Oregon Health Authority
2025-27 Ways and Means

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GB Director's Message

Governor Kotek recently released her budget request for the next two-year state budget cycle. The Governor's budget builds on the progress the state has made to reduce homelessness and strengthen the behavioral health and education systems. At a time when the state faces slower revenue growth, Governor Kotek has made it a priority to ensure people in Oregon have health care when and where they need it.

The Governor's proposed budget also makes important investments in OHA's goal to eliminate health inequities and funds important actions in our strategic plan.

The Governor's proposed budget provides $39.6 billion in total funds ($6.2 billion in state general funds) to OHA for the next two-year state budget cycle. The budget would pay for 5,982 full time equivalent positions (FTE). In total, the Governor's budget represents a 6.7% increase to support our programs, our partners and our mission.

Here is a summary of key health-related elements contained in the Governor's Request Budget (GRB):

Investing in OHA's goal to eliminate health inequities: When it comes to health, we're all connected. The Governor's budget invests in OHA's Strategic Plan through:

- $3.6 million to expand Regional Health Equity Coalitions (RHECs).
- Approximately $2.5 million to support traditional health workers in Oregon and ensure meaningful access to inclusive services and facilities, including language access, digital access, and disability access.
- $3.2 million to support ongoing efforts to protect drinking water quality in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA).
- $2 million to promote and sustain public health modernization.
- Increased revenue resulting from an expanded definition of commercial tobacco products which would reduce youth access to harmful emerging synthetic nicotine products by ensuring these products are covered under Oregon's existing tobacco retail laws.

Closing gaps in behavioral health capacity and workforce: As soon as the Governor took office, she directed OHA to determine how many behavioral health treatment beds Oregon needs to ensure that no one goes without the care they need. The GRB provides important investments to end the shortage in Oregon's residential treatment beds and other services, as well as the workforce needed to provide care. These investments include:

- **More than $130 million to maintain Medicaid rates for behavioral health treatment programs** so they can treat more people who need care and retain committed staff.
- **$100 million to expand Oregon's residential mental health and substance use disorder (SUD) treatment capacity** with $10 million dedicated to expanding psychiatric and SUD treatment capacity specifically for children.
- **$50 million to grow and diversify the behavioral health workforce** through tuition assistance, scholarships, loan repayment and other investments; $25 million will be administered in partnership with OHA through the Higher Education Coordinating Commission.
- **$10 million to support the Save Lives Oregon Harm Reduction Clearinghouse** and combat opioid overdoses statewide.
- **$14 million to expand behavioral health services for youth**, including $6 million for school-based mental health services and substance use screening and prevention, $1 million to expand youth suicide prevention programs (especially for youth of color), and $7 million to deliver home and community-based services for children and youth with behavioral health needs.
- **$49.7 million increase to stabilize the Oregon State Hospital (OSH)** and ensure it has the capacity and staffing to sustain compliance with admissions and other requirements, including funding for additional positions, reclassification of some positions, enhanced security contracts, patient vitals monitoring, Native services, some facility improvements, and computer system upgrades.
- **$14.7 million for community behavioral health treatment to support local jail diversion and deflection programs.** These programs help people who

are engaged in substance use and have encountered law enforcement, providing them with needed treatment services, instead of **incarceration**.

- **$14 million to sustain and expand Certified Community Behavioral Health Clinics (CCBHCs)**, which integrate behavioral with physical health care.

Maintaining health coverage and care in Oregon: The Governor's budget builds on Oregon's record rate of 97% health coverage and advances our strategic plan priority to ensure equitable access to affordable health care for everyone in the state. The Governor's proposed budget would:

- **Maintain a stable base of funding for Oregon's Medicaid program** (which provides coverage to 1 in 3 state residents and half of all children) that would increase Medicaid rates for maternity care to prevent families from facing gaps in care. In addition, the Governor's budget fully funds the projected enrollment for the Healthier Oregon Program throughout the 2025-2027 biennium.
- **Add $5 million to protect and expand access to reproductive health care for people in Oregon**, including in the event of federal disruptions in funding.
- **$14.3 million to the carceral re-entry demonstration program under our 1115 Medicaid waiver**, which provides a safer and healthier transition back to the community for adults who have been incarcerated or institutionalized.

At OHA, we stand behind the Governor's budget proposal. In the face of increasingly tighter state budgets, through these investments Governor Kotek has demonstrated her commitment to keeping people in Oregon healthy.

Sincerely,

Sejal Hathi, MD MBA

Legislative Action

- SB5506
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/81436

- SB5006
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/81053

- HB2574
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80513

- HB2656
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80515

- HB2665
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80516

- HB2683
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80517

- HB2696
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80518

- HB2697
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80519

- HB2994
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80545

- HB3396
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/81028

- HB3409
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80871

- SB966
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80858

- SB1089
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/81084

- SB5525
  https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80604

- HB4092
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82726

- HB4129
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82624

- HB4136
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82619

- HB4151

https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82620

- SB1521
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82739

- SB1530
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82477

- SB1557
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82740

- SB1578
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82736

- HB5204
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82483

- SB1552
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82740

- SB5701
  https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureAnalysisDocument/82769

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.

Statutory Authority

Oregon Revised Statute (ORS) 413.006 establishes the Oregon Health Policy Board, and the Oregon Health Authority is established in ORS 413.032. Additional duties, functions and powers are enumerated in ORS 413.007 to 413.800.

Oregon Health Authority rules are enumerated in Oregon Administrative Rule Chapters 101, 111, 331, 332, 333, 338, 409, 410, 415, 431, 816, 817, 819, 824, 834, 853, 943, 944, 945, 950.

Strategic Plan

OHA's Strategic Plan, published in August 2024, sets out the agency's strategic goals, and related strategies and measures, that steer the agency towards its overall strategic goal to eliminate health inequities by 2030. Health equity is at the core of this plan. OHA is guided by the definition of health equity as established by the Oregon Health Policy Board. This definition and a summary of the plan are below, and the full plan is available on the OHA website.

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-begin and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identify, sexual orientation, social class, intersections among these communities or identifies, or other social 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.

Strategic Plan Executive Summary

Our guiding mission

In 2019, OHA became the first health agency in the country to declare an ambitious statewide goal to eliminate health inequities, and to do so by 2030. In the simplest terms, that means establishing a health system where all people in Oregon can reach their full health potential and well-being, without facing disadvantages due to their race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography, or social class.

Health inequities are differences in health outcomes that stem from unfair social, economic and other factors, including racism and other forms of bias, discrimination and oppression, which cause people in some communities to have higher rates of health problems — such as infant mortality, chronic disease and shorter life spans — than people in other communities.

Naming our goal of eliminating health inequities by 2030 is bold and aspirational. It sets a daily intention for us as an agency: in our work, systems, policies and practices. We want every decision, every action, every allocation of resources to move us toward this goal every day. And we know that means shaking up entrenched ways of thinking and doing so that we can ensure Oregon becomes a place where everyone has a chance to thrive.

When people are prevented from accessing good health care by barriers such as high costs, bias, and a lack of trained providers or convenient services, it impacts the broader community. OHA will continue to focus on

eliminating those barriers that prevent both individual people and the broader community from being healthy and accessing the care that every person in Oregon deserves.

Our goal pillars

OHA has identified five principal goals to serve as pillars of progress toward achieving our 2030 vision:

- **Transforming behavioral health:** Build a behavioral health system that works for every child, teen, adult and family experiencing mental illness or harmful substance use by expanding integrated, coordinated and culturally responsive behavioral health services when and where people need them, guided by people with lived experience.
- **Strengthening access to affordable care for all:** Ensure 100 percent of people in Oregon have easy access to affordable health care, prioritizing communities most harmed by health inequities.
- **Fostering healthy families and environments:** Foster healthy families and environments that equitably promote health and well-being, especially among communities most harmed by health inequities. Do this by expanding access to: 1) preventive health services and supports, including for new parents and families before and after birth; 2) safe and accessible housing; 3) healthy food and nutrition; and 4) climate resilience.
- **Achieving healthy Tribal communities:** In honoring the relationships with the Nine Federally Recognized Tribes of Oregon, Urban Indian Health Program and other health partners, OHA commits to support the ultimate goal of achieving healthy Tribal communities. This empowers Tribal individuals, families and communities across Oregon to achieve optimal health and wellness through a fully funded continuum of health care rooted in traditional and culturally specific practices.
- **Building OHA's internal capacity and commitment to eliminate health inequities:** Establish, maintain and resource the internal infrastructure and accountability mechanisms necessary to acknowledge, reconcile and redress racism and other forms of discrimination and oppression that undermine the health, well-being and opportunities of people across Oregon.

Oregon Health Authority: Agency Summary Narrative

Strategies and actions

Each of our strategies is focused on ensuring that we are able to achieve our overall goal and will be guided by individuals and communities with lived experience. Our work will:

- Strengthen access to affordable, quality health care and provide resources for healthier communities;
- Increase availability of culturally responsive clinics and providers;
- Expand mental health and substance use services and clinics; and
- Bolster the workforce needed to deliver those services.

To accomplish these goals, OHA will work closely with partners, listen to and engage meaningfully with community, and practice transparency and accountability.

How we will measure success

OHA will measure progress made toward our goal of eliminating health inequities by 2030 based on the health outcomes within the communities we serve. We will track the prevalence of preventable disease, whether people at all income levels can access quality and affordable health care, and the degree to which communities experiencing systemic marginalization are able to access behavioral health services. We will review aggregated and disaggregated Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data on health access and outcomes to analyze trends and inform our work. And we will monitor how specific factors such as racism, bias and oppression affect access to care.

Criteria for Budget Development

OHA is at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. The agency's key mission is to eliminate health inequities by 2030 and is overseen by a nine-member citizen Oregon Health Policy Board working towards comprehensive health reform in our state. OHA includes most of the state's health programs, including public health services and the Oregon Health Plan. Fundamentally, OHA's budget represents the cost to continue these essential health programs

and services for Oregonians and proposes new investments to address emerging needs, including those raised by community partners.

OHA follows a detailed and more than twelve month process to create its budget, beginning with establishing the agency's priorities for the upcoming biennium. For the 2025-27 GB, OHA focused on investments that advance the goal of eliminating health inequities and the agency's strategic plan focus areas, as well as investments that support the Governor's priorities to address the statewide behavioral health crisis, housing and homelessness, and education. These focus areas serve as a framework by which all budget decisions were made during the GB development process. There are many steps in the process during which proposed investments are reviewed, refined, and prioritized and the final investments included here are those that the agency identified as most important in advancing the 2030 goal of eliminating health inequities, the agency strategic plan, and the Governor's priorities. By leveraging this framework to guide the development of the GB, OHA is ensuring that budgetary decision not only support the agency's strategic objectives, but also contribute to broader state priorities, fostering more equitable and healthier communities.

The 2025-27 budget development process involves staff from across the agency and begins approximately 12 months prior to final ARB submission. In Winter 2023-24, OHA staff developed policy option package (POP) and legislative concepts (LC) proposals based on guiding principles, which included community feedback, Governor priorities, and the agency's strategic plan. Initial POP and LC concepts were reviewed by the Governor's Office and the Department of Administrative Services (DAS), after which agency staff incorporated their feedback and worked to develop complete POP narratives. For this biennial budget, OHA additionally followed guidance to keep all proposed investments within 1 percent of the agency's General Fund in its 2023-25 Legislatively Approved Budget, as directed by DAS, and prioritized POPs that would advance our strategic plan and the Governor's priority of maturing Oregon's behavioral health continuum of care. OHA's POPs were finalized by July for inclusion in the ARB.

Oregon Health Authority: Agency Summary Narrative

The final ARB reflects an enormous amount of strategic planning that aligns priorities from the Governor's Office with the strategic direction of OHA and involves a large number of agency staff. The 2025-27 ARB proposed investments ensure fundamental health services are maintained and strengthened in order to drive forward OHA's commitment to eliminate health inequities and improve the health of all Oregonians.

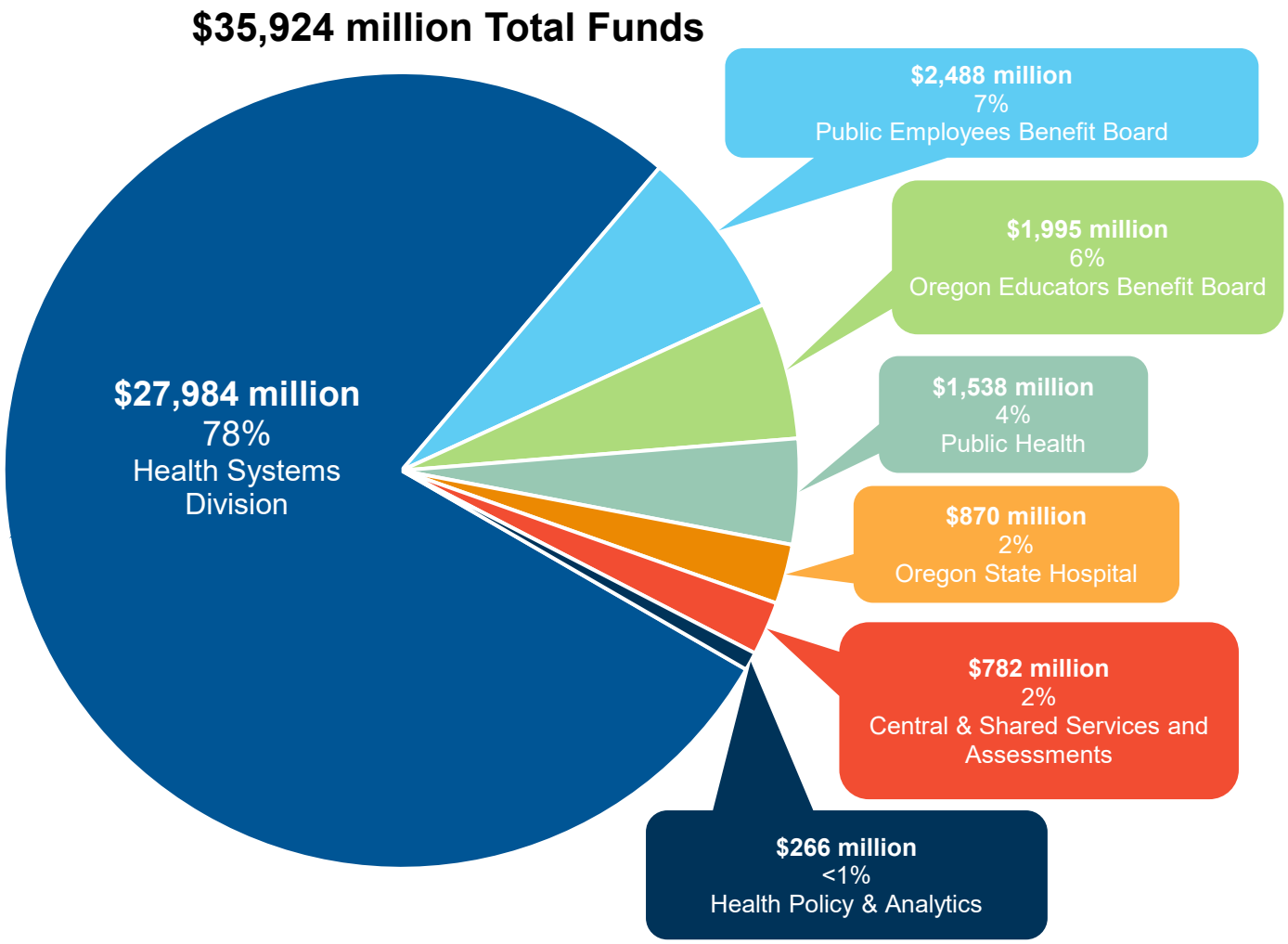
Budget Summary Graphics

Oregon Health Authority's (OHA) 2025-27 Governor's Budget (GB) represents a $3.7 billion increase over its 2023-25 Legislatively Approved Budget (LAB). The graphics below illustrate the 2023-25 LAB by program and by fund type, as well as the 2025-27 GB by program and by fund type.

