporting guide for carriers to fill out and send back to staff. Dates have not been set, nor has frequency of reporting has been established at this time.

c) ***Verifying invoices for mathematical accuracy and contract compliance by staff who have the pertinent training and knowledge of contract terms.***

We have brought invoice review/approval into our monthly consultant account meetings. In addition, invoices are required deliverables under the contracts so we will work with our Finance team to improve internal processes as needed.

d) ***Having a comprehensive program for identifying improper claim payments that is reflected in contracted services.***

We built potential audit work into our respective 2021 consultant budgets to ensure the work would be within scope and accounted for if we have the resources to move an audit forward soon. We have built this work into the upcoming Consultant RFP and will be interested in seeing how different proposers feel they can support this work.

Update: *The processes have been implemented and PEBB will continue to monitor and improve these processes during upcoming contract renewals.*

- Recommend PEBB develop a formal strategic plan that includes elements such as the appropriate amount to be maintained in reserve and steps to take when the reserve reaches higher or lower levels than targeted.

The PEBB board maintains the Stabilization Fund (also known as "the reserve") in the state treasury. The board works with its consultant actuary each year to project an amount in the Stabilization Fund sufficient to meet both anticipated and unanticipated fluctuations in claims costs. The Board has used the fund to stabilize premiums, subsidize the employee premium share, and fund programs designed to reduce premium increases, but the board has no formal policy for how to manage funds in the event that reserves exceed the fully funded target level.

When the PEBB Reserve exceeds the targeted fully funded reserve level, the legislature has in recent years legislated a "fund sweep" of those excess reserves that have resulted in an OMB Circular A87 Federal payback for an unallowable transfer. Over the next 12 months the PEBB board will consider developing a "Formal" reserve policy that includes direction for handling of excess funds in the reserve when they exceed the target. One item to note is that PEBB's legislatively adopted biennial budget is developed using a 3.4% annual increase. For the board to "buy-down" a higher than anticipated annual contract renewal beyond the 3.4%, it would likely need to secure additional budget limitation from the legislature in an Emergency Board rebalance request, or full legislative session. A formal reserve policy may inhibit future fund sweeps.

***Update**: The due date is being pushed out to accommodate the awarding of the consulting contract currently out for RFP. This was done because the actuarial analysis to support this formal strategic plan will be performed and supported by that consulting firm.*

4. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Award for the Year Ended June 30, 2020, audit #2021-13 (dated April 2021)

- Recommend management ensure transaction review is adequate and includes examination of proper and complete coding, accounting periods, and supporting documentation.

  OFS has reviewed and updated all year-end procedures and is engaged with staff for more accurate accrual data.

- Recommend management strengthen year-end review procedures to ensure necessary system processing has occurred, and account balances are reasonable and properly classified.

Year-end methodologies have been reviewed and we continue to engage closely with the staff providing year-end transaction details to educate on the importance of accurate estimates. The MMIS contractor has made the FMAP rate updates from 2020 at this time.

- Recommend department and authority management strengthen controls to perform timely eligibility redeterminations and provide periodic training to caseworkers to reduce the risk of administrative errors. We also recommend management implement corrections in the ONE system to address the weaknesses identified in verifying income. Management should also review the entire duration of the claim identified to determine if there are additional questioned costs from previous years. Additionally, management should reimburse the federal agency for unallowable costs.

  The Department is committed to providing timely benefits to only those individuals who are appropriately determined eligible. The Department has taken positive steps since 2016 to continuously improve and automate reporting capabilities for tracking and remediating untimely Medicaid redeterminations, including the successful implementation of the new Integrated Eligibility (IE) system, named "ONE" in February 2021. This new system provides improved client eligibility controls specifically related to timeliness of determinations, correct enrollment, automated notification of redeterminations and subsequently, actions to close eligibility if necessary, along with electronic retention of eligibility data elements such as signed applications. With implementation of ONE and as we move the rest of the cases into ONE over the next year of redeterminations., we expect the errors associated with these areas to be reduced.

  The Department has collaborated across OHA and ODHS programs to develop a combined eligibility manual that incorporates all relevant policy and process for determining eligibility for the medical benefits contained in the IE system. This allows our eligibility workers and case managers in the local offices an upgraded tool and a singular resource that allows us to work collaboratively in

our efforts to better serve and be good stewards to Oregonians. We anticipate releasing this in July 2021.

In addition, new program and system training has been developed and deployed collaboratively across OHA and ODHS programs to ensure new and existing eligibility staff are trained sufficiently in the ONE system and all programs contained therein.

The department and authority are committed to providing training and guidance to staff to ensure information related to an eligibility determination, that is not captured by the ONE system, will be include in the individual's case record. The department will review and update any existing training material as needed and send a communication to staff highlighting the importance of recording any information related to the eligibility decision, that is not already captured by ONE.

The authority has submitted a change request to update the logic used by the ONE system to determine whether income information received by the Federal Data Services Hub is reasonably compatible with information contained within a case record. Additionally, the authority will review the identified individual's case and reimburse the federal agency for any questioned costs for the duration of the claim.

***Update:** Staff materials have been updated, communications have been sent, training and guidance have been provided:*
◦ *The combined eligibility manual that was updated can be found on the DHS forms: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de2818.pdf*
◦ *Information about verifying and documenting income sent May 3, 2021 in a staff Weekly Update*
◦ *Attached All staff transmittal sent in March 2021*
◦ *Income related trainings provided in the months listed below; recordings of these are still available online for staff: July 2021 and December 2021*

- Recommend authority management strengthen controls to ensure documentation supporting a provider's eligibility determination and revalidation is retained. Additionally, we recommend management review the automated processes to ensure databases are checked timely.

  As of June 30, 2021, the state had addressed all bullet points noted in the finding and obtained the missing managing employee information, new disclosure statements or new eenrollment agreements for all providers in the sample with one provider being inactivated who failed to respond. New enrollment agreements and provider disclosure documents for revalidating providers are now required.

  Since April 2019, the State has been running monthly missed validation reports for newly enrolled or revalidated providers to ensure missed validations are completed.

- Recommend authority management continue to implement procedures to monitor potential unauthorized changes to the application, as well as continue to verify the effectiveness and completeness of the claim's edits and audits function.

  HSD has taken the following corrective action for 2020-2021:

  1. *Rewrote the deliverable from Gainwell, the MMIS contractor, so that testing results are easier to read and understand.*
  2. *OHA conducts monthly meetings involving managers from Provider Services, Claims, EDI, and BSU to review any claims/EDI issues, including new edits being proposed or developed. This meeting is a checkpoint to be sure that all units impacted by claims edit and audit changes are aware of proposed & pending changes, and to create accountability before implementing a new edit or audit in MMIS. (meeting once a month since January 2021)*

3. *Regular auditing reports reviewed on the four analyst positions who can update edits and audits in the MMIS. These reports allow HSD Leadership & Management to monitor activity by the analyst in MMIS to determine if any incorrect actions have occurred. (reports are being developed weekly)*
4. *The MMIS Business Support Unit has explored ways that the monitoring of edits can be automated. However, HSD has found this is not a viable solution to date and that manual oversight and control processes implemented before July 1, 2021, will continue.*

***Update**: BSU continues to monitor selected claims edits and audits each quarter, and Gainwell continues testing throughout the year on the top 20% of edits with significant financial impact.*

Monthly meetings are schedule with the EDI Manager and lead worker, Provider Services Manager and lead worker, and also includes from the MMIS BSU the Claims and Reference subsystem analysts. Among the many agenda items is a check in regarding any new edits or audits that have been implemented into the MMIS over the previous 30 days.

Additionally, a monthly usage audit is conducted for the 4 individuals in MMIS BSU who can update edits and audits in the MMIS.

- Recommend authority management strengthen controls over review to ensure transactions are adequately supported and the federal financial participation rate is correctly applied. Additionally, we recommend the authority reimburse the federal agency for unallowable costs.

  The agencies immediately corrected the questioned costs by charging the transaction to the correct period federal participation rate and reimbursing the federal agency. The questioned costs of $124,851 was corrected with document BTCL8375 on March 4, 2021. The questioned federal

costs of $213,575 was corrected with document number BTCL8382 on March 18, 2021. The refund was reported on the Title XXI FFY 2021 Q2 report to CMS.

To ensure the appropriate program coding is used, OFS will send the Public Health program staff the appropriate program coding for inclusion on the CHIP Vaccine Value Report that is submitted quarterly to the Office of Financial Services (OFS). Adding the coding elements to the report (used as entry documentation) will help ensure the correct program codes are used on the approved request and entry.

To ensure the correct FFP rate is used on the CHIP vaccine draw entry, OFS will update the internal process document to show the methodology change to claiming funds based on the date vaccines are administered rather than based on the date the vaccines are purchased.