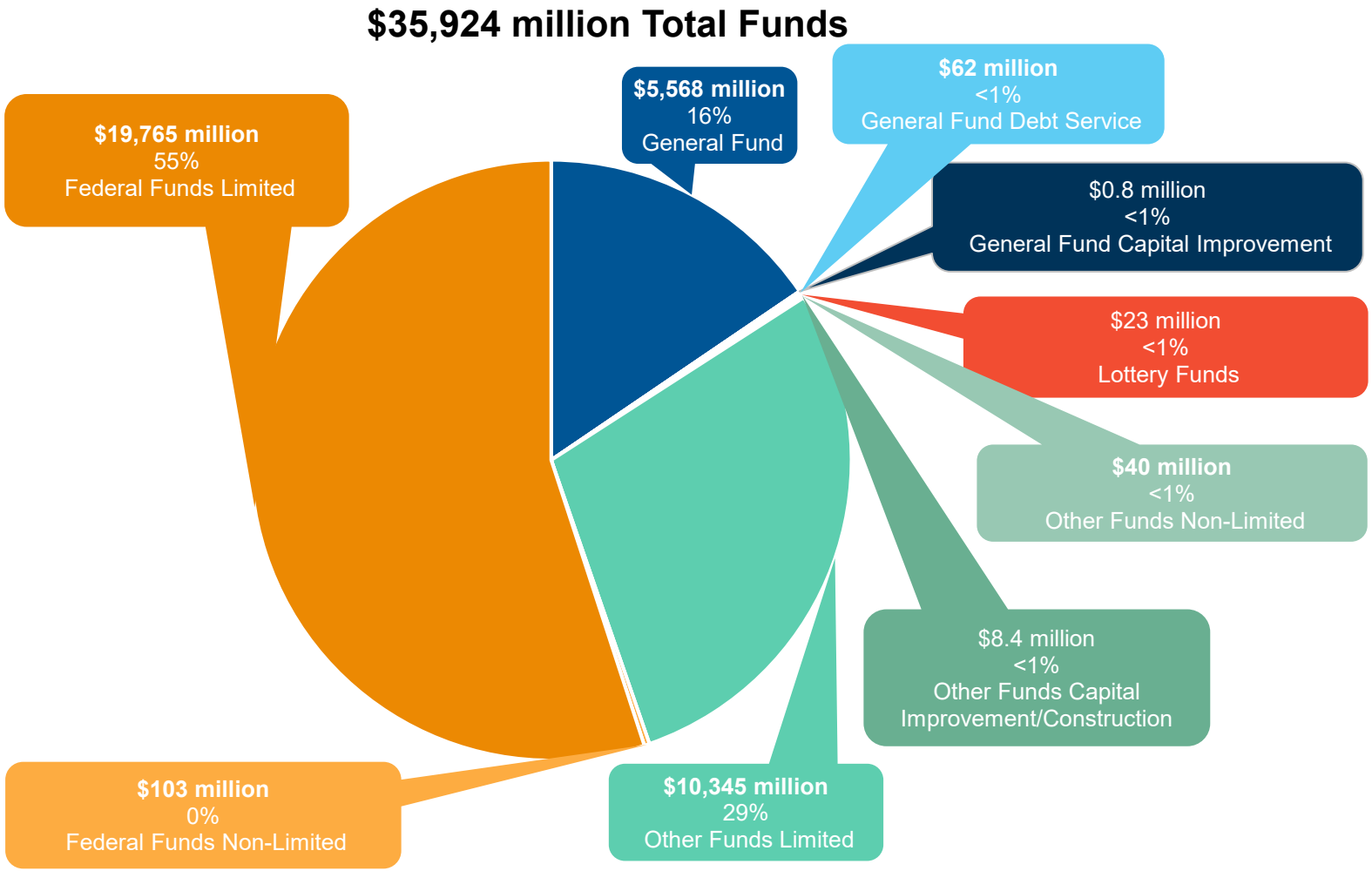
When comparing the 2023-25 LAB to the 2025-27 GB, there are several factors to note. General Fund increased significantly due to a combination of inflationary adjustments, caseload increases, behavioral health related policy option requests, and fund shifts related to decreases in Other Funds revenue. Increases in Federal Funds are primarily driven by continued implementation of the Medicaid 1115 waivers and the Basic Health Program.

Additionally, the Health Systems Division present in the 2023-25 biennium has been separated into two discrete programs beginning for the 2025-27 biennium: the Medicaid and Behavioral Health Divisions. Distinguishing these two programs better aligns OHA's budgetary structure and the Governor's priorities – specifically those pertaining to the behavioral health continuum of care – and will enhance transparency of programmatic budgetary reporting for future biennia.

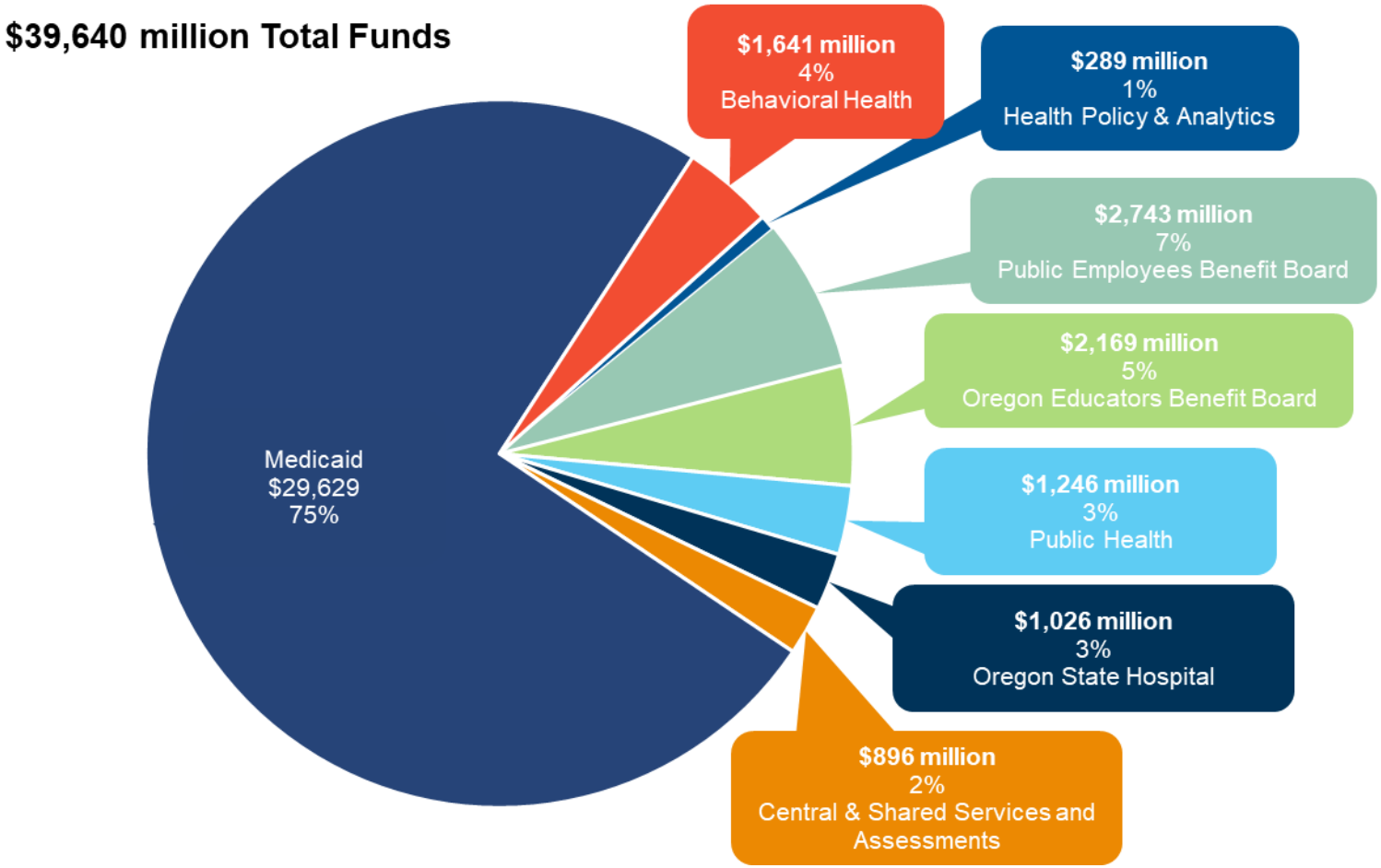
Oregon Health Authority
2023-25 Legislatively Approved Budget
By Program



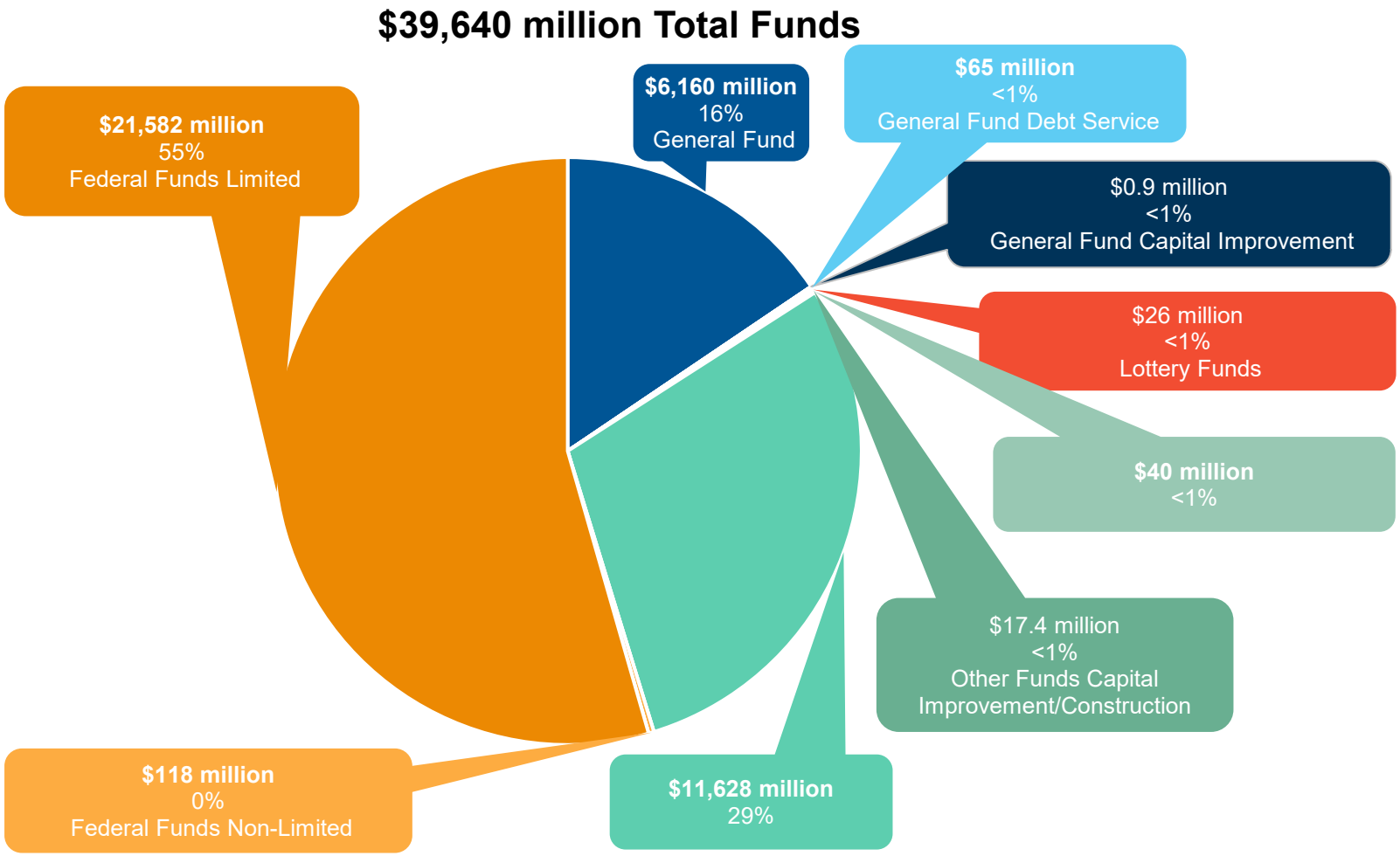
Oregon Health Authority
2023-25 Legislatively Approved Budget
By Fund Type



Oregon Health Authority
2025-27 Governor's Budget
By Program



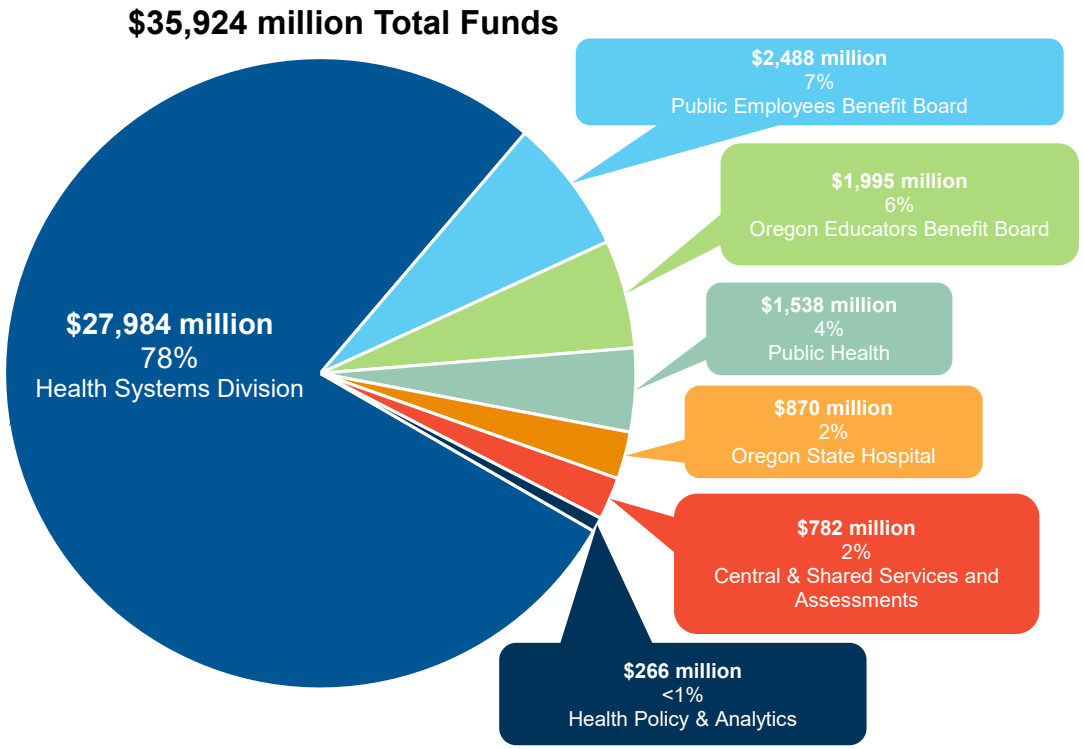
Oregon Health Authority
2025-27 Governor's Budget
By Fund Type