Remaining questioned costs in the amount of $77,214 were refunded using document BTCL8588 with a May 13, 2022, effective date. The refund is being reported to CMS on the FFY2022 Q3 CMS-21.

- Recommend authority management strengthen controls by providing periodic training to eligibility staff to reduce the risk of administrative errors. This training should ensure eligibility staff know how to verify and document income support. In addition, management should review benefits and program eligibility related to cases identified with questioned costs to ensure proper funding within CHIP and other applicable federal programs and should reimburse the federal agency for unallowable costs.

  The ODHS and OHA are committed to providing training and guidance to ensure staff know how to verify and document income support. The ODHS and OHA will review and update any existing training material and eligibility manuals and send communications to staff with this information. Additionally, the authority will work with the federal agency to reimburse for the unallowable costs.

OHA requested technical guidance from the Center for Medicare and Medicaid Services (CMS) on March 23, 2021. As 42 CFR 435.956(e), Oregon Administrative Rule, and Oregon's State Verification Plan all indicate that the state will accept self-attestation for this eligibility criteria, and not require proof, either pre- or post-eligibility, unless questionable, OHA is seeking CMS' position on whether this should be an audit finding of non-compliance resulting in the return of FMAP. At the time that the individual attested that she was pregnant, it was not questionable, staff followed procedure, and appropriate regulations, rules, and the State Verification Plan were followed. If CMS deems it a valid finding, OHA will work with the CMS to reimburse for the unallowable costs.

The Center for Medicare and Medicaid Services (CMS) responded that per 42 C.F.R. § 435.945(a), states are permitted to accept self-attestation of information needed to determine the eligibility of an individual for Medicaid, except where law requires other procedures (e.g. citizenship or immigration status). States have flexibility to accept self-attestation of eligibility criteria, such as age or date of birth, income, state residency, and household composition. Consistent with 42 C.F.R. § 435.956(e), states must accept self-attestation of pregnancy, unless the state has information that is not reasonably compatible with the attestation. Additionally, states must describe these policies in their Verification Plan, per 42 C.F.R. § 435.945(j). In instances where an attestation is later determined to be incorrect, the state is not held liable for such an eligibility determination if the state followed its documented policies and procedures and all applicable federal rules.

- Recommend authority management strengthen controls over provider eligibility determinations and revalidations to ensure maintenance of updated agreements and disclosure statements in accordance with federal regulations and ensure all databases are checked timely.

  For the first item noted in this finding the validation box was missed due to staff error and as of February 2021, OHA obtained an updated disclosure statement and verified the death master file for the managing employee. The ongoing corrective action plan is already in place but was

implemented after this provider was enrolled. To ensure current and future required validations are completed accurately and timely, the State pulls the missed validation report monthly seeking validations which were missed by enrollment staff. Validations which were missed are remediated. The missed validation reports have been pulled and worked monthly since April 2019 and will continue.

For the second item noted in this finding OHA contacted both providers to obtain the missing documentation. As of March 1, 2021, OHA obtained a completed disclosure statement with required managing employee details from one of these providers. The second provider must complete the revalidation process by submitting a managing employee. This provider requested and was granted an extension. The Provider Enrollment Unit anticipates receiving information and completing revalidation by April 30, 2021. Should the provider fail to revalidate by the deadline, they will be inactivated as a Medicaid provider.

For the third item noted in this finding OHA obtained a signed provider enrollment agreement and completed disclosure statement from one of these providers as of March 1, 2021. While the second provider failed to comply and is in the process of having their Medicaid participation inactivated.

For the fourth item noted in this finding OHA obtained a completed disclosure statement for this provider as of March 1, 2021. The provider submitted the information prior to the close of the audit and prior to the March 31, 2021, revalidation deadline.

For the fifth item noted in this finding OHA obtained signed provider enrollment agreements and disclosure statements from five of the six providers as of March 1, 2021. The remaining provider failed to comply and is in the process of having their Medicaid participation inactivated. These providers are also currently going through the revalidation process and will all be required to provide updated enrollment agreement and disclosure forms.

The State is in the process of revalidating these providers but has been delayed due to the federal COVID-19 Disaster Relief 1135 waiver. The waiver allows revalidation to be delayed for providers that were due during the public health emergency. Federal guidelines state these revalidations must be completed within six months after the end of the public health emergency for compliance. To meet these requirements, OHA has begun revalidations and is on track to complete this work by August 31, 2021. The ongoing corrective action plan is already in place. Since 2019, the provider revalidation process mirrored the provider enrollment process by requiring the submission of an enrollment agreement and disclosure statements. Providers will not be enrolled or revalidated without the managing employee information, signed provider enrollment agreements or disclosure statements. All missing provider documents were received and one provider was end dated because they failed to respond by August 31, 2021.

5. OHA: Timely Notification of Inpatient Hospital Stays Could Help Reduce Improper Medicaid Payments, audit #2021-37 (dated December 2021)

- Reimburse the federal government for the federal portion of the identified improper payment amount.

  OHA is reviewing the NEMT claims and will pursue the appropriate actions to reimburse the Centers for Medicare and Medicaid Services (CMS) for any improper payments. Additionally, technical assistance will be provided to the NEMT brokerages and providers found to be inappropriately billing. If intentional fraud, waste, or abuse is identified through this research and outreach OHA will pursue the appropriate legal remediations. OHA is collaborating with ODHS on the In-home service and private duty nursing for children that involves cross agency funding. ODHS has committed to researching the individual claims identified through the audit to

determine necessary actions including repaying the Centers for Medicare and Medicaid Services for any inappropriate billing.

- Develop and implement cost-effective controls that would prevent or detect improper payments for unallowable services while a Medicaid client is inpatient. Consider ways timely notification of hospital admissions could be integrated efficiently into claims processing.

  OHA is collaborating across program areas to identify cost-effective automation and process improvements.

  OHA is assessing the feasibility of expanding its current software analytical tools to perform pre and post-payment reviews. This could facilitate the automated review of payments to providers.

  Until OHA can accomplish a cost-effective automation, OHA will conduct a quarterly data pull to include In-Patient claims where there is an additional claim type for the same dates of service as the In-Patient stay. The data elements of that report will include the following: Member Information, From Date of Service to Date of Service, and Claim Type. This quarterly report will be sent to the Medicaid Policy Unit in the Health Systems Division for assessment, analysis, and determination regarding any further action on those claims. If the Medicaid Policy Unit determines there is some potential solution that can be administered, they will work collaboratively with the MMIS team to determine the best course of action, or if any action can be taken in the current system environment. The inpatient claims data will also be shared with ODHS for review and remediation of claims outside of MMIS. During the Public Health Emergency related to COVID-19, beginning in 2020, OHA and ODHS collaborated on an emergency waiver to Home and Community Based Services (HCBS) to stabilize the system and offer additional supports to Medicaid eligible individuals. Specifically, one part of the waiver allowed OHA and ODHS to provide personal care supports while an individual was hospitalized. OHA and ODHS have found that the waiver has provided a necessary benefit to the members we serve. Jointly, we have

included this flexibility as a new, ongoing service as part of the state's 1915(k) and 1915(i) state plan amendments to be a permanent component of HCBS to eligible individuals. Approvals for HCBS providers to serve individuals in hospitals are made by the case management entities or the central policy teams. Additionally, ODHS is currently researching further controls the agency can put in place to prevent future inappropriate billing from occurring and will be included in OHA discussions regarding potential automation of reviews. As the single state Medicaid agency for Oregon, OHA holds the ultimate responsibility for the administration, compliance, and accuracy of Oregon's Medicaid program and will establish quarterly meetings with ODHS to ensure mechanisms are in place to identify and implement cross systems risks and mitigation.

6. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2021, audit #2022-18 (dated July 2022)

- We recommend department and authority management strengthen review controls to ensure only allowable expenditures are charged to the Medicaid program. Additionally, we recommend the authority reimburse the federal agency for unallowable costs.

  The Office of Financial Services will continue to consult with and advise program on the need for accurate coding and review of vendor payments to ensure proper funding is used for the services provided. Questioned costs were corrected with documents BTCL4471 and BTCL4473 and the appropriate amount was refunded to the federal agency.

- We recommend department and authority management strengthen controls to ensure documentation supporting a provider's eligibility determination and revalidation is retained and is complete.