Oregon Health Authority

2023-25 Legislatively Approved Budget

By Program

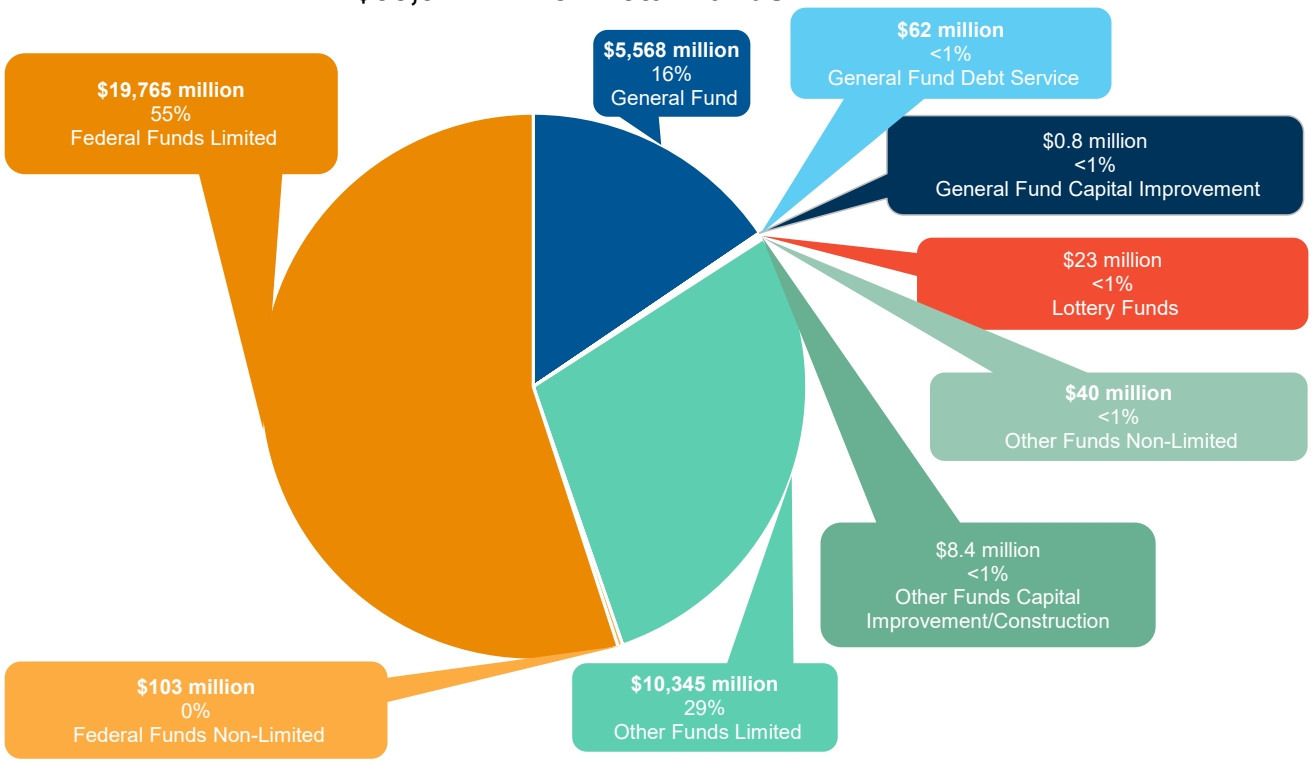


Oregon Health Authority

2023-25 Legislatively Approved Budget

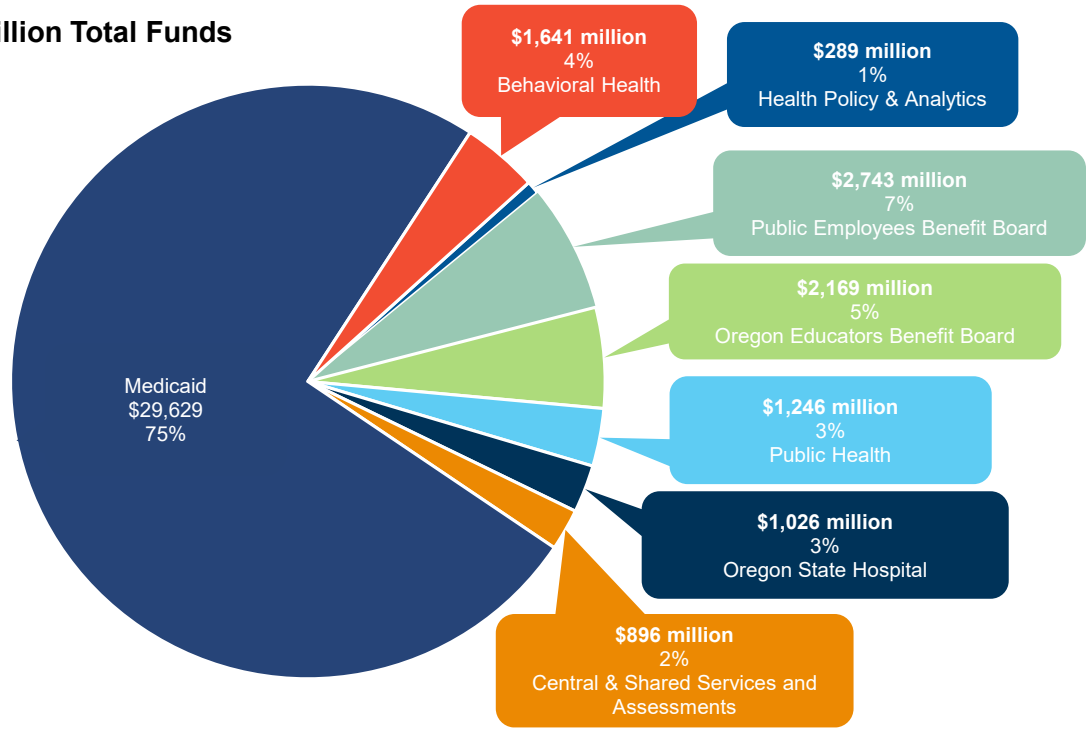
By Fund Type

$35,924 million Total Funds



Oregon Health Authority
2025-27 Governor's Budget
By Program

$39,640 million Total Funds

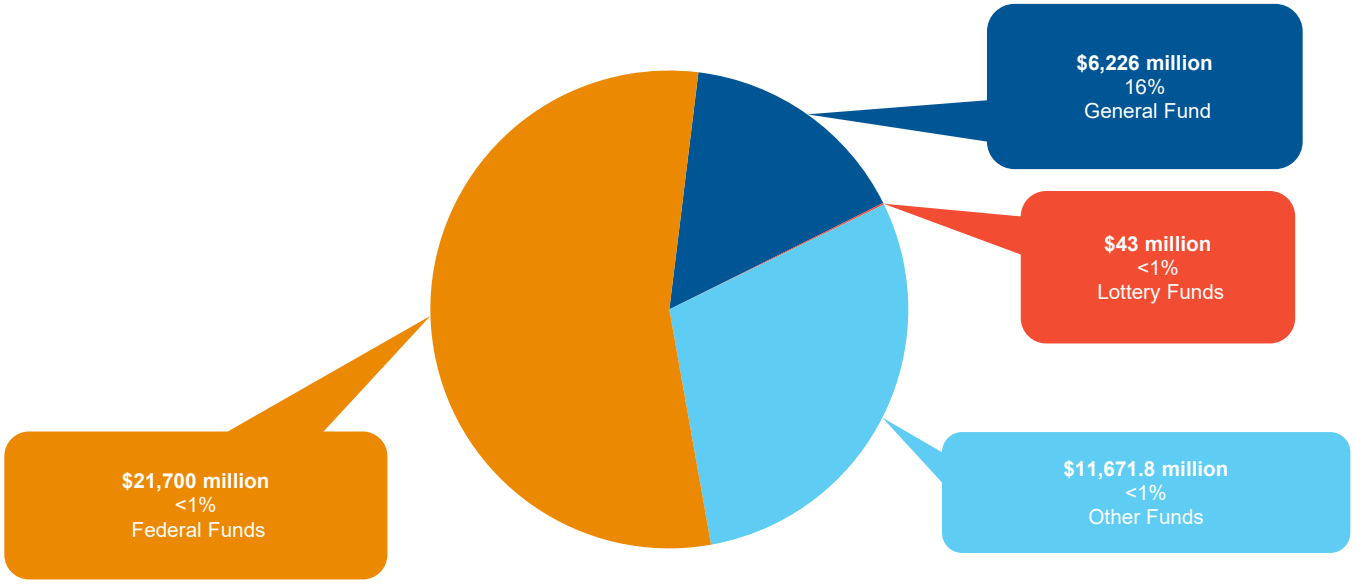


Oregon Health Authority

2025-27 Governor's Budget

By Fund Type

$39,640 million Total Funds



PROGRAM PRIORITIZATION FOR 2025-27

Agency Name: Oregon Health Authority

2025-27 Biennium **Agency Number: 44300**

The Oregon Health Authority is prioritizing the elimination of health inequities across a wide range of health outcomes in which people in communities of color experience greater health burdens than white people, due to the unfair effects of systemic racism. This requires the largest and most ambitious transformation in health care in the nation. OHA believes all divisions and programs of the agency must support equity and inclusion at every level; therefore health equity is not ranked as a specific program priority as it is an integral foundation of OHA's work.

Agency-Wide Priorities for 2025-27 Biennium

1	4			5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Priority (ranked with highest priority first)	**Program or Activity Initials**	**ORBITS DCR Title**	**Is Program leveraged for the DSHP Waiver?**	**Program Unit/Activity Description**	**Identify Key Performance Measure(s)**	**Primary Purpose Program-Activity Code**	**GF**	**LF**	**OF**	**NL-OF**	**FF**	**NL-FF**	**TOTAL FUNDS**	**Pos.**	**FTE**	**New or Enhanced Program (Y/N)**	**Included as Reduction Option (Y/N)**	**Legal Req. Code (C, D, FM, FO, S)**	**Legal Citation**
Agcy																			
1	Health Programs	Health Programs Medicaid	No	This budget includes the Oregon Health Plan, which provides medical coverage for Medicaid under Title XIX of the Social Security Act, and Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Medicaid has traditionally provided medical coverage to low-income seniors, people with disabilities, children, and pregnant women. Since January 2014, the Oregon Health Plan has also covered all Oregon adults with income at or below 138 percent of the federal poverty level.	Preventive services for OHP youth and adults, Preventive services for OHP children, Appropriate prenatal care for OHP clients, PQI Hospitalizations of OHP clients	12	4,051,063,015	2,433,240	4,554,363,585		19,794,468,303		28,402,328,143	-	-	N	Y	FM	ORS 414, Title XIX, XXI
2	Health Programs	Health Programs Behavioral Health	No	Behavioral Health administers contracts and agreements with local mental health authorities such as LMHAs, CMHPs, non-profit providers, and tribes to develop and administer community-based behavioral health services and supports that are not covered by Oregon's Medicaid program. HSD services restore functioning, promote resiliency, health and recovery, and protect public safety by serving adults, children and adolescents with substance use disorders, mental and emotional disorders and problem gambling disorders as well as providing resources to their families. These services and supports are delivered in outpatient, residential, school, hospital, justice and other community settings. Culturally specific statewide and regional programs provide services for Native American, Hispanic/Latino and African American populations. These programs are designed to deliver evidence-based services that restore individuals and their families to the highest level of functioning possible. These programs employ peer support specialists, qualified mental health associates (QMHAs), qualified mental health professionals (QMHPs), psychiatrists, psychiatric nurse practitioners, qualified health services (QHS) providers, psychologists and other independently licensed providers, Certified Alcohol and Drug Counselors (CADCs), Certified Gambling Addiction Counselors (CGACs), and personal care providers. Individual consumers and their families also are key partners. These partnerships are critical to successfully treating behavioral health conditions.	Completion of alcohol & drug treatment, Alcohol & drug treatment effectiveness: Employment, Child reunification, School performance	12	840,515,026	18,005,488	466,689,716		293,945,426		1,619,155,656	-	-	N	Y	S,FO	45 CFR Part 96-SAPT and MH Block Grants; ORS Chapter 430
3	Public Health Programs	Center for Prevention and Health Promotion	No	Responsible for chronic disease prevention and health promotion, injury prevention, Prescription Drug Monitoring program, Women, Infants and children (WIC) Nutrition program, family planning, oral health, prenatal care, newborn hearing screening, and school-based health centers.	Teen suicide, Tobacco use, Cigarette packs sold, Teen pregnancy, Early prenatal care	10	56,633,790	-	42,675,375	40,000,000	89,902,549	117,338,409	346,550,123			N	Y- partial	S,FO	42 U.S. Code Chapter 6A; ORS Chapter 431
4	Public Health Programs	State Public Health Director	No	Responsible for state emergency preparedness, planning, and response.		8, 10	113,305,331	-	705,043		9,694,768	-	123,705,142			N	Y- partial	S,FO	42 U.S. Code Chapter 6A; ORS Chapter 431
5	Public Health Programs	Center for Public Health Practice	No	Responsible for state support to local health departments core capacity in disease control and surveillance, HIV/STD/TB, immunization, statewide communicable disease control and testing, maintaining vital records and health statistics.	HIV rate, child immunizations, Influenza vaccinations for seniors	8,10	4,086,363		23,696,867		24,392,866	-	52,176,096			N	Y- partial	S,FO	42 U.S. Code Chapter 6A; ORS Chapter 431
6	Public Health Programs	Center for Health Protection	No	Responsible for the State Drinking Water Program (Primacy) and EPA Revolving Loan Fund which provides approx. $12M annually to local water systems for capital improvement initiatives. Also identifying and preventing environmental and occupational safety hazards, and initiatives such as the health facilities licensure, quality improvement and regulation, medical marijuana, and Patient Safety Commission.		9,10	3,388,083		27,887,919		32,316,224	-	63,592,226			N	Y-partial	S,FO	42 U.S. Code Chapter 6A; ORS Chapter 431
7	Oregon State Hospital	State Hospital System	No	The State Hospital System - with locations in Salem and Junction City provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have either been civilly committed to the Department as a danger to themselves or others, or have been found guilty except for insanity, or require hospital care to restore competency in order that they may aid and assist in their own defense during a criminal proceeding.	OSH restraint rate, OSH length of stay (others to consider might be ratio of # served/# of budgeted beds, and/or recidivism/revocation rates. These new measures should be vetted a bit with Cabinet and or AMH, in light of the fact that KPMs are part of a larger OHA/DHS picture)	12	924,868,615		15,688,542		26,190,817	-	966,747,974	2,739	2,733.32	Y	N	S,FO	
8	Oregon State Hospital	State Delivered SRTF's	No	The state operated 16-bed facilities permit the safe movement of persons from the State Hospital(s) into the community that current providers choose not to serve.		12	8,314,698		226,066		6,250,601	-	14,791,365	45	45.00	Y	N	S,FO	

Priority (ranked with highest priority first)	Program or Activity Initials	ORBITS DCR Title	Is Program leveraged for the DSHP Waiver?	Program Unit/Activity Description	Identify Key Performance Measure(s)	Primary Purpose Program-Activity Code	GF	LF	OF	NL-OF	FF	NL-FF	TOTAL FUNDS	Pos.	FTE	New or Enhanced Program (Y/N)	Included as Reduction Option (Y/N)	Legal Req. Code (C, D, FM, FO, S)	Legal Citation
9	Public Employee's Benefit Board	PEBB/Stabilization, Self Insurance, Flex Benefit, Fully insured Plans, and Optional Benefits	No	(1) There is created the Public Employees' Revolving Fund The balances of the Public Employees' Revolving Fund are continuously appropriated to cover expenses incurred in connection with the administration of ORS 243.105 to 243.285 and 292.051. Among other purposes, the board may retain the funds to control expenditures, stabilize benefit premium rates and self-insure. The board may establish subaccounts within the Public Employees' Revolving Fund. (2) There is appropriated to the Public Employees' Revolving Fund all unused employer contributions for employee benefits and all refunds, dividends, unused premiums and other payments attributable to any employee contribution or employer contribution made from any carrier or contractor that has provided employee benefits administered by the board, and all interest earned on such moneys. Fully insured premiums are treated as a pass-through account and funds are sent directly to the Fully Insured provider. (1) In addition to the powers and duties otherwise provided by law to provide employee benefits, the Public Employees' Benefit Board may provide, administer and maintain flexible benefit plans under which eligible employees of this state may choose among taxable and nontaxable benefits as provided in the federal Internal Revenue Code. (2) In providing flexible benefit plans, the board may offer: (a) Health or dental benefits as provided in ORS 243.125 and 243.135. (b) Other insurance benefits as provided in Optional benefits are insurance premiums paid by members and are treated as pass-through account and funds are sent directly to the Optional Benefit provider.	243.167 Public Employees' Revolving Fund; continuing appropriation to fund, 243.221 Options that may be offered under flexible benefit plan.	10			2,742,582,467				2,742,582,467			Y		
10	Oregon Educators Benefit Board (OEBB)	OEBB Stabilization	No	There is created the Oregon Educators Revolving Fund, separate and distinct from the General Fund. Moneys in the Oregon Educators Revolving Fund are continuously appropriated to the Oregon Educators Benefit Board to cover the board's expenses incurred in connection with the administration of ORS 243.860 to 243.886. Moneys in the Oregon Educators Revolving Fund may be retained for limited periods of time as established by the board by rule. Among other purposes, the board may retain the funds to pay premiums, control expenditures, stabilize premiums and self-insure.	243.884 Oregon Educators Revolving Fund; continuous appropriation to board; purposes; rules; moneys paid into fund	10			2,168,950,460				2,168,950,460	-	-	N	Y	S	ORS 243.860 to 243.886
							6,002,174,921	20,438,728	10,043,466,040	40,000,000	20,277,161,554	117,338,409	$ 36,500,579,652	2,784	2,778.32				

Oregon Health Authority: 10 Percent Reduction Options

As supplemental information to the Governor's Budget, Oregon law requires each state agency to include reduction options of 10 percent from the estimate of projected costs of continuing currently authorized activities and programs for the next biennium.