  ODHS – Aging and People with Disabilities (APD) Response:

The department's expectation to have a correctly completed and retained I-9 for homecare workers was reinforced by the department with APD and Area Agency on Aging (AAA) program managers, district managers, supervisors, and support staff responsible for completing I-9s in APD and AAA offices meetings held on 4/13/22, 5/10/22, 5/11/22, and 5/26/22. The Local office staff were reminded of the legal requirement to correctly complete and retain the form and have it readily available for inspection. Local office staff were reminded of the resources available to assist with completing and retaining I-9s, particularly referencing the information memorandum issued in 2019 on how to correctly fill out an I-9 for homecare workers (APD-IM-19-062), the U.S. Citizenship and Immigration Services' Handbook for Employers (M-274) and referenced the information available on the case management tools webpage for APD/AAA staff. Additionally, in August 2021, we implemented the process of uploading HCW provider applications, supporting documentation and renewals into EDMS as noted in APD-AR-21-039, which were previously maintained in paper files at the local office. This will assist with the finding and retention of records.

ODHS - Intellectual/Developmental Disabilities Response:

For a short-term solution, we are implementing a random sampling Quality Assurance by the Provider Enrollment team. Currently, there is a QA staff who is monitoring agency enrollments, but we are having them also include Personal Support Worker items as well. Our current Fiscal Intermediary, Public Partnerships, are processing the I-9s currently and we will go into their system to check for any missing items.

- We recommend authority management strengthen internal controls to ensure each MLR report contains all required information.

  OHA has increased the staff assigned to the medical loss ratio report review for CY2020 and based on feedback through the audit, has already improved review to ensure the allocations are filled out by all CCOs for CY2020 (current filing period under review). The three managed care entities

missing this information in CY2019 completed the information for the updated filing. OHA will continue to review and follow-up with filings from managed care plans to ensure they are complete for this filing and future filings.

OHA completed the 2020 review and ensured the allocations are filled out by CCOs in the evaluation phase.

- We recommend department management develop and implement procedures to help ensure the accuracy of amounts reported in the monthly financial reports. Additionally, we recommend department management work with the CDC to revise and resubmit the inaccurate reports.

  Our corrective action plan to improve financial reporting accuracy is as follows:

  - *All ELC monthly financial reporting will be assigned to our current ELC Fiscal Analyst.*
  - *ELC Fiscal Analyst will submit monthly financial reports and the query used to generate the reports to the Office of Financial Services (OFS) for review and approval.*
  - *ELC Fiscal Analyst will then revise monthly financial reports based on OFS feedback.*
  - *Following OFS approval, monthly financial reports will be entered into REDCap by ELC administrative staff. A second staff member will verify that data entry is accurate.*
  - *ELC Fiscal Analyst will reach out to CDC to develop a plan to revise and resubmit inaccurate reports.*

- We recommend the authority return the questioned costs to the Department of Health and Human Services.

The Oregon Health Authority has processed the refund with a May 13, 2022, effective date using document BTCL8588.

- We recommend management strengthen internal controls to ensure appropriate subrecipient monitoring is performed. Specifically, monitoring procedures should be performed timely and should be designed to ensure subrecipients use program monies for allowable purposes. We also recommend management seek reimbursement of program monies that were not spent by subrecipients or were used for indirect costs and reimburse the federal agency for unallowable costs.

  Finding: Evidence of monitoring not retained

  Health Systems Division (HSD) – Behavioral Health Response:

  - *HSD is already in the process of developing a more robust grant compliance monitoring process and is currently in the pilot phase. We are currently planning for widespread training and socialization Summer 2022 with continued compliance monitoring on all grants quarterly thereafter. However, the internal compliance team (Governance & Process Improvement – GPI unit) is attempting to acquire dedicated staff for grant monitoring as this team has not grown at the rate of the Behavioral Health teams.*

  Finding: Indirect Costs/Unspent monies not reimbursed.

  HSD – Behavioral Health Response:

  - *As of the writing of this response, OHA has received final expenditure reports and recovered $99,613 in unspent funds from one entity. Since completion of the audit, HSD – Behavioral*

health, has also confirmed through expenditure reports that the other two entities expended all their funding appropriately

- *Behavioral health is working statewide to ensure that all county-based CRF reports are submitted, and any unspent funds will be returned to OHA by September 15, 2022. Additionally, OHA will ensure that any unspent funds will be returned to the US Department of Treasury promptly.*

Public Health Division (PHD) Response:

- *PHD will complete a full analysis of all CRF contracts and posted payments for any errors or miscoding during adjustment requests. PHD has issued settlement letters to CBOs owing funds to OHA during Fall 2021. OHA will ensure that any unspent funds will be returned to the US Department of Treasury promptly.*

- We recommend management strengthen internal controls to ensure subaward information is accurately communicated to all subrecipients. We also recommend management ensure a risk assessment is completed for each subrecipient.

  Finding: Inaccurate/incomplete subaward information communicated

  HSD – Behavioral Health Response:

  - *Corrected the link to subaward information website; created an internal tracking sheet for subrecipients of federal funds and to verify that all required subaward information has been accurately posted.*

Public Health Division Response:

- *The Public Health Division will ensure that subrecipient designations are reviewed and validated as a part of the contract amendment process. Should funds that operate like CRF come to the Public Health Division in the future, necessary grant documentation such as Project Officer name will be collected from DAS in the grant set-up process.*

Health Equity Response:

- *Future awards related for these purposes that have federal funds will provide all appropriate subaward information in communication.*

Health Equity Response:

- *Future awards for these purposes that have federal funds will assure that risk assessments are completed as required.*

PLACEHOLDER-details are not available at this time

Oregon Health Authority

Reduction Options: 2023-25 Agency Request Budget

Reductions included in the 2023-25 Ways and Means re in strike through font.

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2023-2025 Biennium

(Limited Other and Federal Funds only - does not include Non-Limited Funds)

Current Service Level Budget (OHA LEVEL)	**5,066,452,882**	**9,362,873,623**	**16,529,047,618**	**30,958,374,123**
10% Target	**(506,645,288)**	**(936,287,362)**	**(1,652,904,762)**	**(3,095,837,412)**

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
~~-0.02%~~	~~4~~	~~SAEC: FACILITIES~~	~~Reduction thru inflation/savings in budget projections for Expendable Prop and Office Expense~~		~~(1,044,000)~~	~~(372,000)~~	~~(534,000)~~	~~(1,950,000)~~	~~-~~	~~-~~	
~~-0.85%~~	~~2~~	~~Medicaid~~	~~Reduce Oregon Health Plan inflation for managed care and fee-for-service from 3.4% to 3.0% per year.~~	~~N~~	~~(41,900,000)~~		~~(100,300,000)~~	~~(142,200,000)~~			~~This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.~~
-1.26%	3	Medicaid	Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset indirect costs associated with their GME programs. IME includes indirect costs that arise from the inexperience of residents such as extra medical tests and reduced productivity. CMS APPROVAL REQUIRED.	Y	(20,710,000)		(30,231,000)	(50,941,000)			Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on these ten teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payment will also impact the physician workforce as there is already a shortage in the primary care specialty, which is one of the largest specialties in a teaching program. A reduction of trained providers may limit access to quality healthcare.
-1.33%	4	Medicaid	Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset costs associated with their graduate medical education programs. GME includes costs associated with stipends or salaries for residents, payments to supervising physicians, and direct program administration costs. CMS APPROVAL REQUIRED.	Y	(3,945,000)		(5,758,000)	(9,703,000)			Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing payments would be a hardship on these ten teaching facilities and would de-incentivize hospitals from training new physicians. Discontinuing GME payment will also impact the physician workforce as there is already a shortage in the primary care specialty, which is one of the largest specialties in a teaching program. A reduction of trained providers may limit access to quality healthcare.
-1.47%	5	Non-Medicaid	Remove inflation for Community Mental Health and Substance Use Disorder Programs.	N	(6,989,084)	(5,164,770)	(1,893,880)	(14,047,734)			Removal of inflation for the 2023-25 biennium will be devastating to the BH system. Programs reliant on OHP reimbursement for treating clients are in workforce crisis, with vacancies and tighter budgets impact availability of programing and services. Cuts disproportionately hurt the most susceptible to historic and contemporary racism and inequities, including BIPOC, those who are homeless, and children. Oregon has one of the highest rates of mental illness and addiction in the USA and drug overdose deaths in Oregon more than doubled between 2019 and 2021; suicide is the leading cause of death for children. Disruptions to daily life due to the COVID-19 pandemic have increased the need for behavioral health services that the system is not able to fully meet without continued investment and adequate fudning levels in an economy that is experiencing substantial inflation. We will see an increase in costly services including EDs, inpatient care and pressure on a health system that doesn't have capacity to address the need. Oregon will be at increased risk for non-compliance with current lawsuits, audit findings and increase the risk of more judicial oversight.