The Oregon Health Authority (OHA) is mission-focused on addressing health inequities in Oregon, and a large proportion of OHA's budget is expended on services directly provided to clients pursuant to this mission. Budget reductions are proposed with the ultimate aim of minimizing impact on the ability of the agency to address health inequities, thus permitting OHA to continue to pursue strategic focus areas, including improvements to the behavioral health continuum of care.

General criteria and principles applied to the reduction list included:

- Avoid reductions that have a negative impact on populations already disproportionately impacted by health inequities and health disparities.
- Identifying reductions that do the least harm to the fewest number of clients.
- Applying the OHA goals of containing costs, improving quality and increasing access to health care.
- Avoiding reductions that shift people to more costly service models within OHA or ODHS.
- Minimizing effect on the obligation to maintain the growth of health care costs to 3.4 percent per year or below.

Any necessary reductions would potentially affect OHA programs in the following areas:

The 2025-27 Governor's Budget includes agency-wide reductions:

- ***Adjusts Attorney General charges***
- ***Service and supplies reduction across OHA except for the Oregon State Hospital***

Central Office and Shared Services

The budget for facility projects would be reduced.

DAS price list items would be reduced by 10 percent. This would have to be in alignment with a potential statewide DAS reduction.

Medicaid

Maximization of the diagnostic-related group (DRG) hospital assessment would increase the amount of assessment collected and reduce the amount of general fund support required for the Oregon Health Plan. ***The 2025-27 Governor's Budget includes this reduction.***

Reduction of out-of-state hospital rates in the Oregon Health Plan reduces expenditures to OHA. ***The 2025-27 Governor's Budget includes this reduction.***

Inflation increases for coordinated care organization (CCO) capitation rates and Oregon Health Plan fee-for-service provider rates would be less than 3.4 percent annual inflation.

Indirect and Direct Medical Education payments to teaching hospitals would be eliminated — at the very time we need more trained medical professionals to serve our growing population.

Reimbursement for DRG hospitals would be reduced, which would adversely affect OHA's relations with DRG hospitals that serve a large majority of OHP clients across the state. Reduced reimbursement could lead to overall reduction in level of care or other services provided to Medicaid clients.

Reimbursement to OHSU would be reduced, potentially impacting their ability to provide quality services to Oregon Health Plan members.

Quality incentive funds to CCOs would be reduced, likely impacting the scale, scope or effectiveness of the efforts that CCOs have in place to pursue quality outcomes for their members. ***The 2025-27 Governor's Budget includes this reduction.***

Leverage program allows OHA to claim Medicaid funding for other governmental entities. This reduction option is included to satisfy the requirement of other and federal fund reduction targets. Reducing these programs would not save OHA state funds.

Behavioral Health

Inflation increases for behavioral health services would be reduced. Service costs would not be able to keep up with inflation, effectively lowering the amount paid for services. This would additionally impact the possibility for any increase in pay for direct care staff, further exacerbating the behavioral health staffing crisis.

Public Health

Staff support for the Advance Directive Adoption Committee would be eliminated and related educational materials would be limited.

Inflation increases for the Office of the State Public Health Director would be reduced. This reduction removes inflation built into the CSL 25-27 budget to meet the anticipated program needs. Public Health is a critical component in ensuring Oregonians are healthy, safe and informed. Reducing any portion of these funds will impact the ability of public health to be effective in Oregon. This reduction will impact the critical work both the state and local partners are completing as costs continue to rise and inflation is already insufficient to maintain the increase in cost.

Health Policy & Analytics

Health Care Incentive Fund would be reduced by 35 percent, limiting incentives offered to health care providers in underserved areas.

PEBB and OEBB

Oregon Health Authority: 10 Percent Reduction Options

Reduction to OEBB and PEBB plans may default OEBB and PEBB in their contractual obligation with insurance carriers. Premium shifts to members would not change the pass-through budget dollars needed to meet the contractual obligations with carriers.

Oregon Health Authority
Reduction Options: 2025-27 Agency Request Budget **10% General Fund / 10% Other & Federal Fund Reduction Options for the 2023-2025 Biennium**
Reductions included in the 2025-27 Governor's Budget are in strikethrough font. **(Limited Other and Federal Funds only - does not include Non-Limited Funds)**

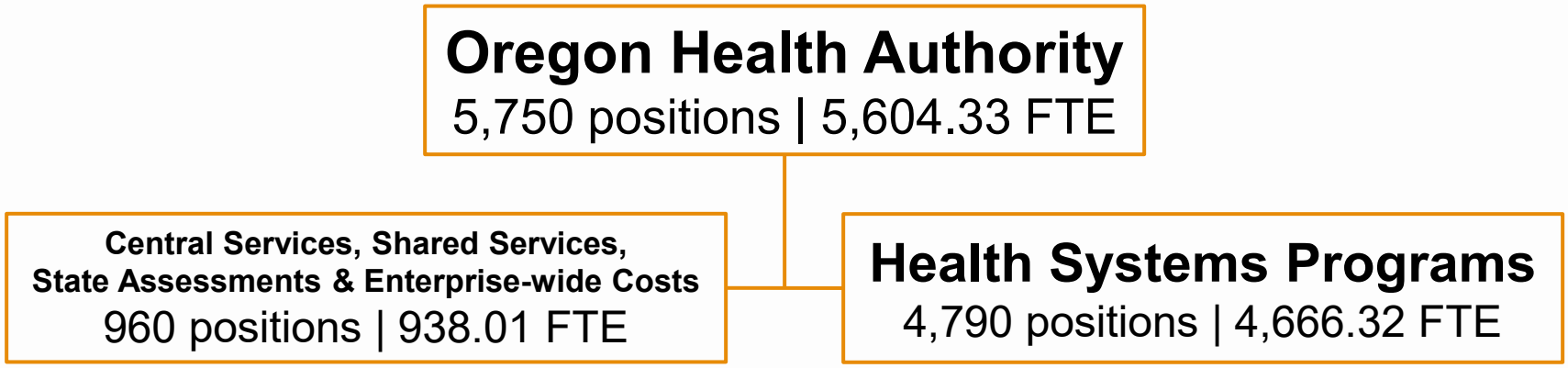
Current Service Level Budget (OHA LEVEL) updated at GB	**8,061,650,172**	**8,987,048,187**	**19,804,278,713**	**36,852,977,072**
10% Target	**(806,165,017)**	**(898,704,819)**	**(1,980,427,871)**	**(3,685,297,707)**
	0	**(0)**	**-**	

	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)
~~-3.49%~~	~~1~~	~~Medicaid~~	~~Maximize the DRG (large hospital) assessment; no changes to program. Reduction option included in the Gov's Budget~~	~~N~~	~~(281,000,000)~~	~~401,000,000~~	~~281,000,000~~	~~401,000,000~~	~~-~~	~~-~~	~~No impact, the program would continue as it currently structured.~~
~~-3.49%~~	~~2~~	~~Medicaid~~	~~Reduce Oregon Health Plan Out-of-state hospital rates - Reduction option included~~	~~N~~	~~(243,000)~~		~~(567,000)~~	~~(810,000)~~	~~-~~	~~-~~	~~This reduction removes reimbursement increases built into the CSL 25-27~~
~~-3.49%~~	~~3~~	~~Agency Wide~~	~~Attorney General DAS adjustment - Reduction option included in the Gov's Budget.~~	~~N~~	~~(476,055)~~	~~(434,474)~~	~~(223,864)~~	~~(1,134,393)~~	~~-~~	~~-~~	
~~-3.62%~~	~~4~~	~~SAEC~~	~~Department of Administrative Services Charges for Services Adjustment – Reduction option included in the Gov's Budget.~~	~~N~~	~~(9,945,267)~~	~~(893,426)~~	~~(1,695,902)~~	~~(12,534,595)~~	~~-~~	~~-~~	
~~-3.68%~~	~~5~~	~~Agency Wide~~	~~Services & supplies reduction - Reduction option included in the Gov's Budget.~~	~~N~~	~~(5,000,000)~~	~~-~~	~~-~~	~~(5,000,000)~~	~~-~~	~~-~~	~~Administrative reductions are challenging given the expanding work of OHA.~~
~~-3.88%~~	~~6~~	~~Medicaid~~	~~Reduce Oregon Health Plan inflation for fee-for-service from 3.4% to 2.9% per year. Reduction option included in the~~	~~N~~	~~(16,000,000)~~		~~(25,000,000)~~	~~(41,000,000)~~	~~-~~	~~-~~	~~This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program~~
~~-4.11%~~	~~7~~	~~Medicaid~~	~~Reduce Quality Pool for CY 2025 from 4.25% to 3.48%. Reduction option included in the Gov's Budget.~~	~~Yes~~	~~(18,600,000)~~	~~-~~	~~(43,400,000)~~	~~(62,000,000)~~	~~-~~	~~-~~	~~CMS may have concerns with rate cuts. The CCO Quality Incentive Program (QIP) provides financial incentives to~~
-4.63%	**8**	Medicaid	Reduce Oregon Health Plan inflation for managed care 3.4% to 3.0% per year.	N	(42,300,000)		(103,300,000)	(145,600,000)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-4.89%	**9**	Medicaid	Reduction for OHSU Reimbursement from 87% - 84% of Cost	N	(21,000,000)	-	(52,000,000)	(73,000,000)	-	-	HB2010 passed in 2019 required OHA to reimburse OHSU up to a minimum of 87% of OHSU's costs for providing
-4.89%	**10**	OSPHD	Advance Directive Reduction	N	(51,490)	-	-	(51,490)	-	-	These funds would eliminate the ability to continue staffing and facilitating the Advance Directive Adoption Committee
-4.93%	**11**	OSPHD	Reduce GF Inflation	N	(3,094,723)	-	-	(3,094,723)	-	-	
-5.03%	**12**	SAEC: price list	SGSC, Risk, ETS - all DAS Price list items - reduce by 10%	N	(7,925,145)	(1,263,429)	(2,297,144)	(11,485,718)	-	-	The price list totals 114M in the 25-27 Biennium, DAS would need to reduce the price list for this to Actualize
-5.04%	**13**	SAEC: Facilities	Cut 1/2 Facilities Project funding	N	(522,000)	(686,000)	(967,000)	(2,175,000)	-	-	This would leave half of the project funding and force programs to pay for their own needs with regards to facilities
-5.37%	**14**	BH Program	Inflation	N	(26,711,816)	(2,124,596)	(9,338,817)	(38,175,229)	-	-	Service costs will not be able to keep up with inflation, effectively lowering the amount paid for services in the 23/25
-5.56%	**15**	Medicaid	Further reduce Quality Pool for CY 2025 from 3.48% to 2.75%	Yes	(15,600,000)	-	(41,300,000)	(56,900,000)	-	-	CMS may have concerns with rate cuts. The CCO Quality Incentive Program (QIP) provides financial incentives to
-5.88%	**16**	Medicaid	Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program. The agency	Y	(25,947,000)		(37,481,000)	(63,428,000)	-	-	Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing

-5.95%	**17**	Medicaid	Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program. The	Y	(4,943,000)		(7,139,000)	(12,082,000)	-	-	Oregon's teaching hospitals depend on these payments to supplement their teaching programs. Discontinuing
-5.98%	**18**	Medicaid	DRG Hospitals : DSH3.	Y	(2,900,000)		(4,300,000)	(7,200,000)	-	-	Reducing the reimbursement rate/level for DRG hospitals could adversely affect the Oregon Health Authority's relations
-6.12%	**19**	HPA: DSI/PCO	Reduction in Funding for the Health Care Incentive Fund by 35%	N	(10,776,139)	(7,221,845)	-	(17,997,984)	-	-	The Health Care Incentive program provides financial and non-financial incentives to providers of physical, oral
-6.65%	**20**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 3.0% to 2.7% per year.	N	(43,400,000)		(95,400,000)	(138,800,000)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-6.83%	**21**	Medicaid	Reduce Quality Pool for CY 2026 from 4.25% to 3.5%	Yes	(14,300,000)	-	(37,800,000)	(52,100,000)	-	-	CMS may have concerns with rate cuts. The CCO Quality Incentive Program (QIP) provides financial incentives to
-7.01%	**22**	Medicaid	Further reduce Quality Pool for CY 2026 from 3.5% to 2.75%.	Yes	(14,300,000)	-	(37,800,000)	(52,100,000)			CMS may have concerns with rate cuts. The CCO Quality Incentive Program (QIP) provides financial incentives to
-7.55%	**23**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.7% to 2.4% per year.	N	(43,300,000)		(95,000,000)	(138,300,000)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-8.26%	**24**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.4% to 2.0% per year.	N	(57,500,000)		(126,300,000)	(183,800,000)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-8.79%	**25**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 2.0% to 1.7% per year.	N	(42,900,000)		(94,500,000)	(137,400,000)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-8.98%	**26**	Medicaid	Further reduce Quality Pool for CY 2025 from 2.75% to the 2% minimum as published in the draft contract.	Yes	(15,600,000)	-	(41,300,000)	(56,900,000)	-	-	CMS may have concerns with rate cuts. The CCO Quality Incentive Program (QIP) provides financial incentives to
-9.16%	**27**	Medicaid	Further reduce Quality Pool for CY 2026 from 2.75% to the 2% minimum as published in the draft contract.	Yes	(14,300,000)	-	(37,800,000)	(52,100,000)	-	-	CMS may have concerns with rate cuts. The CCO Quality Incentive Program (QIP) provides financial incentives to
-9.69%	**28**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.7% to 1.4% per year.	N	(42,900,000)		(94,100,000)	(137,000,000)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-10.00%	**29**	Medicaid	Further reduce Medicaid inflation for managed care and fee-for-service from 1.4% to 1.2% per year.	N	(24,629,382)		(62,600,000)	(87,229,382)	-	-	This reduction removes reimbursement increases built into the CSL 25-27 budget to meet the anticipated program
-10.00%	**30**	PEBB	PEBB fully insured and self-insured plan reductions	N	-	(411,387,370)	-	(411,387,370)	-	-	PEBB contracts with insurance carriers for employee benefit plans. PEBB program budget is dedicated funding for
-10.00%	**31**	OEBB	OEBB plan reductions	N	-	(325,342,569)	-	(325,342,569)	-	-	OEBB contracts with insurance carriers for Entity and Self-Pay member benefit plans. OEBB budget is dedicated funds
-10.00%	**32**	Medicaid	Remove OHP Medicaid and/or Leverage program to hit OF/FF targets	N	-	(550,351,110)	(1,209,818,145)	(1,760,169,255)	-	-	
-10.00%					-	-	-	-	-	-	
					-	-	-	-	-	-	
					-	-	-	-	-	-	
			Total		**$(806,165,017)**	**$(898,704,819)**	**$(1,980,427,871)**	**$ (3,685,297,707)**	**0**	**0.00**	

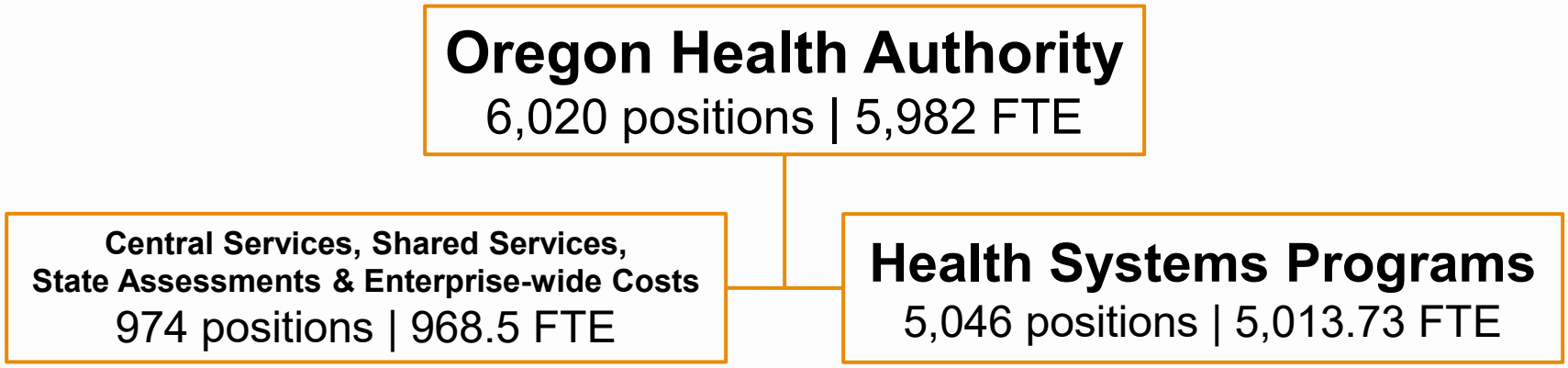
Difference to 10% Target (over)/under **0** **(0)** **-**

2023-25
Legislatively Approved Budget



Oregon Health Authority

2025-27
Governor's Budget



Oregon Health Authority

Oregon Health Authority Revenue Narrative
2025-27 Governor's Budget

Revenue for the Oregon Health Authority (OHA) comes from multiple funding sources classified as the state General Fund, Other Funds, Lottery Funds and Federal Funds. Most General Fund revenue is used as match to receive Federal Funds, particularly for the Oregon Health Plan (OHP), Oregon's Medicaid program. General Fund is also used to fund programs not eligible for Federal Funds match. General Fund is the primary funding source for the Oregon State Hospital. In addition to Medicaid, Federal Funds support a variety of grant programs across OHA. Lottery Funds finance gambling addiction, prevention, and treatment services. Other Funds revenues come from various sources, including hospital and insurer assessments, tobacco taxes, Tobacco Master Settlement Agreement funding, retail marijuana taxes, beer and wine taxes, licensing fees, grants, estate collections, health care premiums, third-party recoveries, pharmaceutical rebates, and charges for services.

Forecast methods and assumptions

There are several methodologies used to project OHA revenues:

To estimate Federal Funds from Medicaid and Children's Health Insurance Program (CHIP), OHA uses caseload forecasts, cost per person, match rates, and state and federal policy changes. To estimate Federal Funds from block grants, OHA considers grant cycles and where they fall within the biennium and makes assumptions around prior grant averaging and the anticipated effect of federal budget changes. The historical receipt trends method is used for Other Funds sources, such as collections of overpayments and fees, unless the agency has additional information including anticipated special projects that would increase revenue. Where appropriate, OHA uses reports from the Office of Economic Analysis (Tobacco Tax and Lottery Funds, for example) and analyses from other state agencies that collect revenues for distribution to OHA, such as beer and wine tax revenues, for budget forecasting.

OHA projects revenues based on assumptions that consider:

- Essential packages that adjust the existing base budget to the 2025-27 modified current service level (MCSL) for all legislatively approved programs, where those adjustments would have an impact on revenues. Essential packages include phasing in or out program changes, one-time costs, Department of Administrative Services inflation factors, mandated caseload changes, and any needed fund shifts.
- Applicable federal funding limits and requirements, including the availability of state funds to meet matching or maintenance of effort (MOE) requirements.
- Changes in federal policies that affect federal revenues available for OHA programs.
- Policy packages that generate new sources of revenue.
- Expected non-mandated program caseload changes.
- Any recent changes in state or federal statutes and regulations that affect the availability or timing of revenue receipts.

Fee schedules and proposed increases

OHA uses many fees as funding sources. Most of these fees are in Public Health. See the Detail of Fee, License, or Assessment Revenue Report for details on proposed changes.

Significant known revenue changes or risk factors

OHA received significant temporary federal funding in the 2019-21 and 2021-23 biennia in response to the COVID-19 pandemic as provided by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan Act of 2021 (ARPA). Some of the funding from ARPA continued into the 2023-25 biennium and will remain available to expend in the 2025-27 biennium.

- Several federal grants were awarded to the Public Health Division which include supplemental funding for pandemic response and preparedness; data modernization; infection prevention and control in congregate care facilities; distribution of testing supplies; state laboratory modernization and the expansion of genomic sequencing, detection of COVID-19 in confinement facilities, and homeless service sites; wastewater

surveillance; maternal, infant and early childhood home visiting; and funding to bolster the public health workforce in response to the public health crisis.
- OHA continues to seek reimbursement from the Federal Emergency Management Agency (FEMA) for eligible COVID-19 related expenses.

Major funding sources

The following section identifies the major funding sources for OHA. All references to a grant "Title" indicate the applicable chapter (i.e., title) of the federal Social Security Act (SSA).

Federal Funds

Medicaid (Title XIX)

Medicaid provides reimbursement to states for medical care and related services to people with lower incomes and other medically needy individuals. This includes financing for:

- Health care services provided under the Oregon Health Plan.
- Private insurance premiums.
- Long-term care in institutional and community-based care settings.
- Some client care provided in state hospitals.
- Residential treatment services to adults and youth.
- Central administration of alcohol and drug programs.
- Medical and non-medical transportation for Medicaid eligible individuals.
- Family planning services for individuals not enrolled in the Oregon Health Plan.
- Uncompensated care provided by hospitals serving a high proportion of Medicaid and individuals without health insurance.

State General Fund or Other Funds must be used to match federal Medicaid dollars for administration and direct service payments. For Medicaid staffing and administrative expenditures, the match rate is generally 50 percent, but

the agency can claim a 75 percent match rate for administrative activities directly related to eligibility determinations and enrollment. A 75 percent match rate is also available for skilled professional medical personnel, certification of nursing facilities, and related information systems activities, including the Medicaid Management Information System (MMIS) computer system support and Preadmission Screening and Resident Review (PASRR) activities.

Health Policy & Analytics receives federal match on health information technology (IT) efforts. The federal match various by each phase of a project. The planning and implementation stages are commonly funded at 90 percent federal match and the maintenance and operations stages of the projects are commonly funded at 75 percent or 50 percent federal match. In the 2025-27 biennium it is anticipated that the Office of Health Information Technology & Analytics Infrastructure (OHITAI) projects will qualify for both planning/implementation and maintenance/operations match rates.

The federal Title XIX match rate or “FMAP” (Federal Medical Assistance Percentage) for service payments to providers is currently estimated to be an average of 58.05 percent for the 2025-27 biennium. It is a decrease from the 2023-25 average match rate of 59.82 percent, which included the enhanced FMAP step-down through December 2023, provided by the Families First Coronavirus Response Act of 2021 (FFRCA) which provided a temporary increase to the FMAP rate. The Title XIX match rate applies to OHP (non-ACA expansion), emergency medical care for members who do not meet Medicaid citizenship or residency requirements (Healthier Oregon, formerly CWM), and Qualified Medicare Beneficiary (QMB) caseloads. The cost of services and supplies for family planning is matched at 90 percent. The Breast and Cervical Cancer Treatment program, which is an optional Medicaid program, will receive the CHIP Title XXI match rate which is estimated to be 70.64 percent for the 2025-27 biennium, a decrease from the 2023-25 average rate of 71.88 percent.

The match rate for the Affordable Care Act (ACA) expansion population has been 90 percent since January 1, 2020. However, a provision for Continuous Eligibility (CE) under Oregon’s 1115 demonstration waiver reduces the effective ACA rate. The effective ACA rate for 2025-27 is estimated to be 89.17 percent. Continuous Eligibility (CE)

took effect July 2023. CE provides OHP individuals up to the age of six to stay continuously eligible and not go through an annual eligibility redetermination. CE also allows individuals six and older to be redetermined every 2 years. In allowing for CE, CMS requires 2.6 percent of ACA expenditures to receive the Title XIX match rate, which effectively lowers the overall rate received on ACA expenditures.

Most of these services in Oregon are provided through Medicaid programs that require waivers of federal requirements. The Oregon Health Plan, authorized under Section 1115 of the SSA, is the largest of these waiver programs, followed by seven waivers authorized under Section 1915(c). OHA must obtain approval from the federal Centers for Medicare and Medicaid Services (CMS) to make changes to its Medicaid program whether the changes are Medicaid state plan services or waiver services. This approval process can be lengthy, sometimes affecting the timing of program changes and the receipt of federal revenues.

Effective September 28, 2022, CMS approved Oregon's 1115 demonstration waiver. It provides for new federal funding available through the Designated State Health Program (DSHP). Starting in 2023-25, federal financial participation became available on previously state-funded only expenditures. The saved state-funds are being reinvested in new innovative services like ones that address Health-Related Social Needs (HRSN) such as housing and nutrition.

Effective April 8, 2021, CMS approved the Substance Use Disorder (SUD) 1115 demonstration waiver. It provides additional federal revenue for the Medicaid Division by allowing federal financial participation for SUD services provided in SUD residential settings that have been designated as Institutions for Mental Disease (IMD), which were previously paid with General Fund dollars only.

Medicaid currently funds services in all OHA program areas. The projection method used to calculate funding is expenditures based on caseload forecasts, cost per person, match rates, and state and federal policy changes.

Children's Health Insurance Program (Title XXI)

The Children's Health Insurance Program (CHIP) provides federal matching funds to the state for medical care of children through age 18 who do not have insurance but whose parents earn too much for traditional Medicaid. These services are covered through the Oregon Health Plan administered by the Medicaid Division. The average federal Title XXI match rate for the 2025-27 biennium is estimated to be 70.64 percent, a decrease from the 2023-25 average rate of 71.88 percent.

The projection method used to calculate available funds are expenditures based on caseload forecasts, cost per person, match rates, and state and federal policy changes.

January 2024, Oregon changed from having a separate CHIP (S-CHIP) designation to a Medicaid expansion (M-CHIP) designation. The Governor's Budget includes newly available federal CHIP matching funds due this designation change. It allows Oregon to claim higher match rates for certain individuals and claim drug rebates on CHIP expenditures not previously allowed.

HHS Office of Population Affairs Family Planning Service Grant (Title X Program)

Oregon's Reproductive Health Program within the Public Health Division re-entered the federal Title X Program in 2022, receiving $3.4 million annually for five years. The US Department of Health and Human Services Title X Program funds comprehensive reproductive health services through fee-for-service reimbursement to the Reproductive Health Program's network of certified clinics.

Temporary Assistance for Needy Families (TANF; Title IV-A)

Under the Personal Responsibility and Work Act of 1996 (PRWOA), Oregon is eligible to receive an annual Temporary Assistance for Needy Families (TANF) federal block grant. OHA uses TANF revenue to fund non-Medicaid programs in the Health Services Division such as alcohol and drug treatment services. The Oregon Department of Human Services (ODHS) uses TANF revenues to fund cash assistance for single and two parent families, domestic violence emergency assistance, and employment and training (JOBS) services. Other agencies

use TANF revenue to fund transportation, and housing assistance for people experiencing homelessness. Administrative and direct service costs can also be reimbursed using TANF revenues. Administrative costs are limited to no more than 15 percent of total TANF expenditures, with certain limited exceptions.

To qualify for this grant, states must expend a minimum of state and local revenues on TANF-related services to meet federal maintenance of effort (MOE) requirements. The block grant concept also places restraints on service delivery. Federal Funds are capped, which means no federal revenue is available for increasing program costs. This limitation on revenue requires Oregon to essentially self-fund any program increases. The method used to project revenue is the grant cycle.

Center for Mental Health Services block grant (CMHS)

Federal CMHS funds are granted to states to carry out activities for providing comprehensive community mental health services. These program dollars are administered by the Behavioral Health Division and are targeted towards helping adults with serious mental illness and children with serious emotional disturbances. Funds for children are contracted in all counties throughout the state. At least ten percent of the funding must support evidence-based programs that address the needs of individuals with early serious mental illness, and five percent of the funding is designated for Community Crisis Services for adults and children. The funding projection is based on the grant cycle.

Maternal and Child Health Grant (Title V)

The Maternal and Child Health Grant (MCHG) enables states to maintain and strengthen their leadership in planning, promoting, coordinating, and evaluating health care for pregnant women, mothers, infants, and children, including children with special health care needs. Grant funds also promote leadership in providing health services for mothers and children who do not have access to adequate health care. MCHG is a formula grant partially based on the state's population of children in poverty. States must expend $3 for every $4 of Federal Funds they receive.

This grant currently funds Public Health Division programs. The grant will request approximately $12.5 million

Federal Funds for the 2025-27 fiscal years. Presently, 30 percent ($3.75 million) of the award is transferred to the Oregon Health & Science University Institute on Development and Disability (IDD) as an earmark requirement for health services for children with special health care needs.

Nutrition and Health Screening (WIC) program

The Public Health Division Center for Prevention and Health Promotion receives funding through the Nutrition and Health Screening – Woman, Infants & Children (WIC) program, which is a fully federally funded program that provides individual assessment of growth and health, as well as education and counseling on nutrition and physical activity. This includes promoting a healthy lifestyle and preventing chronic diseases. The program also provides breastfeeding education and support, as well as referrals to other preventive health and social services. WIC also receives federal funding (state match is required) to operate the WIC and Sr. Farm Direct Program.

Public Health Federal Funds grants

The Public Health Division receives over 72 categorical Federal Funds grants targeting specific activities. The variety of programs administered by Public Health using Federal Funds include, but are not limited to: Cancer Prevention, Emerging Infections, Immunization, HIV prevention and care; Drinking Water State Revolving Fund; Environmental health monitoring and assessment, Climate and Health grants, health facility surveys and certification, EMS for children, Diabetes Reduction, Alzheimer's Dementia Prevention and Overdose Prevention and Disaster Preparedness.

Public Health received enhanced funding from the Centers for Disease Control and Prevention (CDC) through the Epidemiology and Laboratory Capacity (ELC) cooperative agreement, Emerging Infections Program, Immunizations and Vaccines for Children grant, National Initiative to Address COVID-19 Health Disparities (Equity) grant, and the CDC Public Health Crisis Cooperative Agreement for Emergency Response grant in the 2021-23 biennium to combat COVID-19. Public Health received a no cost extension for those grants and will spend down them through the 2025-27 biennium. The division projects Federal Funds grant revenues using applicable federal funding limits and requirements, including the availability of state funds to meet matching or maintenance of effort (MOE)

requirements.

Substance Use Prevention Treatment Recovery Services (SUPTRS) grant. The SUPTRS grant, formerly known as the Substance Abuse Prevention and Treatment (SAPT) grant, funds alcohol and drug programs and some administrative costs in the Behavioral Health Division and Public Health Division. Starting in 2023-25, the grant also supports county-level overdose prevention and infrastructure. To qualify for this grant, states must expend a minimum of state and local revenues on substance-use related services to meet the maintenance of effort requirement. States must also spend 20 percent of the grant on prevention and service levels must be maintained for specified populations, such as women and women with children. The grant funds projection is based on grant cycle methodology.