Accumulative % Reduction of CSL GF	Program Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF	FF	TF	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-2.09%	6	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 3.0% to 2.7% per year.	N	(31,200,000)		(74,600,000)	(105,800,000)			This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-2.70%	7	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.7% to 2.4% per year.	N	(31,000,000)		(74,400,000)	(105,400,000)			This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-2.70%	8	PH HST	Eliminate funding for Or-Epi	N	(21,000)	-	-	(21,000)	-	-	Eliminate of support for the annual Oregon Epidemiology Conference.
-2.70%	9	PH HST	Reduce services & supplies	N	(34,650)			(34,650)	-	-	Reduce training, travel and development support for internal and external partners.
-2.72%	10	PH OSPHD	Reduce Service and Supplies	N	(733,931)	0	(3,000,000)	(3,733,931)			Reduce ability to support office wide activities, including trainings and travel and greatly reducing supplies.
-2.72%	11	PH OSPHD	Eliminate Advance Directive activities	N	(51,490)	-	-	(51,490)	-	-	These funds would eliminate the ability to continue staffing and facilitating the Advance Directive Adoption Committee and would limit educational materials development related to the Oregon Advance Directive Form.
-2.72%	12	HPA	Reduce all staff supplies, development, travel to only essential activities (assume 90% reduction from previous expenditure)	N	(328,362)	-	(426,000)	(754,362)	-	-	The effectiveness of current staff would be greatly impacted by this reduction. Without continued training, knowledge of current best practices, innovation concepts, federal policy and program implementations, etc. may not be understood. Maintaining modernized programs would be extremely difficult.
-2.73%	13	HPA DSI / Transformation Center	Reduce Transformation Center technical assistance by 20%	N	(150,000)	-	(150,000)	(300,000)	-	-	These budget cuts will significantly impact the Transformation Center's capacity to support CCOs' innovation in key CCO 2.0 areas: value-based payment, social determinants of health and health equity, and behavioral health. The result will be an almost 20% decrease in the technical assistance CCOs receive, jeopardizing CCOs' ability to achieve CCO 2.0 goals. The remaining 80% of the program would shift reprioritize to focus first on health inequities.

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-2.74%	**14**	HPA DSI / PCPCH	Reduce PCPCH Program by 30%	N	(596,211)	-	(381,186)	(977,397)	-	-	These cuts to the Patient-centered Primary Care Home (PCPCH) Program would lead to a significant scaling back of the PCPCH program, resulting in a decrease in the ability of Oregon's primary care system to deliver high-quality, high-value, equitable care, which is especially essential during COVID. The model was designed to promote holistic, patient-centered care, and has recently been redesigned through the lens of promoting health equity and minimizing disparities. Further, according to a 2016 Portland State University evaluation, each patient receiving care from a PCPCH experiences $162 lower annual total health care expenditures compared with a patient who receives care in a non-PCPCH clinic. Since almost 90% of all Oregonians currently receive care from a PCPCH, the program is associated with total annual savings of $614 M—savings that would decrease substantially with a significantly smaller PCPCH program. These budget reductions would also prevent the launch of the Behavioral Health Home (BHH) program, which is a building block for the Governor's CCO 2.0 vision of establishing high-quality, integrated behavioral and primary health care at the clinic level and is particularly essential during COVID recovery.
-2.74%	**15**	HPA DSI/PCO	Eliminate HRSA Oral Health Workforce Grant	N	-	-	(841,458)	(841,458)	-	-	The grant program builds on previous federal grants to increase the oral health workforce and access to services in areas of Oregon with the highest unmet health care need. This grant will integrate teledentistry services into primary care clinics, utilize new technology to expand dental preceptor capacity for student clinical rotations, and develop a tiny mobile dental home to provide comprehensive services to underserved populations. Eliminating this grant will have a huge impact on the state's ability to introduce innovative care delivery models for meeting oral health service needs in areas experiencing health inequities.
-2.75%	**16**	HPA DSI/Pharmacy	Reduction in Strategic Clinical Services by 50%	N	(577,412)	-	(1,044,141)	(1,621,553)	-	-	These budget cuts would significantly impact two priority areas for clinical support: pharmacy and oral health. Strategies to ensure patients have access to—and the state pays for— high-value medication will not be implemented. In addition, Oregon will lack oral health leadership, resulting in a continued delay in robust oral health and physical health integration, which will contribute to statewide delays in access to oral health care. This reduction would significantly reduce support for the Center for Evidence-based Practice related to oral health and pharmacy.
-2.75%	**17**	PH OMMP	Monitor staffing and services and supplies for Oregon Cannabis Commission	N	(49,313)			(49,313)			Reducing this budget might have some small impact to work done for the Oregon Cannabis Commission. Given current budget trends and intent to fill both positions (AS1 and OPA3), this reduction might have some impact that will cause a reduction in S&S spending and/or a decrease in percent time that one of the staff can charge to this fund. If that happens, the percent time reduced in GF will be offset by the same percent time increase to the OMMP OF fee.
-2.75%	**18**	PH Admin	Reduce Center administrative activities	N	(209,900)	-	-	(209,900)	-	-	Reduce ability to support Center wide activities, including trainings and travel
-2.76%	**19**	PH ADMIN	CHP-Center for Health Protection Administration	N	(104,023)			(104,023)			This amount represents a cost shift from GF funding to OF and FF for the administration of the Center for Health Protection.

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-2.80%	20	Central Services	S&S reduction of Standard Inflation for all offices - pkg 31-01	N	(2,439,371)	(78,430)	(447,584)	(2,965,385)	-	-	
-2.84%	21	SAEC	S&S reduction of Standard Inflation for all offices - pkg 31-01	N	(1,723,384)	(562,888)	(727,509)	(3,013,781)	-	-	
-3.06%	22	SAEC: price list	SGSC, Risk, ETS - all DAS Price list items - reduce by 15%	N	(11,052,305)	(1,218,946)	(1,429,388)	(13,700,638)	-	-	This Comp Source Group, is directly audited to the Price list, if DAS doesn't pass along savings, this won't actualize. Achieved thru DAS lowering their invoice costs, and passing along their cuts to the agency's thru their invoicing.
-3.07%	23	HPA Health Information Technology	Eliminate contract for statewide Collective Platform	N	(769,338)	-	(2,308,008)	(3,077,346)	-	-	This contract covers Medicaid users on the statewide Collective Platform (aka Emergency Department Information Exchange (EDIE)/fka PreManage), including CCOs, Medicaid fee for service contractors, Tribal clinics, and OHA/ODHS programs. The Collective Platform plays a critical role in ensuring that all health care organizations working with high-risk patients to know when they have been in the emergency department or hospital, and coordinate their care across their primary care, CCO, behavioral health team, hospital, skilled nursing facilities, and OHA/ODHS programs. Without OHA's CMT contract, Medicaid members and OHA/ODHS clients would face increased barriers to coordination of care and worse health outcomes, including many people that typically face disparities due to racism and other social factors. OHA's funding is in partnership with all hospitals, CCOs and most commercial health plans, which together ensure participation by all hospitals and a huge swath of physical, behavioral, oral clinics and skilled nursing facilities across Oregon. OHA has also leveraged the Collective Platform infrastructure to support and promote health system transformation and health equity priorities, including behavioral health interventions, CCO metrics, and public health use cases including PDMP, MDRO, and COVID data sharing. OHA's participation is a cornerstone for this program – removing our participation will end the current statewide footprint for this infrastructure which would impact our public health, behavioral health, Medicaid and health system transformation work.
-3.21%	24	HPA DSI/PCO	Reduction in Funding for the Health Care Incentive Fund by 35%	N	(6,770,544)	(7,936,811)	-	(14,707,355)	-	-	The Health Care Incentive program provides financial and non-financial incentives to providers of physical, oral and behavioral health in underserved areas. The program has successfully established primary care providers in 20 of the 25 rural service areas that were lacking primary care services altogether. The program focuses on culturally competent health care - 36% of the providers receiving loan repayments speak a language other than English or come from a racial/ethnically diverse background. This reduction option would decrease funding by over 35%, significantly impacting multiple contracts currently in place and greatly reducing the intended outcomes of the program.

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-3.55%	**25**	Medicaid	Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients. The agency would no longer cover the following dental services for adults (including pregnant adults) on OHP: Crowns, full and partial dentures; scaling & root planning. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	Y	(17,271,381)		(62,989,178)	(80,260,559)			Eliminate dental coverage for OHP non-pregnant adults, which would eliminate all services for non-pregnant adult dental coverage for the OHP benefit package. Legislative action and CMS negotiation and approval are required. The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits. Dental benefit reductions will impact an individual's over-all health. Reductions will create a worsening of chronic diseases such as diabetes, poor pregnancy outcomes, and create a shift in treatment need. Patients not receiving needed dental care will experience need to go to the Emergency Department, possibly elevating need for opioids and/or requests for opioids and higher ED costs. People will lose teeth unnecessarily with no means to replace them. People will experience more difficulty in getting jobs due to poor oral appearance and experience missed days from work due to oral disease and pain. Dental benefit reductions will hinder populations impacted by health inequities from achieving health equity or equitable health outcomes. Marginalized populations suffer the highest incidence or oral disease in all categories. It is well known these disease states also impact comorbid conditions, such as diabetes and high blood pressure, again, with the highest incidences in marginalized minority communities. Optimal diabetes care is vitally important for those individuals with diabetes, and as it relates to potential outcomes for those who become COVID involved, again with the minority and marginalized communities being the hardest hit.
-4.48%	**26**	Medicaid	Eliminate dental coverage for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits.	Y	(47,117,013)		(190,394,609)	(237,511,622)			Eliminate coverage for specific dental services for adult Oregon Health Plan (OHP) clients, no longer covering the following dental services for adults (including pregnant adults) including: crowns, full and partial dentures, scaling and root planning. CMS negotiation and approval are required. The Health System Transformation waiver Special Terms and Conditions prohibit the state from reducing eligibility or benefits. Dental benefit reductions will impact an individual's over-all health. Reductions will create a worsening of chronic diseases such as diabetes, poor pregnancy outcomes, and create a shift in treatment need. Patients not receiving needed dental care will experience need to go to the Emergency Department, possibly elevating need for opioids and/or requests for opioids and higher ED costs. People will lose teeth unnecessarily with no means to replace them. People will experience more difficulty in getting jobs due to poor oral appearance and experience missed days from work due to oral disease and pain. Dental benefit reductions will hinder populations impacted by health inequities from achieving health equity or equitable health outcomes. Marginalized populations suffer the highest incidence or oral disease in all categories. It is well known these disease states also impact comorbid conditions, such as diabetes and high blood pressure, again, with the highest incidences in marginalized minority communities. Optimal diabetes care is vitally important for those individuals with diabetes, and as it relates to potential outcomes for those who become COVID involved, again with the minority and marginalized communities being the hardest hit.
-4.48%	**27**	Medicaid	Leverage Reduction	Y/N	-	(165,923,016)	(277,183,717)	(443,106,733)	-	-	Reduction of Leverage programs including: GME-OHSU, MAC School Based, DOE School Based, BRS, TCM, UMG, Poison Control, GEMT (HB2910), GEMT HB4030

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-5.29%	28	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.4% to 2.0% per year.	N	(41,300,000)		(98,900,000)	(140,200,000)			This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-5.90%	29	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.0% to 1.7% per year.	N	(30,900,000)		(73,800,000)	(104,700,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
~~**-5.91%**~~	~~30~~	~~PH HCRQI~~	~~Oregon Patient Safety Commission.~~	~~N~~	~~(468,000)~~			~~(468,000)~~			~~Early Discussion Resolution program, pass-through funding. This will reduce the amount sent to the Patient Safety Commission. A 24% reduction to Early Discussion and Resoultion program funding for OPSC's biennial budget would be accounted for with the following reduction strategies:~~ ~~□ Eliminate in-person educational offerings~~ ~~□ Share EDR personnel with our PSRP program that currently has a vacancy.~~
-5.91%	31	PHD/NHS	Elimination of the USDA/Senior Farmer's Market Program	N	(6,169)		(1,028,288)	(1,034,457)			Provides vouchers to 43,000 low income seniors each summer to purchase fresh locally grown fruits and vegetables. Additionally, there would be reduced income to local farmers as over 90% of the dollars of directly to 500+ local farmers; biennium; and reduced access to healthy choices for this population at risk for inadequate intake of fruits and vegetables and food insecurity. This program supports the SHIP priority: Slow the increase of obesity, Strategy 4: improve availability of affordable, healthy food and beverage choices for adults, a primary target group.

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~~-5.93%~~	~~32~~	~~PHD/MCH~~	~~Reduction in the Universally offered Home Visiting program~~	~~N~~	~~(1,032,119)~~			~~(1,032,119)~~			~~The Universally offered Home Visiting/Family Connects Oregon initiative will bring evidence-based nurse home visiting services and referrals to all families of newborns in Oregon. SB 526 mandates OHA design, implement and sustain the program and commercial health plans cover these services for their members. Four of 8 Early Adopter communities are currently engaged in providing services and referrals. COVID paused work in the other 4 communities. The proposed reductions would reduce the CSI GF funding levels from $7,792,011 to $6,5444,615. This reduction would come from temporary staff vacancies, reduced Medicaid match needs due to the slower rollout, and temporary and reduced local support due to fewer implementing communities. We will also postpone establishing a Center of Excellence in Oregon for model implementation. We would maintain CSL for the TA contract for Family Connects International; program evaluation and current level of state infrastructure. The plan was to increase the 23-25 investment to continue the statewide rollout of the initiative. This reduction will minimally maintain the initial implementation started in the 21-23 biennium and not provide resources to re-engage the paused communities or expand into new communities. This will further lengthen the timeframe to statewide reach of the program.~~
-6.00%	**33**	OSPHD	Reduce state Support to Local Public Health Authorities	N	(3,700,000)		-	(3,700,000)	-	-	Local public health authorities (LPHAs) would receive 35% fewer dollars per capita for public health services. Funds are used to conduct early detection, epidemiological investigations and prevention activities to help report, monitor, and control communicable diseases, tuberculosis, sexually transmitted infections, influenza, foodborne illnesses, Zika and emerging infectious diseases such as Novel Coronavirus. Communicable diseases disproportionately impact BIPOC communities due to longstanding health inequities as a result of systemic racism and oppression. As a result, local public health authorities will have a decreased ability to prevent communicable diseases within BIPOC communities.
-6.01%	**34**	OSPHD	Reduce Planning and Response to Public Health Emerging Events	N	(300,000)	-	-	(300,000)	-	-	This would reduce the funds the public health division receives to address urgent issues. Examples of the work are wildfires, Vaping, COVID-19, and currently drinking water services. This funding provides $1.0M GF state level support for the planning, and operational readiness for communicable disease preparedness and response, and mitigation for other disasters to Oregon communities. The PHD is funded largely through categorical federal grants and fee revenue statutorily dedicated to specific programs and activities which prevents the division from being able to plan, respond and help vulnerable Oregon communities respond to and recover from hazards and emergencies. Public health emergencies disproportionately impact BIPOC communities due to longstanding inequities rooted in systemic racism and oppression. Elimination of these funds will impact emergency response efforts targeting BIPOC communities.

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-6.08%	**35**	OSPHD	Reduce Public Health Modernization	N	(3,700,000)	-	-	(3,700,000)	-	-	Reduce the Local support to LPHA's by 11%. This reduction will greatly impact the critical work both the state and local partners are completing. A focus area of public health modernization is to transform governmental public health in the area of health equity and cultural responsiveness through internal and community policy and program change. This reduction would impact local public health work with the BIPOC community. The locals will have to reduce staff and be unable to address emerging events, provide critical support to Oregonians and will impact the work done to modernize the public health system. Currently, both the state and local partners are addressing COVID-19. Reducing funding will impact the state's ability to address this pandemic. At the state level reductions will impact our equity work with various communities and data collection, the BRFSS survey will not be conducted, all health equity and learning collaborative work addressing health disparities will not occur and staffing will be reduced. Public Health is a critical component in ensuring Oregonians are healthy, safe and informed. Reducing any portion of these funds will greatly impact the ability of public health to be effective in Oregon.
-6.08%	**36**	OSPHD	Reduce Indirect Limitation	N	0	(500,000)	(4,000,000)	(4,500,000)			As PHD is working to create a division-wide indirect cost rate this limitation is needed to provide the technical accounting entries required to operationalize an indirect cost rate to ensure we do not have duplicative expenditure data in an internal services fund specific to tracking and reconciling indirect costs assessed to Public Health.
-6.12%	**37**	OSPHD	Reduce GF Inflation	N	(2,000,000)	-	-	(2,000,000)	-	-	This reduction in inflation would result in LPHAs receiving a 29 percent decrease on GF received for Modernization and State Support of Local Pubilc Health.
-6.93%	**38**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.4% to 1.0% per year.	N	(40,900,000)		(97,800,000)	(138,700,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-7.53%	**39**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.0% to 0.7% per year.	N	(30,600,000)		(73,100,000)	(103,700,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.