Health Policy and Analytics Federal Funds grants

Health Policy and Analytics has been awarded two federal grants from the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) that help support a variety of health reform and transformation activities across several areas of OHA. These activities include an ongoing cooperative agreement with HRSA's Primary Care Office to support state efforts to expand access to primary care by helping communities recruit providers and sustain clinical resources and the HRSA Oral Health Grant to support expanded dental services throughout the state.

Oregon State Hospital

The largest source of Federal Funds for the Oregon State Hospital is the Disproportionate Share Hospital entitlement, which grants Federal Funds to hospitals that serve a large percentage of patients that are unable to meet their expenses through any other source. This is an expected annual entitlement of $19 to $20 million. These payments are subject to a federal fund match at the current FMAP rate, with the hospital receiving federal fund revenue for the FMAP percentage of the entitlement requests. An increase or decrease in the FMAP rate will result in a corresponding decrease or increase in the matching General Fund need.

The state hospital also receives Medicaid revenue, primarily from the Pendleton campus. As a 16-bed secure residential treatment facility, Pendleton is not subject to the Institute for Mental Disease exclusion that limits revenue from Medicaid at the other two campuses.

Other Funds

Hospital Assessment

The hospital assessment provides funding for the Oregon Health Plan, enhanced reimbursement, and qualified directed payments to hospitals to maintain quality and access. House Bill 2391 (2017) revised the structure of the hospital assessment program by establishing an assessment for Type A and Type B rural hospitals and exempting the Oregon Health and Sciences University (OHSU) from the assessment. The bill also increased the assessment rate paid by diagnostic related group (DRG) hospitals from 5.3 percent to 6.0 percent by adding a 0.7 percent true tax. This additional assessment was set to end June 30, 2019, prior to the start of the 2019-21 biennium; however, House Bill 2010 (2019) extended the DRG hospital assessment at 6.0 percent, but the additional 0.7 percent will no longer be a true tax. House Bill 2010 also extended both the assessment on DRG and Type A and Type B hospitals through September 30, 2025. The Type A and Type B rural hospital tax rate increased from 5.5 percent to 6.0 percent in 2021-23.

The assessment is imposed on both inpatient and outpatient net revenues of each hospital subject to the assessment. As required by Oregon law, the OHA Director sets the hospital assessment rate after consulting with hospital representatives. The assessment rate is continually evaluated to determine if any adjustment to the rate is needed to meet funding targets. The Governor’s Budget includes an extension of both the A&B and DRG assessments at the existing 6 percent rate through the biennium. The Governor's Budget includes additional revenue from DRG hospitals due to a change in the calculation to include previously excluded hospitals' revenue in determining the 6 percent.

Oregon Health & Science University (OHSU) Intergovernmental Transfer Program (IGT)
The Legislature exempted OHSU from the hospital assessment program in House Bill 2391 (2017). In lieu of their participation in the assessment, OHA and OHSU established a separate intergovernmental transfer funding program (IGT) in 2019-21 collapsing several Medicaid payments into the new program. This change generates additional Other Funds and Federal Funds revenue to support the Oregon Health Plan. In addition, IGT allows OHSU to transfer federal Medicaid dollars to leverage funds for more federal matching dollars.

Tobacco Tax
Oregon imposes a per pack cigarette tax, a percent of the wholesale price tax on other tobacco products and cigars, and a per ounce tax on moist snuff, subject to adjustment by the Legislature and collected by the Department of Revenue. A portion of Tobacco Tax funds are used to support the Oregon Health Plan in the Medicaid Division, the Behavioral Health Division and the Public Health Division.

The Office of Economic Analysis forecasts tobacco tax revenue using a 12-month moving average consumption level developed from the Department of Revenue's tax distribution record data. Price effects and per capita consumption effects are applied, as well as the forecast for the 21-year-old and older population.

In November 2020, voters approved Measure 108 to increase the state's cigarette tax by $2.00 per pack, extend the existing wholesale tax on other tobacco products to vaping products and increase other non-cigarette tobacco taxes effective January 1, 2021. After administration costs, 90 percent of the additional revenues will support the Oregon Health Plan, and 10 percent will support tobacco use prevention and cessation programs. Lastly, the Governor's Budget includes additional Tobacco Tax revenue starting in 2025-27 by expanding the definition of oral synthetic nicotine products. With an expanded definition, a broader range of tobacco-related products could be taxed.

Tobacco Master Settlement Agreement (TMSA)
On November 23, 1998, Oregon and 45 other states, and the four largest domestic tobacco manufacturers (referred to as the Original Participating Manufacturers or OPMs) ended a four-year legal battle over past, present, and future

smoking-related claims made by the states by executing the Tobacco Master Settlement Agreement (TMSA). In exchange, the OPMs agreed to make annual payments (due each April) to the settling states in perpetuity beginning with the year 2000. Funds are deposited to the Tobacco Settlement Funds Account, administered by the Department of Administrative Services. Although not dedicated to medical assistance programs, OHA receives a portion of the settlement to fund programs in the Medicaid Division and Behavioral Health Division. In the 2023 Legislative Session, House Bill 2128 passed, which will also allocate payments from non-participating manufacturers (NPMs) to OHA moving forward.

Vaping Settlement

In September 2022, Oregon and 34 other states and territories resolved a two-year bipartisan investigation into JUUL Labs marketing and sales practices. That agreement recommends payments are used for vaping prevention, cessation, research, enforcement, and schools and school districts. JUUL Labs is required to pay Oregon $18.8 million over 7-10 years. The Public Health Division is expected to receive $4.4 million in payments by the end of 2025-2027 to complete this work.

Retail Recreational Marijuana Tax

Measure 110, passed by voters in November 2020 and modified by Senate Bill 755 (2021) and House Bill 4002 (2024), redistributes a significant portion of marijuana tax revenue to the Drug Treatment and Recovery Services Fund, which can be used for operating new Behavioral Health Resource Networks (BHRNs) to expand access to treatment and recovery services. The Behavioral Health Division will continue to receive marijuana revenue each biennium for community mental health and community substance use disorder services and for alcohol and drug abuse, early intervention, and treatment services. With the passage of House Bill 4056 (2022), the amounts will be increased annually based on the change in Consumer Price Index (CPI).

Opioid Settlements

In July 2021, the State of Oregon reached agreement on a national lawsuit against four companies for their role in the opioid crisis. These lawsuits hold prescription opioid manufacturers, distributors, and retailers accountable for

their role in creating and fueling the opioid epidemic. In addition, in March 2022, Oregon settled with Purdue Pharma and the Sackler family for their role in the opioid epidemic, which will provide additional funds to address the opioid epidemic.

House Bill 4098 (2022) established the Opioid Settlement Prevention, Treatment, and Recovery Fund for the deposit of revenue from opioid settlements. Determinations for how the revenue is allocated will be directed by the Opioid Settlement Prevention, Treatment and Recovery Board also established by House Bill 4998. Allocations made by the Board must be for statewide and regional programs identified in the settlement agreements or applicable judgments, including for evidence-based programs to treat opioid use disorder and other behavioral health issues.

Insurers Assessment

House Bill 2391 (2017) established the Health System Fund within the Department of Consumer and Business Services (DCBS) to administer the Oregon Reinsurance Program and transfer monies to OHA. The bill also created a 1.5 percent assessment on insurer and managed care premiums for the period January 1, 2018, through December 31, 2019.

House Bill 2010 (2019) increased the tax from 1.5 percent to 2.0 percent and broadened the tax base by including stop-loss coverage effective January 1, 2020. A portion of these revenues help fund a reinsurance program for eligible health benefit plans, while the remaining revenue supports the Oregon Health Plan. The insurer assessment was set to end on December 31, 2026. The Governor's Budget includes an extension of the existing insurers assessment restoring revenue for the 2025-27 biennium.

OHA projects the revenue from coordinated care organizations contracted to provide health coverage to Oregon Health Plan members, Oregon Educators' Benefit Board health plans, and Public Employers' Benefit Board self-insured and contracted health plans. OHA projects the revenue based on member enrollment forecasts and cost trends. The Department of Consumer and Business Services projects the revenue from the insurer assessment for

commercial insurers.

Beer and Wine Taxes
The Oregon Liquor and Cannabis Commission (OLCC) collects beer and wine revenue based on a set percentage of tax revenues. The Behavioral Health Division uses the revenue for alcohol and drug programs. The Department of Administrative Services Office of Economic Analysis provides projections for beer and wine tax revenues.

Public Employees' Benefit Board (PEBB) Administrative Assessment and Revolving Fund
PEBB administrative expenses are paid through a 1.30 percent administrative assessment added to medical and insurance premiums and premium equivalents. Per ORS 243.185, the assessment amount cannot exceed 2 percent of the monthly employer and employee contributions to benefits and is appropriated to the Public Employees' Benefit Account.

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. 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.

ORS 243.167 continuously appropriates to the Public Employees' Revolving Fund balances to cover expenses incurred for the administration of employee benefits. Revenues from this account are used to control costs; subsidize premiums; self-insure, and pay premiums and premium equivalents for medical, dental, and optional benefits.

Revenue estimates are based on an actuarial projection of a premium composite rate per employee per month.

Oregon Educators Benefit Board (OEBB) Administrative Assessment and Revolving Fund
OEBB has two sources of revenue authorized in statute for funding operating expenses and establishing a

stabilization fund. ORS 243.880 authorizes the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated by a 1.30 percent administrative assessment paid by members along with their premiums. The administrative assessment cannot exceed 2 percent of total monthly premiums. Per ORS 243.882, the balance in the account cannot exceed 5 percent of the monthly total of employer and employee contributions for more than 120 days.

ORS 243.884 establishes the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and subsidize premiums. The revenue source is the monthly premium collections which are reconciled and passed through to the insurance carriers for payment of premiums. The interest earnings retained on the premium collection pass-through enable OEBB to generate a reserve fund for stabilizing premiums.

Health Care Provider Incentive Fund

ORS 676.450 establishes and continuously appropriates to the Health Care Provider Incentive Fund to fund the Health Care Provider Incentive Program for the purpose of assisting qualified health care providers who commit to serving medical assistance and Medicare enrollees who live in rural or medically underserved areas of this state. Contributions are also received to expand this program.

Drug Rebates

The Medicaid Drug Rebate Program includes CMS, state Medicaid agencies, and participating drug manufacturers. It helps to offset federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients. Nearly 800 drug manufacturers participate in this program. The program requires a drug manufacturer to enter, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services in exchange for state Medicaid coverage of most of the manufacturer's drugs. Manufacturers are then responsible for paying a rebate on those drugs. Drug rebate revenues offset General Fund support of the Oregon Health Plan in the Medicaid Division.

In January 2024, Oregon changed from a separate CHIP (S-CHIP) designation to a Medicaid expansion (M-CHIP)

designation. It allows OHA to claim drug rebates on CHIP expenditures, which were not previously allowed.

The Medicaid Division projects drug rebates using past expenditure history and expected future trends. Rebates are collected monthly based upon rates CMS transmits to the states. Drug rebate revenue is based on the OHP drug expenditures forecast and uses the historical percentage of revenue compared to expenditures.

988 Crisis Intervention

The Governor's Budget includes a $0.40 per line per month charge on phone lines. The assessment began January 1, 2024 and continues until January 1, 2030. This assessment will provide revenue for OHA to support the 988 Suicide & Crisis Lifeline and crisis intervention. This legislation was passed during the 2023 legislative session through HB 2757.

Health Policy and Analytics Fees

Health Policy and Analytics collects Other Funds revenue from fees. OHA began collecting fees for the Health Care Market Oversight Program on January 1, 2023. House Bill 2365 (2021) requires OHA to review proposed transactions, such as mergers and acquisitions, that involve health care entities, including hospitals, health insurance companies, and provider groups. Other fee-supported programs include the Conrad J-1 Visa Program (ORS 409.745), Healthcare Workforce Data Collection and Reporting and Health Care Data Reporting.

Health Insurance Marketplace (HIM)

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. This funding is used to administer the program. The Health Insurance Marketplace was transferred from Department of Consumer and Business Services to the Oregon Health Authority in the 2021-23 biennium.

Intoxicated Driver Program Fund (IDPF)

Court fines, fees and assessments related to driving under the influence of intoxicants are statutorily dedicated by

ORS 813.270 to provide education, treatment, and financial assistance to intoxicated driving offenders and are deposited into the Intoxicated Driver Prevention Fund. The Behavioral Health Division provides this funding to counties for intoxicated driver services, as well as contracting with Guardian Interlock to provide breathalyzer machines for IDPF clients.

Law Enforcement Medical Liability Account (LEMLA)
LEMLA is funded with Other Funds revenue from assessments added to fines and bail forfeitures paid into the courts system. The Behavioral Health Division makes payments from this account to medical providers for services to persons injured as a result of law enforcement efforts. A small portion of this fund is used to administer the program. Projections are based on estimates from Department of Revenue and Department of Justice.

Community Housing Trust Account
This trust fund was established with the sale of the Dammasch hospital property (ORS 413.101). Interest from the fund is dedicated to new housing and facility maintenance to benefit people with mental illness. These funds are budgeted in the Behavioral Health Division.

Third-Party Liability Recoveries
The Third-Party Recovery Program recovers medical portions of the collections from insurance companies, providers, and clients, and cash assistance by filing liens on personal injury settlements when clients are involved in accidents. The state's share of the recovery becomes Other Funds revenue to offset Medicaid expenditures.

Efforts to increase cost avoidance through provider education and an emphasis on up-front payment accuracy and coordination of benefits will impact recoveries in the coming biennium. The systematic early identification of clients with third-party insurance coverage will increase cost avoidance, reduce program expenditures and directly impact the expected amount of recovery.

Public Health Other Funds Sources

The Public Health Division has more than 126 sources of Other Funds revenue. These revenue sources include negotiated agreements to provide services, lab fees, inspection fees, certification fees, grant awards, client co-pays and other charges. The large number of revenue streams reflects the variety of programs and services administered by Public Health. These diverse programs include: Tobacco Prevention, Juvenile Violence Prevention, Medical Marijuana Certification, Environmental Laboratory Accreditation, Coordinated School Health, Reproductive Health and Adolescent Health, Psilocybin Services, the Prescription Drug Monitoring Program, Radiation Control, Water System regulation, Drinking Water Operator Certification, Health Records and Statistics, Emergency Medical Services providers and ambulance services, Newborn Screening, and Cross Connection, and Backflow Inspection.

The Public Health Division generates Other Funds revenue from fees for activities in such areas as licensing of facilities, including hospital and special inpatient care facilities; registration inspection and testing of X-ray equipment; and testing and certification of Emergency Medical Technicians. Public Health's Health Licensing Office (HLO), which regulates over 75,000 authorizations among 19 boards and councils including 5,300 facilities, collects fees for applications, examinations, issuance and renewals of licenses and registration, disciplinary actions, and other administrative fees. Each board, council and program have their own statutory fees, which are used to cover their administrative costs and HLO. The boards collect more than $9 million in fees, which continues to increase as new boards, programs or license types are added to HLO.

Recent program additions include the Oregon Psilocybin Services, which started collecting fees in 2021-23. The fees from Measure 109, passed by voters in November 2020, are used to support costs in regulating the administration of psilocybin in supervised settings. In addition, the Oregon Tobacco Retail License Program was established in Public Health in January 2022. The Department of Revenue assesses a fee from licensed retailers and remits payments back to OHA.

The largest Other Funds revenue source supporting Public Health programs is the non-limited Women, Infants, and Children (WIC) infant formula rebate. Public Health projects Other Funds revenue sources using historic data,

contract agreements, anticipated levels of service and changes to fees.