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-8.13%	**40**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 0.7% to 0.4% per year.	N	(30,400,000)		(73,000,000)	(103,400,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-8.93%	**41**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 0.4% to 0% per year.	N	(40,500,000)		(96,900,000)	(137,400,000)	-	-	This reduction is removing inflation that was built into the CSL 23-25 budget to meet the anticipated program growth. Removing this inflation will leave a greater gap between what is able to be reimbursed for Medicaid expenses in comparison to the reimbursement rate by other insurers. If the above inflation reduction were to take place it would require program expenses to be cut by a corresponding amount. There would be tough decisions to be made about which programs could be reduced or cut to stay with in budgetary constraints. In making these cuts Medicaid would work to prioritize protection of priority populations, however since Medicaid operates with virtually no reserve it will be impossible not to impact even priority populations. Less reimbursement for Medicaid services may make it harder to recruit providers to serve in demographics that service largely aged, disabled or impoverished areas where provider growth is noted as being needed most.
-9.39%	**42**	Medicaid	DRG Hospitals : DSH3.	Y	(23,000,000)		(34,000,000)	(57,000,000)			Reducing the reimbursement rate/level for DRG hospitals could adversely affect the Oregon Health Authority's relations with DRG hospitals that serve a large majority of our clients across the state. Reduced reimbursement could lead to a corresponding provider reduction of expenditures to adjust for the reduced amount of reimbursement, potentially leading to overall changes in the level of care or other service levels provided to Medicaid clients.
-9.52%	**43**	Non-Medicaid	SUD and CMH Inflation	Y/N	(6,693,791)			(6,693,791)	-	-	
-9.52%	**44**	PEBB	PEBB fully insured and self-insured plan reductions	N	-	(451,244,858)	-	(451,244,858)	-	-	PEBB contracts with insurance carriers for employee benefit plans. The operating budget for PEBB is 0.50%. The remaining 99.5% is program budget, which is dedicated funding for payment of self-insured and fully insured benefit plans. Taking reductions at any level may potentially default PEBB in its contractual obligations with carriers. Major plan design changes could possibly hit the reduction targets, but it would take a major reduction in medical plan coverage and would jeopardize the stabilization of the statewide risk pool. A major shift in cost sharing between employee, and employer could also potentially hit the reduction target but the reductions would have to be taken at the state agency budget level, as it passes employee benefit dedicated dollars through to PEBB.

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-9.52%	45	OEBB	OEBB plan reductions	N	-	(301,545,594)	-	(301,545,594)	-	-	OEBB contracts with insurance carriers for Entity and Self-Pay member benefit plans. The operating budget for OEBB is 0.5%. The remaining 99.5% are dedicated funds for payment of fully insured benefit plans that OEBB is contractually obligated to pass-through to carriers. The passthrough premiums include other taxes and fees at the state and federal level. Taking reductions at any level may potentially default OEBB in its contractual obligations with carriers. Premium shifts to members will not change the pass-through budget dollars needed to meet contractual obligations with carriers.
-9.54%	46	Central Services	S&S reduction could take - but would hurt programs some	N	(1,055,017)	(112,050)	(221,124)	(1,388,191)	-	-	
-9.58%	47	SAEC	S&S reduction could take - but would hurt programs some		(2,100,000)	(2,000,000)	(1,000,000)	(5,100,000)	-	-	ETS, Unemployment, OAH and P&H DCR's
-10.00%	48	Medicaid	Cut to Medicaid .2%	Y/N	(21,202,480)	-	(48,450,000)	(69,652,480)	-	-	About 4% cut to programs, including BH New Investments
-10.00%	49	Medicaid	Remove Federal Match				(222,200,032)				
							.				
					-	-	-	-	-	-	
			Total		**$ (506,645,288)**	**$ (936,287,362)**	**$ (1,652,905,102)**	**$ (2,874,543,720)**	**0**	**0.00**	
			Difference to 10% Target (over)/under		**0**	**(0)**	**(340)**				

2021-23 Mandatory Special Report on Community Mental Health

Treasury Account Report

July 2021 to June 2023

Per ORS 426.506 Community Mental Housing Fund; Community Housing Trust Account

Restricted Funds — Permanent Fund Principle		$5,726,586
Unrestricted 2019–21 Balance Forward		1,249,837
Prepayment of Funds		370,353
Interest:	Actual July 2021 through December 2022	118,282
	Projected January 2023 through June 2023 (6 months @ $6,571)	39,427
	Total Revenue	**$7,504,485**

Restricted Funds — Permanent Fund Principle		$5,726,586
Awarded Amounts Funded July 2021 through June 2023		0
Amount Reserved for Awarded Housing Development		919,870
Available to be Awarded — Housing Development		594,529
Available to be Awarded — Institutional Housing		224,073
Interest:	Projected January 2023 through June 2023 (6 months @ $6,571)	39,427
	Total Expenditures	**$7,504,058**

UPDATED OTHER FUNDS ENDING BALANCES FOR THE 2021-23 & 2023-25 BIENNIA

Agency: **Oregon Health Authority**
Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2021-23 Ending Balance In LAB	2021-23 Ending Balance Revised	2023-25 Ending Balance In CSL	2023-25 Ending Balance Revised	Comments
Limited	030-02	1389/ Prescription Drug Purchasing Fund	Operations	ORS 414.312	0	39,589	0	40,000	Oregon Prescription Drug Program. Three months of reserve to cover payroll.
Limited	030-02	1793/ Healthcare Provider Incentive Fund	Other, Incentive Fund	ORS 676.450	0	21,192,973	0	20,000,000	These funds have been obligated via loan repayment and other incentive agreements with providers and will be fully obligated.
Limited	030-02	2093/ COFA Premium Assistance Program Fund	Operations	ORS 413.613	0	630,489	0	0	COFA Premium Assistance Program. Program sunset 12/31/21 and closeout costs are still being processed.
Limited	030-02	2094/ Health Insurance Exchange Fund	Operations	ORS 741.102	0	5,677,095	0	3,500,000	Oregon Health Insurance Marketplace. Six months of reserves allowed in statute. Excess funds will be used for the State Based Marketplace (POP 416) if approved
Limited	030-02	0401/ General	Operations	ORS 442.466	0	83,056	0	80,000	All Payers All Claims (APAC). 24 months of reserve to cover data contract.
Limited	030-02	0401/ General	Operations	ORS 409.745	0	112,773	0	112,000	J-1 Conrad Physician Visa Waiver Program is funded by small application fees. These fees are spent in full for program operations costs. Eighteen months of reserves to cover payroll.
Limited	030-02	0401/ General	Other, Donation	ORS 413.570	0	0	0	0	Pain Management Commission donations for supplemental meeting costs.
Limited	030-02	0401/ General	Operations	ORS 442.468	0	694,563	0	650,000	Oregon Healthcare Workforce Database. 24 months reserve for payroll and data/research contracts.
Limited	030-02	0401/ General	Operations	ORS 442.468	0	38,731	0	38,731	Ambulatory Surgery Data fees collected when the program was active resulted in a small amount of remaining revenue. HB 4020 (2018) re-establishes the need for a data contract and fees to be collected to cover those costs. Funds allocated to restart the data collection.
Limited	030-01	Fund 3400 - Grant 100000 - Medicaid Map	Grant Fund: Medicaid		0	0	0	0	
Limited	030-01	Fund 3448 - Treasury Fund 1385, Grant 426600 Hospital Assessment	Grant Fund: Medicaid	Section 2, Chapter 736m Oregon Laws 2003, as amended	0	26,000,000	0	0	
Limited	030-01	Fund 3449 - Grant 100000 - Medicaid-Map	Grant Fund: Medicaid		0	0	0	0	
Limited	030-01	Fund 3511 - Grant 421201 - HSD - Ballot Measure 110-MJ Tax Revenues	Grant Fund: Medicaid		0	49,700,000	0	0	
Limited	030-01	Fund 3400 - Grant 400460 - Vibrant Emotional Health OF (988 Grant)	Grant Fund: Non Medicaid		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 411535 - HSD Settlement Community	Grant Fund: Non Medicaid		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 421100 - AMH Beer & Wine (OLCC)	Grant Fund: Non Medicaid		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 421200 HSD Marijuana	Grant Fund: Non Medicaid	ORS 475B.759	0	0	0	0	
Limited	030-01	Fund 3402 - Grant 424000 Law Enforcement Medical	Grant Fund: Non Medicaid	414.85 Law Enforcement Medical Liability Account	0	2,350,296	0	0	Restricted account, designated to be spent on medical liability claims related to harms obtained by individuals during police custody.
Limited	030-01	Fund 3405 - Grant 411504 - HSD Tobacco Settlement	Grant Fund: Non Medicaid		0	0	0	0	
Limited	030-01	Fund 3407 - Grant 411510 - A&D Outpatient	Grant Fund: Non Medicaid	ORS 813.270	(42,884)	3,000,000	0	0	Intoxicated Driver Program Fund is restricted to pay for specific treatments for individuals in diversion. The IDPF fund will have about $3M left in 21-23 but no ending balance is expected in 23-25.
Limited	030-01	Fund 3410 & Fund 3409 - Grant 400998 - American Rescue Plan Act -ARPA	Grant Fund: Non Medicaid		0	62,904,857	0	0	The grant period for this fund goes through 2025. Ending balance for payments to be made in 23-25.
Limited	030-01	Fund 3414 - Grant 400999 - Coronavirus Relief Funds	Grant Fund: Non Medicaid		0	0	0	0	