Medicare Revenue
Medicare revenue is based on submitted claims for services rendered to Oregon State Hospital patients. Claims are submitted upon patient discharge or exhaustion of insurance benefits, whichever comes first. Medicare Part A provides limited days of lifetime coverage per patient, regardless of length of stay or number of admissions. These revenues are contingent upon the patients having those benefits and vary based upon payor mix and applicable Medicare provisions. A decline or increase in patients with available benefits will correlate to a decline or increase in hospital revenue.

Local Revenue
The Oregon State Hospital has several areas of Local Revenue that account for a small portion of other funds revenue. These include patient supported employment programs for various activities such as fabrication of wood products and bench work, as well as patient stores, campus cafeterias and coffee shops.

Bond Sale Revenue
The Governor's Budget includes revenue from bond sales in the 2023-25 biennium for the Behavioral Health Division to expand community acute psychiatric facility capacity. These funds were requested to be moved into the 2025-27 biennium to allow for community partners and provider the time required to acquire, build and/or remodel facilities as needed to create the additional capacity.

It also includes revenue from bond sales for the Oregon State Hospital (OSH) for deferred maintenance projects.

Lottery Funds

One percent of the state's lottery proceeds are allotted by ORS 461.549 to OHA for problem gambling treatment and prevention services in the Behavioral Health Division. The Oregon Constitution requires that 1.5 percent of lottery

proceeds be distributed to the Veterans' Services Fund to support veterans' access to housing, health care, and mental health services. Additionally, OHA started receiving an allocation from this fund to support veteran's behavioral health services in 2019-21 and to support veteran's dental care in 2021-23. The Department of Administrative Services Office of Economic Analysis provides the projection of lottery funds.

Detail of Fee, License, or Assessment Revenue Increase

Proposed for Increase/Establishment

Purpose or Type of Fee, License or Assessment	Who Pays	2023-25 Estimated Revenue	2025-27 Agency Request	2025-27 Governor's Budget	2025-27 Legislatively Adopted	Explanation
Health Insurance Marketplace Assessment - POP 424	Insurance Carriers	18,092,136	25,000,000	25,000,000		Will request increase in assessment fees for transition from the federally facilitated marketplace to a state-based eligibility and enrollment platform.
Hospital Licensing - POP 426	Hospitals	712,700	3,513,700	3,513,700		Requesting increase in hospital licensing fees. Statutory change is needed. GB rev stays the same

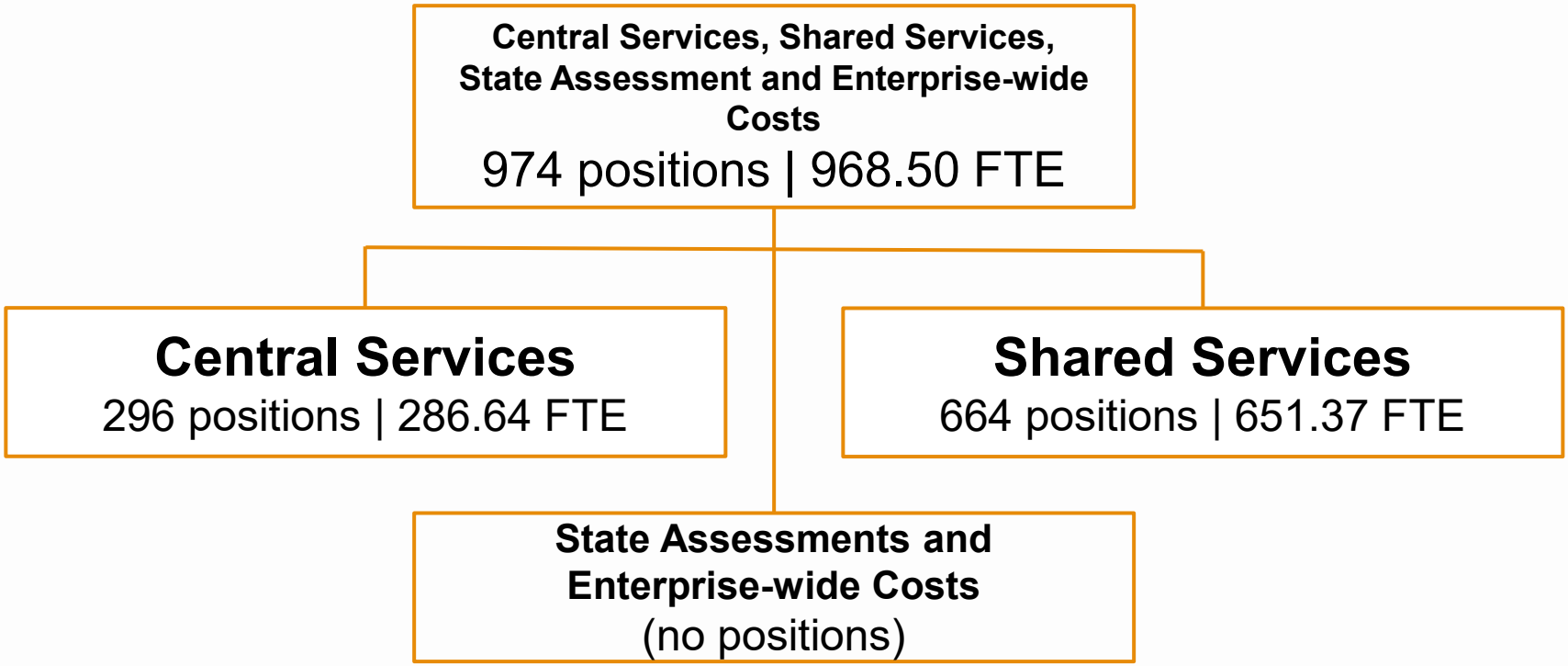
___ Agency Request __X__Governor's Budget _____Legislatively Adopted

Instructions

Column A	**Purpose**	Identify the purpose or type of fee, license or assessment. For example: day care licensing, underground storage tank permit, gasoline marketing fee.
Column B	**Who Pays**	Explain the various individuals or groups that pay the fee. For example: day care providers, owners of underground storage tanks, gasoline distributors and retailers in carbon monoxide control areas.
Column C	**2023-25 Estimated Revenue**	Estimate the revenue that will be collected in the current biennium.
Column D	**2025-27 Agency Request**	Estimate the revenue that will be collected in 2025-27 based on the increase requested in policy packages.
Column E	**2025-27 Governor's Budget**	Enter the amount approved in the Governor's Recommended Budget.
Column F	**2025-27 Legislatively Adopted**	Enter the amount approved by the Legislature.
Column G	**Explanation**	Describe the requested increase. Separate the increase due to volume change from an increase in the fee, license, or assessment. Identify if the increase is provided for by administrative rule or if statutory change is needed.

2023-25

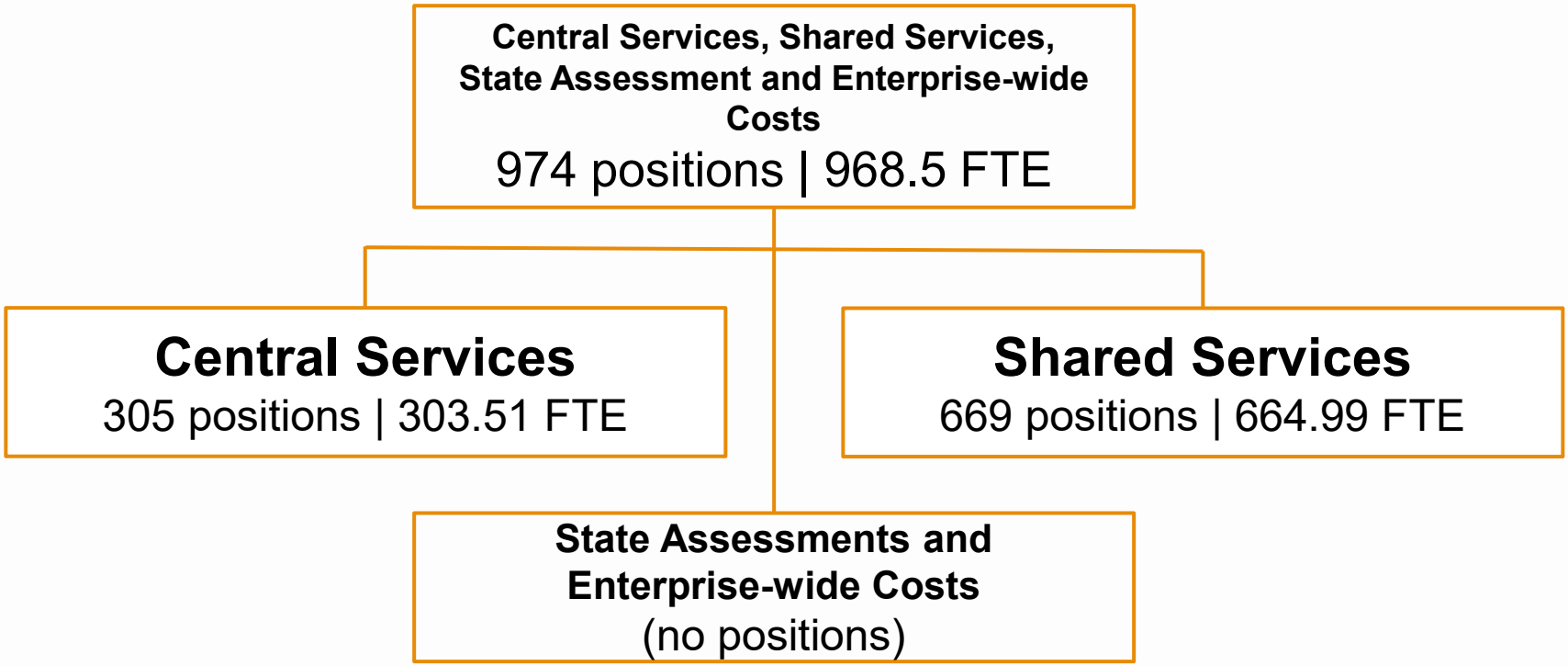
Legislatively Approved Budget



Oregon Health Authority

2025-27

Governor's Budget

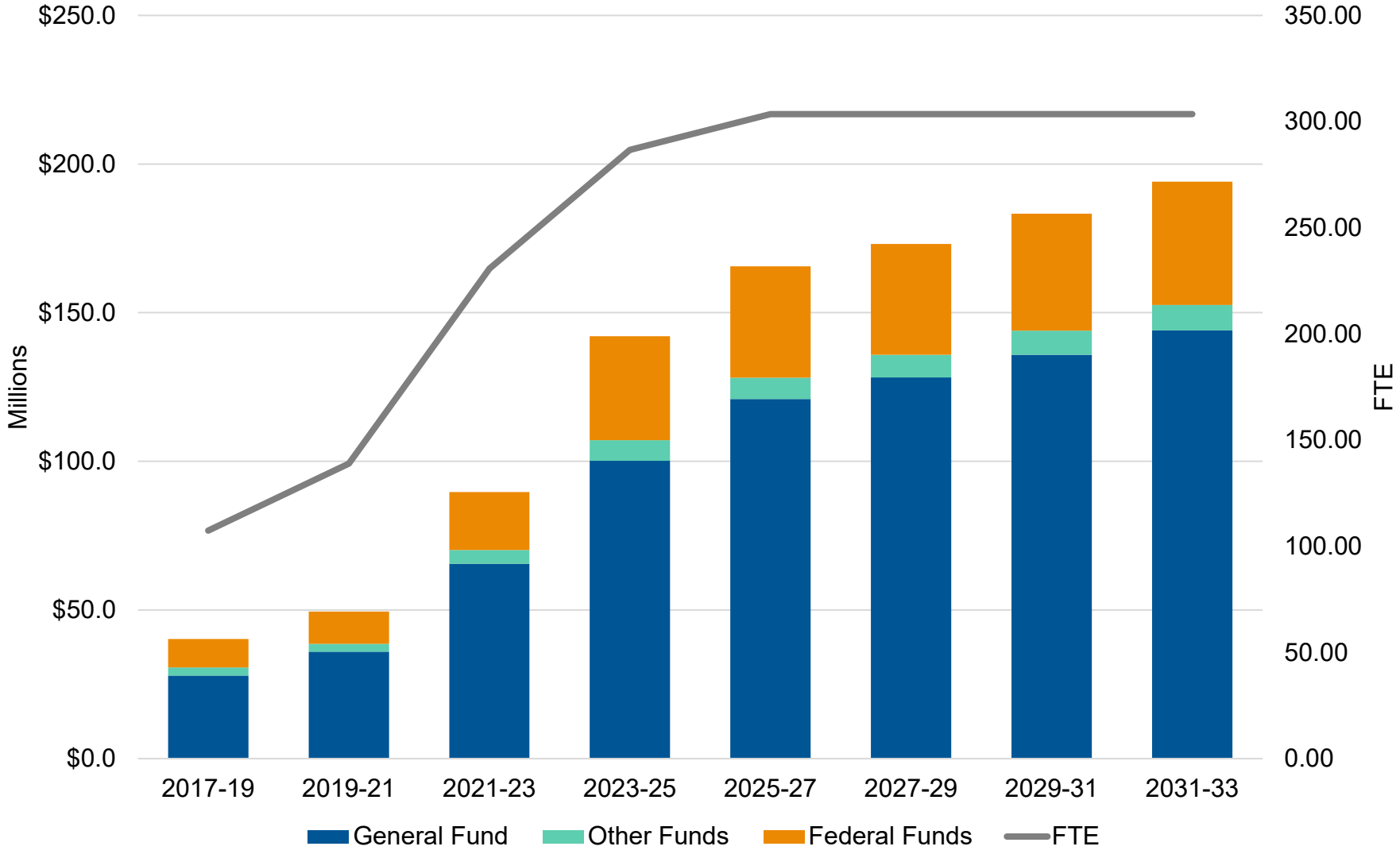


Oregon Health Authority

Oregon Health Authority: Central Services

Executive Summary

Program Contact: Kris Kautz, Agency Operations Director



Executive Summary

Central Services (in millions)	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2023-25 LAB	$100.18	$6.93	$34.96	$142.07	296	286.64
2025-27 GB	$120.93	$7.19	$37.51	$165.64	305	303.51
Difference	$20.75	$0.26	$2.55	$23.56	9	16.87
Percent	21%	4%	7%	17%	3%	6%

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
- Tribal Affairs
- Equity and Inclusion Division
- External Relations Division

Recommended funding

The Governor's Budget of $165.6 million Total Funds for Central Services reflects funding at the current service level for the upcoming biennium with some exceptions. Service and Supplies are reduced by $1.1 million Total Funds, while 4 positions are added to the director's office that support strategic agency goals, including advancing OHA's capacity to consistently track agency investments with measurable outcomes. Additionally, $255,000 Total Funds and one position are added to support behavioral health initiatives. The budget also includes policy packages to continue funding priority programs and initiatives and to build out OHA capacity in areas that directly support the agency's strategic plan. These include:

- POP 406 Required Inclusive and Supportive Access

Executive Summary

- POP 411 Regional Health Equity Coalition Expansion and Sustainability
- POP 412 Operationalizing Health Equity

Program descriptions

The **Director's Office** is responsible for overall leadership, policy and development, and administrative oversight for OHA. This office coordinates with the Governor's Office, the Legislature, other state and federal agencies, the Nine Federally Recognized Tribes of Oregon, partners, 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 centered around the strategic goal of eliminating health inequities by 2030. Under the strategic plan, OHA has committed to the following five goals:

1. Transforming behavioral health;
2. Strengthening access to affordable care for all;
3. Fostering healthy families and environments;
4. Achieving healthy Tribal communities; and
5. Building OHA's internal capacity and commitment to eliminate health inequities.