UPDATED OTHER FUNDS ENDING BALANCES FOR THE 2021-23 & 2023-25 BIENNIA

Agency: Oregon Health Authority

Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2021-23 Ending Balance In LAB	2021-23 Ending Balance Revised	2023-25 Ending Balance In CSL	2023-25 Ending Balance Revised	Comments
Limited	030-01	Fund 3440 - Grant 400462 - OHA BH Housing Incentive Fund (HB2316)	Grant Fund: Non Medicaid		0	20,000,000	20,000,000	20,000,000	Mostly empty limitation. This is a program that moved to OHA from OHCS in June 2022. The intent is for the Legislature to direct OHA on projects.
Limited	030-01	Fund 3418 - Grant 711000 - CMH Community Housing Fund	Grant Fund: Non Medicaid		0	1,772,895	1,772,895	0	Coding issues caused the ending balance in 2021-23; expected to be corrected and fully spent in 23-25
Limited	030-01	Fund 3420 - Grant 711000 - CMH Community Housing Fund	Grant Fund: Non Medicaid	ORS 595.431	0	5,726,586	5,726,586	5,726,586	Restricted fund. Oregon Laws 2009, Chapter 595, Section 431 (3)(a)(b) establishes a Community Housing Trust Account due to sale of state property, remains in perpetuity and non-spendable. Fund can expend earnings, such as interest, and be applied to Fund 3418.
Limited	030-01	Fund 3449 - Grant 411503 - HS AMH Tobacco Tax CMH Investments	Grant Fund: Non Medicaid		0	0	0	0	
Limited	030-01	Fund 3471 - Grant 411540 - Birth Certificates for Homeless	Grant Fund: Non Medicaid		0	50,000	0	0	
Limited	030-01	Fund 3400 - Grant 100100 - Medicaid Admin	Grant Fund: Program Support		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 400011 - Synectic's Contracts	Grant Fund: Program Support		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 426650 - 1.5% OCCF Admin Revenue	Grant Fund: Program Support		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 400800 - HSD GEMT Admin Fees Other Fund	Grant Fund: Program Support		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 421300 - HB 2032 TANF Housing Pilot Program	Grant Fund: Program Support		0	547,726	0	0	
Limited	030-01	Fund 3405 - Grant 411504 - HSD Tobacco Settlement	Grant Fund: Program Support		0	0	0	0	
Limited	030-01	Fund 3449 - Grant 411503 - HS AMH Tobacco Tax CMH Investments	Grant Fund: Program Support		0	0	0	0	
Limited	030-01	Fund 3400 - Grant 400464 - Opioid Settlement Grant	Grant Fund: Program Support		60,000	0	0	0	
Limited	030-04	1387 Operations	Operating	Senate Bill 426, Section 12	550,000	550,000	303,163	0	OEBB is moving Operations from SCR 30-04 to 30-02 in 23-25
Limited	030-02	1387 Operations	Operating	Senate Bill 426, Section 12	0	0	0	550,000	New SCR Program Area. OEBB is moving Operations from SCR 30-04 to 30-02 in 23-25. Increase to reflect the same ending balance as 2021-23
Limited	030-04	1388 Revolving	Revolving Fund (Stabilization)	Senate Bill 426, Section 12	9,150,000	9,150,000	33,549,000	37,149,000	OEBB is a fully insured plan. Premiums in=premiums out. Interest taken onto consideration for 23-25 ending balance
Capital Improvement	030-06	Fund 3421 - Treasury Account 0401. Grant # 400089 OSH Capital Improvement OF	Operations	Section 2, Chapter 838, Oregon La	785,452	600,000	0	0	Capital Improvement - OSH Facilities department have identified projects that would utilize all available funds. However, the utilization of funds may span across both the AY23 and AY25 biennia. We anticipate that any residual funding from AY23 will be fully utilized by the end of AY25.
Limited	030-06	0401 General	Operations	n/a	0	1,828,787	0	2,618,995	Protected account for Safety Grant revenue provided by SAIF when OSH continues to have workers perform duties instead of the worker going out on a SAIF claim. Expenditures must be for purchases/projects safety and worksite modifications approved by the OSH Safety Committee, making it nearly impossible to accurately estimate how much of the revenue will be utilized.
Limited	030-06	0401 General	Operations	n/a	0	0	0	0	Forensic Certification Program - Revenues received from the certification program for Forensic Evaluators. We anticipate no revenues to be carried forward at this time, as these revenues are used to offset program expenditures.
Limited	030-03	0433 Operations	PEBB Operating	ORS 243.165	5,347,052	5,347,052	4,986,273	0	PEBB is moving Operations from SCR 30-03 to 30-02 in 23-25
Limited	030-02	0433 Operations	PEBB Operating	ORS 243.165	0	0	0	4,986,273	New SCR Program Area. PEBB is moving Operations from SCR 30-03 to 30-02 in 23-25

UPDATED OTHER FUNDS ENDING BALANCES FOR THE 2021-23 & 2023-25 BIENNIA

Agency: **Oregon Health Authority**
Contact Person (Name & Phone #): Janell Evans 503-385-7654

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	Program Area (SCR)	Treasury Fund #/Name	Category/Description	Constitutional and/or Statutory reference	2021-23 Ending Balance In LAB	2021-23 Ending Balance Revised	2023-25 Ending Balance In CSL	2023-25 Ending Balance Revised	Comments
Limited	030-03	1381 Flex Benefits	PEBB Flexible Spending Admin	ORS 243.165	305,939	305,939	305,939	305,939	shouldn't change, funds in/funds out
Limited	030-03	1384 Stabilization	PEBB Self-Insured, Stabilization	ORS 243.165	252,490,690	402,000,000	240,641,376	264,641,376	2021-23 ending balance projection revised since reporting in Oct22 to include necessary reserves and claims contingencies which were excluded previously. 2021-23 Target reserves estimated at $254m. Ending balance depends on enrollments. Interest calculations taken into consideration for 23-25 ending balance
Limited	030-05	0401 General	Operations	ORS 441.020, 060, 442.315, 443.035, 315, 860, 682.126, 155, 157, 212, 216, 688.645, 682.047	1,264,000	1,322,407	1,264,000	1,264,000	HRCQI-Revenue estimates are higher.
Limited	030-05	0401 General	Operations	ORS 475.309, 797, 475B.785, 949, 950, 797, 810, 840, 858, 895	3,689,006	3,407,038	1,165,750	1,150,000	OMMP-Revenue estimates continue to decrease.
Limited	030-05	0401 General	Operations	ORS 448.131, 279, 450, 448	889,000	1,802,002	889,000	1,200,000	DWS
Limited	030-05	0401 General	Operations	ORS 453.757, 454.757	316,000	(47,300)	316,000	500,000	RPS-Costs are outpacing revenues
Limited	030-05	0401 General	Operations	ORS 431.29X, 92X, 446.321, 446.35X, 453.894, 624.02X, 624.57X, 431A.270	738,000	756,248	738,000	738,000	EPH
Limited	030-05	0401 General	Operations	ORS 675.405, 676.595, 605, 607, 615, 640, 800, 678.410, 680.525, 687.435, 688.728, 830, 834, 690.235, 385, 415, 550, 694.185, 700.080	3,288,000	2,327,517	3,270,146	3,270,146	HLO, new fee increases assisting with long term deficits in some programs
Limited	030-05	0401 General	Operations	TURA	0	2,000,000	2,000,000	2,000,000	Prevention
Limited	030-05	0401 General	Grant	Settlement/restricted fund	2,123,775	1,060,428	1,060,428	1,060,428	JP Morgan settlement account dedicated to TWIST to Web Implementation
Limited	030-05	0401 General	Other	WIC	0	4,686,373	4,686,373	4,686,373	WIC Food Rebate
Limited	030-05	0401 General	Operations	ORS 431A.855, 431A.880	650,000	91,486	0	0	PDMP
Limited	030-05	0401 General	Operations		0	100,000	100,000	100,000	Health Promotion & Chronic Disease Prevention
Limited	030-05	0401 General	Operations		0	70,000	70,000	65,000	Maternal & Child Health - may contribute from PRAMS & ECHO telephone survey
Limited	030-05	0401 General	Operations		0	25,000	25,000	25,000	CP&HP General
Limited	030-05	0401 General	Grant	Governed by Federal law/HRSA guidelines	43,975,727	90,000,000	42,048,811	90,000,000	Care Assist; restricted fund
Limited	030-05	0401 General	Grant		0	9,077,050	0	0	HST
Limited	030-05	0401 General	Other		700,000	700,000	0	900,000	Contributions dedicated to ALERT IIS
Limited	030-05	0401 General	Grant		0	6,869,609	0	0	Immunization services
Limited	030-05	0401 General	Grant		0	1,490,915	0	1,490,915	Practice General/Health Records
Limited	030-05	0401 General	Other		0	1,174,455	0	0	FEMA Covid/PDES
					326,279,757	747,216,635	364,918,740	468,848,762	

Objective: Provide updated Other Funds ending balance information for potential use in the development of the 2023-25 legislatively adopted budget.

Instructions:

Column (a): Select one of the following: Limited, Nonlimited, Capital Improvement, Capital Construction, Debt Service, or Debt Service Nonlimited.
Column (b): Select the appropriate Summary Cross Reference number and name from those included in the 2021-23 Legislatively Approved Budget. If this changed from previous structures, please note the change in Comments (Column (j)).
Column (c): Select the appropriate, statutorily established Treasury Fund name and account number where fund balance resides. If the official fund or account name is different than the commonly used reference, please include the working title of the fund or account in Column (j).
Column (d): Select one of the following: Operations, Trust Fund, Grant Fund, Investment Pool, Loan Program, or Other. If "Other", please specify. If "Operations", in Comments (Column (j)), specify the number of months the reserve covers, the methodology used to determine the reserve amount, and the
Column (e): List the Constitutional, Federal, or Statutory references that establishes or limits the use of the funds.
Columns (f) and (h): Use the appropriate, audited amount from the 2021-23 Legislatively Approved Budget and the 2023-25 Current Service Level at the Agency Request Budget level.
Columns (g) and (i): Provide updated ending balances based on revised expenditure patterns or revenue trends. Do not include adjustments for reduction options that have been submitted. The revised column (i) can be used for the balances included in the Governor's budget if available at the time of submittal.
Column (j): **Please note any reasons for significant changes in balances previously reported during the 2021 session.**

PROPOSED SUPERVISORY SPAN OF CONTROL REPORT

In accordance with the requirements of ORS 291.227, the Oregon Health Authority presents this report to the Joint Ways and Means Committee regarding the agency's Proposed Maximum Supervisory Ratio for the 2021-2023 biennium.

Supervisory Ratio for the effective January 1, 2023

The Agency actual supervisory ratio is calculated using the following calculation:

1. **Total # of Agency Employees = 4794**
2. **Total # of Agency Employees not assigned a representation = 9**
3. **Total supervisors (i.e., vacant and filled supervisory positions) minus the Agency head position = 430**
4. **Total non-supervisors (i.e., vacant and filled non-supervisory positions) = 4355**

The Oregon Health Authority has a current actual supervisory ratio of:

1:11.15	=	4794	/	430
(Actual span of control)		(Total non - Supervisors)		(Total Supervisors)

When determining an agency maximum supervisory ratio all agencies shall begin of a baseline supervisory ratio of 1:11, and based upon some or all of the following factors may adjust the ratio up or down to fit the needs of the agency.

← Narrow Span		Wide Span →
High	**RISK TO PUBLIC/EMPLOYEE SAFETY**	Low
Dispersed	**GEOGRAPHIC LOCATION(s) OF SUBORDINATES**	Assembled
Complex	**COMPLEXITY OF DUTIES/MISSION**	Not complex
Low	**BEST PRACTICES/INDUSTRY STANDARDS**	High
Small	**AGENCY SIZE/HOURS OF OPERATION**	Large
Many	**NON AGENCY STAFF/TEMPORARY EMPLOYEES**	Few
High	**FINANCIAL RESPONSIBILITY**	Low
← More Supervisors		Fewer Supervisors →

Ratio Adjustment Factors

Is safety of the public or of State employees a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The safety and health of Oregonians is a major governmental priority and the reason the Oregon Health Authority was established. OHA's activities are indicative of these priorities, and include:

- Delivering integrated physical, behavioral, and oral health care services.
- Monitoring and addressing water quality.
- Strengthening the coordinated care model.
- Improving health outcomes health policy, and clinical improvement services.
- Administering health plans, group insurance policies and flexible spending accounts for state employees and their dependents.
- Administering medical, dental, vision and other benefits for Oregon's school districts community colleges, and education service districts.
- Addressing behavioral and social drivers of health by working to ensure that physical and social environments promote health.
- Reducing the need for costly health care services.
- Ensuring compliance with regulatory and health-based standards.
- Protecting Oregonians from environmental health hazards.
- Preventing chronic disease, child developmental delays, and physical and behavioral problems.
- Ensuring emergency public health services in natural and human caused disasters.
- Helping people recover from their mental illness and return to life in their communities.

All of these Agency functions contribute to the safety, health, and the overall quality of life of all Oregonians and requires a narrow span of control to administer and provide oversight to this major governmental priority.

Is geographical location of the agency's employees a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The nature of the Agency's work has statewide impact and touches all Oregonians, spanning the four corners of the state. The Agency has presence in forty-five distinct facilities and in 18 cities, including rural and major metropolitan areas, ranging from St. Helens to Ontario; and from La Grande to Medford. Such broad dispersion requires a narrow span of control for effective oversight.

Is the complexity of the agency's duties a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The public's health is a major indicator of quality of life. OHA's mandate is a primary driver affecting quality of life of all Oregonians. To ensure that the Agency's mandate is met requires a complex framework of activities and a narrow span of control in order to provide the appropriate oversight to staff. The complexity of the Agency's duties is further reflected through the knowledge, skills, and abilities that required by most Agency positions in order to perform their deliverables. To determine Agency complexity, the Agency has made a thoughtful exposition of the complexity of its programs and provided an objective framework to determine the complexity of individual Agency positions in addressing this complexity factor.

Are there industry best practices and standards that should be a factor when determining the agency maximum supervisory ratio? **Yes** ☐ **No** ☒

OHA, as an organization, is *sui generis*. The various components (e.g., OSH, HSD, PEBB, OEBB, etc.), which the State of Oregon has brought together under one umbrella, are discrete governmental functions-yet interrelated. However, in most states, these various functions are performed by distinct organizational entities. Given the multi-program nature of the Agency, and its multiple objective, it is not possible to obtain a span of control ratio, or schema that would reflect an industry best practice or standard, in relation to such a broad and varied mandate. Neither federal, nor state governmental entities that OHA is aware of, survey for span of control data on an industry-wide basis that would be an analogue to the varied functions OHA performs. There are private sector organizations that provide span of control research and other related benchmarking data, but they are limited to unrelated private sector industries (e.g. finance, insurance, technology, utilities, etc.). Furthermore, the data is restricted to a few companies and only provided these data to their members. Although some of these members may include public sector entities, the data does not have "industry wide" breadth, to establish relevant benchmarks for OHA's organizational needs, or establish a best practice.

Is size and hours of operation of the agency a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The Oregon State Hospital provides services 24/7. Agency FTE's allocated to the OSH program constitute a majority of OHA positions. In addition, the emergency support function (ESF-8), provided by the Agency, and requires the associated staff to be prepared, at a moment's notice, in the event an emergency situation arises.

Are there unique personnel needs of the agency, including the agency's use of volunteers or seasonal or temporary employees, or exercise of supervisory authority by agency supervisory employees over personnel who are not agency employees a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The Agency has classes of workers that are neither permanent nor limited duration. These workers include temporary workers (including GALT temporary workers), contractors, interns, student workers, and volunteers that in many instances work under the control of Agency supervisory positions. The duties performed by these workers range from audiologists to trauma managers. These classes of workers not only need to be on-boarded through the ad hoc personnel processes that have been established (e.g., background checks, system password issuance, computers, desks, etc.), but in some instance may require supervisory oversight to ensure the State's and Agency's codes of conduct are adhered to, and performance standards are met. These activities add to the managerial burden. Hence, these workers are within the span of control relationship of the organization.

Is the financial scope and responsibility of the agency a factor to be considered in determining the agency maximum supervisory ratio? **Yes** ☒ **No** ☐

The Oregon Health Authority seeks to protect and promote the health and safety of all Oregonians; and, reinforces the State's commitment to making the public's health a foundational pillar of the State's goal to enhance the quality of life of all Oregonians. Funding for OHA's mandate reflects the importance that both the Legislature and the Governor has placed on this priority. To provide for this mandate the legislature allocates the largest portion of the State's funds towards the goal of achieving the Agency's mission

Based on the foregoing factors DAS CHRO has authorized an "Agency Maximum Supervisory" ratio of 1:8.6

as published by DAS CHRO (see attached)

Unions Requiring Notification_____

Date unions notified_____

Submitted by: _____ Date _____

Signature Line _____ Date _____

Signature Line _____ Date _____

Signature Line _____ Date _____

Signature Line _____ Date _____