OHA has embedded a health equity framework approach into the work of all programs in order to bring equity into the forefront of the agency's work innovating, improving and transforming the state's health care system.
The **Agency Operations Division** provides operational support and human resources services to OHA. The division includes the following functional areas:

- Central Operations – Supports agency operations including public records requests, facility coordination, strategic planning and performance system management, and Shared Services engagement with the Oregon Department of Human Services (ODHS) is also coordinated through Central Operations. The Office of Information Services also reports up through Central Operations as a shared service between OHA and ODHS.

Executive Summary

- 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 in Federal Law, including the Federal Trust Responsibility to provide health care to Indian people, State Law requirements in ORS 182.162 to 182.168 (SB770, 2001), Relationship of State Agencies with Indian Tribes and the OHA Tribal Consultation and Urban Indian Health Program Confer Policy

Tribal Affairs supports Tribal Governments 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 communities. 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 **Equity and Inclusion (E&I) Division,** on behalf of OHA and the state of Oregon, is leading the most ambitious, equity centered health system transformation in the nation, working in partnership with priority populations, all OHA divisions, and the statewide health delivery system to eliminate health inequities in Oregon by 2030. In alignment with the agency's health equity definition and the state's goal to develop policy, program and practice that promotes optimal health for all people in Oregon, the E&I Division provides expertise and technical assistance on equity, inclusion, anti-racism, anti-oppression, inclusive accessibility and social justice topics. The work of the division links to all five OHA strategic plan goals by building organizational equity infrastructure and creating equitable health services delivery system across the full health spectrum.
OHA's E&I Division is structured into four sections:

Executive Summary

- The Civil Rights, Learning and Inclusion (CRLI) Section has a leading role in advising agency executives, health system partners—including Coordinated Care Organizations (CCOs), workforce partners, policymakers, and federal, state and municipal entities—to eliminate avoidable health inequities, improve health outcomes for all people in Oregon, and remove institutional and historic barriers experienced most deeply by people in priority populations, while also managing significant internal and external civil rights responsibilities. The Section's work is primarily governed by Federal, State and DAS statutes, regulations and policies, including U.S. Department of Justice's (DOJ) requirement for comprehensive digital accessibility and U.S. Health and Human Services' regulations on non-discrimination and language access.
- The Equity and Policy Section works from an anti-racism framework to develop, implement, coordinate, monitor and evaluate strategies to promote and advance health equity. This includes efforts to identify policy, programs, systems, and environmental solutions that are community-centered, community-led and community-driven. The section's programs and initiatives, many of which are legislatively mandated, require extensive collaboration across all OHA divisions, the Governor's Office, Legislators, CCOs, other state and federal partners.
- The READ & SOGI Section is legislatively mandated per ORS 413.161 – 413.167 and is charged with implementing data collection standards and building a centralized integrated registry/repository system, including monitoring and remediating non-compliant data systems owned by other OHA programs. Additionally, the section leads the Integrated Registry/Repository Project and administers a grant program for community health organizations and community-based groups to provide culturally responsive, trauma-informed trainings.
- The Operations Section is responsible for diversified and multi-functional processes to support the Division in leading health systems transformation on behalf of OHA, as the interface for systems and supports related to human resources; communications; legislative bill analysis and administrative rulemaking; facilities; contracts and grants management; administrative support; technology; project management; and quality improvement.

Within OHA Central Services, the **Fiscal Division** provides leadership and oversight of financing policies, prepares fiscal outcomes and budget tracking, and coordinates budget development and execution for OHA. The division includes four functional areas: budget, financial investments and outcomes, actuarial services and program integrity.

Executive Summary

- 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 the Agency Request Budget, the Governor's Budget, the Legislatively Adopted Budget, rebalance reports and various Emergency Board actions.
- Financial investments and outcomes: Integrating policy, strategy and budget with a focus on the impact of funding provided to OHA. The goal of this group is to enhance budget transparency, reporting and agency priority alignment across OHA divisions.

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 Medicaid Division Program Support and Administrative Unit.

The **External Relations Division (ERD)** enhances and facilitates communications and community and partner engagement to audiences inside and outside OHA. The division's work touches all areas of OHA across all divisions. External audiences include people receiving OHA services, legislators, community partners, nonprofits, contractors, service providers, local and federal government, other state agencies, and media. To advance OHA's goal to end health inequities in Oregon by 2030, the ERD:

- Works closely with the OHA Director's Office on strategic initiatives and shared services.
- Promotes transparency, community engagement and community voice.
- Advises and works across all OHA as experts in communication, government relations and community engagement to inform and improve the experience of those receiving OHA services.

The External Relations Division has four sub-divisions: Communications, Government Relations, Office of Community Health and Engagement, and the Member and Partner Engagement and Support Office which includes the Ombuds Program, Innovator Agent Team and Feedback Team. Together, these teams are responsible for building strong relationships with the public, community partners, media, the Legislature, and other agencies at the

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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, through all agency operations, policies and programs to integrate community voice into agency work.

- The Office of Community Health and Engagement includes the Community Partner Outreach Program (CPOP). CPOP has built a one-of-a-kind network of Community Partner Organizations serving all people 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 Member and Partner Engagement and Support Office includes the following programs:
    - 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 voices throughout 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 16 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 across OHA to ensure CCOs and OHA are working together to prioritize health equity, Tribal relationships, behavioral health, and emerging statewide priorities.
    - The Feedback Team elevates partner and community input into OHA operations, policies, communications, and programs. The Feedback Team collects partner and member feedback from customer service data, partner engagement events and other areas across OHA to track concerns impacting health equity. The team identifies gaps in service or delivery based on emerging issues reported through the feedback system. The team ensures that critical loops are in place to act upon and report back on partner insights and member experiences.
- 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 on pressing healthcare topics. The team elevates content through English and Spanish via social media and other media channels and communications pathways 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 and advances OHA legislative concepts to ensure access to quality health care, contain costs of health care, ensure legislative concepts center OHA's goal to eliminating health inequities, and improve overall health for Oregonians.

Division initiative-specific work includes communications, policy support, as well as coordinating and advocating for priority populations and member experiences related to the following agency-wide priorities:

- Behavioral health
    - Measure 110 program/HB 4002 implementation, fentanyl and methamphetamine substance use disorder crisis.
    - 988 and mobile crisis/capacity/investments.
    - Prevention, treatment and recovery including behavioral health residential capacity expansion.

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- Protecting and expanding health coverage: OHP renewals, Healthier Oregon, OHP 1115 Medicaid waiver implementation and the Basic Health Program.
- 1915(i) Home- and Community-Based Services.
- Lower Umatilla Basin Groundwater Management Area communications and supporting community outreach for well testing and mitigation.
- Oregon State Hospital operations.
- Health care system mergers, finances, facility closures, and workforce challenges.
- CCO performance, rates and finances.
- Public health strategy and response to existing and emerging health issues to improve health outcomes, as well as promote and protect safe, healthy, and resilient environments to improve quality of life and prevent disease.

Program justification and link to long-term outcomes

OHA Central Services provides critical business support necessary to achieve the agency's strategic plan, both directly through program activities as well as through essential services provided to other areas of OHA.

Outcomes from investments made within the E&I Division demonstrate innovative approaches and collectively align with all five of the agency's strategic goals. Long-term, the programmatic and policy work of E&I represents essential levers to achieve the 2030 goal to eliminate health inequities in Oregon. Outcomes of this work include but are not limited to:

- Regional Health Equity Coalitions (RHECs) empower priority populations to participate in policy and systems change efforts to address structural and institutional racism and discrimination for the purpose of improving health equity across the social determinants of health. RHECs have informed legislation and policy development including Cover All Kids, Healthier Oregon, 1115 Medicaid waiver, behavioral health services for gender-diverse communities and have contributed to OHA's consultation with and feedback from community.
- A Health Equity Impact Assessment suite of tools and trainings to build internal capacity centered in equity.

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- A Behavioral Health Equity Community of Practice across OHA divisions to improve cross-agency coordination on behavioral health initiatives.
- Traditional Health Workers (THWs) now comprise eight categories of workforce across the health spectrum, growing from 900 to 7,000+ people (as of 2024), which is mirrored by an increase in the number of THW training organizations.
- The Health Care Interpreter (HCI) Program's continued certification and qualifications of both spoken and sign language interpreters, assessment and work to remove barriers for working as an HCI.
- Based on REALD compliant data sources, the REALD & SOGI Repository can now share more complete and quality data as appropriate and approved via governance, including for several Medicaid related dashboards.
- CRLI's work supports the agency's workforce to equip them to do their jobs in alignment with the agency's objective to ensure that equity is practiced consistently, leading to increased workforce satisfaction, productivity and engagement and that OHA (and the state) meets state and federal statutory and regulatory requirements.
- Through strategic and proactive investment in the CRLI Section's work, there is a foreseeable cost savings in less turnover and fewer internal investigations and litigation.

The **Fiscal Division** has increasingly worked to improve budget transparency, reporting and agency priority alignment. This includes the development of new outcomes-based reporting mechanisms as well as the refinement of budgetary processes within OHA. Through these focused efforts, OHA is working towards greater transparency in demonstrating how investments are utilized and consequential health-related outcomes. Strengthening OHA's ability to demonstrate the outcomes of Legislative and other investments is critical in building trust with Oregonians and additionally serves to exemplify the criticality of the agency's work.

Program performance

Within the **Fiscal Division**, budget staff implement and monitor the OHA budget of over $35 billion Total Funds and over $5.6 billion in General Fund dollars. The Health Care Finance staff provide financial oversight of over $10 billion annually paid to coordinated care organizations and for Medicaid fee-for-service costs.

Executive Summary

Accomplishments from **Equity and Inclusion Division** include:

- Through CCO contracts, implemented 16 THW integration and utilization plans, payment models, and data.
- Launched an online portal for HCIs to submit applications online, effective July 2024, reducing errors and increasing efficiency for HCI credentialing. The registry currently has about 2,018 HCIs, as compared to only 538 in 2019.
- There are currently nine RHECs serving 20 counties. RHEC memberships includes 619 individual members and 163 member organizations. RHEC engagement resulted in meeting 12 policy and system change goals this year, 155 community education events, and a net impact of 32,158 individuals via community trainings.
- Development and implementation of Health Equity Impact Assessment tool pilot on three critical agency projects: 1115 demonstration waiver; Benefit Design Initiative and Fee-for-Service Handbook Redesign.
- Development of Healthier Oregon program and OHP Ecosystem Mapping and implementation of cross-division Healthier Oregon Issue Escalation workgroup.
- Development of collaboration with Health Equity Solutions and State Health and Value Strategies and other internal OHA staff across divisions in the design of the OHA Community Engagement Framework.
- Development and implementation of contract and guidance documents for CCO Health Equity Plans and its evaluations and provision of technical assistance to CCOs.
- Leading inter-agency efforts to increase internal and external capacity to effectively collect, analyze, and use REALD & SOGI data.
- Updated REALD data collection standards in the OARs (July 2024) to include SOGI data collection standards.
- Developed tools, cross-maps and data dictionaries to help data owners comply with REALD & SOGI.
- Updates to the ONE Eligibility system to align with the 2024 REALD & SOGI data standards.
- Developed and delivered a three-day REALD & SOGI Data Analytic Institute (DAI) for analysts from OHA/ODHS (82) and all CCOs (66) to build capacity and share best practices for data equity.
- Developed and launched the REALD & SOGI employee survey to inform Workforce Diversity efforts.
- Leading the development of the REALD & SOGI Registry with assistance from the Office of Information Services.

Executive Summary

- CRLI Section developed and delivered numerous trainings and presentations on compliance-based or equity-centered or both topics to OHA employees, managers, and volunteers (board and commission members) as well as other state executive agencies and regional and national workgroups. These presentations include: (1) civil rights requirements and resources; (2) foundational equity principles and practices; (3) language access principles and processes; (4) equitable recruitment; (5) organizational resilience and healing; (6) integrating equity into legislative processes; (7) digital accessibility considerations and requirements; and (8) integrating meaningful access and inclusion; in addition to providing general technical assistance. The activities listed in numbers two to eight were primarily completed by the newly established Accessibility, Inclusion and Education (AIE) unit which became fully operational in April 2024. AIE has provided 45 hours of ADA-related consultation, 83 Language Access related T/A requests, 20 equity trainings, and processed 36 Digital Accessibility requests for usability testing, remediation, SME consultation, and training. Additionally, the Civil Rights Unit (CRU) has completed approximately 194 investigations from 2023 to present related to civil rights concerns in addition to providing numerous coaching and technical assistance to OHA managers and staff and approximately 20 trainings/presentations in that same period.
- CRLI has requested an inclusive and accessible ticketing platform which would enable more accurate tracking of requests and deliverables to help capture performance measures to quantitative data about number of trainings developed and delivered, number of people completing trainings; and qualitative (and quantitative) data to include training evaluation.
- The CRLI Section plans to conduct readiness assessments to measure the agency's compliance with state and federal requirements.
- The Operations Section led quality improvement activities for E&I's legislative work that supported 50 division staff and played an active role by monitoring 27 bills and doing bill review for seven bills in the 2024 legislative session.
- The division onboarded its first Administrative Rulemaking Specialist and facilitated four rules advisory committees and one public hearing for the functional side of the division's new Rules Chapter 950.

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- The division partnered with NW ADA Center to assess OHA's offices in downtown Portland for accessibility improvements to support meaningful access by all employees and the public interfacing with OHA committees and programs.

OHA's External Relations Division, according to average annual metrics:

- Responds to more than 1,100 media requests per year, and OHA is mentioned in more than 15,000 media articles including national and international publications.
- Connects approximately 250,000 people per year to health insurance and providers through a vast culturally and linguistically appropriate community partner network.
- Produces a wide variety of publications, including a health newsletter with approximately 175,000 subscribers in Oregon and some of the most-visited websites in the state.
- Advocates for approximately 3,000 concerns on an individual and systems level for Medicaid and OHP members through the Ombuds Program, including over 300 Medicaid-related behavioral health concerns.
- OHA Social media posts average a reach of nearly 90,000 people.

Within OHA Central Services, **Human Resources** (HR) activities include carrying out recruitment, retention, learning and development, classification and compensation, and employee and labor relations services with an emphasis on antiracism, equity, and belonging that promotes a vital, prepared, and talented workforce that reflects and truly benefits the Oregonians' that OHA serves.

The Office of Human Resources serves as a business partner and provides proactive, comprehensive human resource services that furthers the agency in achieving its mission and goals. HR works closely with internal partners on workforce initiatives and strategies at the program and agency level. It promotes a healthy workplace culture of ongoing development and feedback to ensure that the workforce has the needed skills to be successful and engaged. HR is committed to the vision of a healthy Oregon and eliminating health inequities by 2030.

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HR serves a growing and complex agency in OHA. HR's strategic focus is on ensuring equity, antiracism, inclusion, and belonging principles in all that OHA does – programs, policies, processes, and service delivery. HR's work impacts all OHA staff, every day. It is imperative that HR model, embody, and carry-out organizational values in order to delivery on the agency's goal of eliminating health inequities. Below are metrics and data that begin to describe HR's scope of work (data time frames are July 1, 2023 to June 31, 2024):

- 46,407 applications for positions, each of which HR manually grades to determine minimum qualifications
- 720 hires
- 402 promotions and 703 transfers
- 43 HR investigations that required corrective action
- 1 manager fact finding that required corrective action
- 7 grievances responded to at Step 2
- 72 managers trained on Performance Accountability & Feedback Module 1, 74 on Module 2, 72 on Module 3
- 136 classification reviews
- 1,968 pay equity analysis completed
- 52 unscheduled review requests completed

Enabling legislation/program authorization

The Oregon Legislature created and authorized OHA 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. OHA's Central Services provides essential leadership and administrative oversight and support to ensure successful delivery of statutorily authorized programs and services.

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Funding streams

OHA's 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.

Significant proposed program changes from 2023-25

Required Inclusive & Supportive Access, POP 406, requests resources to meet new regulatory requirements, and ongoing requirements to provide services that are meaningfully accessible to employees and the public, regardless of language ability, disability status and other protected class factors; and to steward a respectful, professional work environment that supports staff wellbeing.

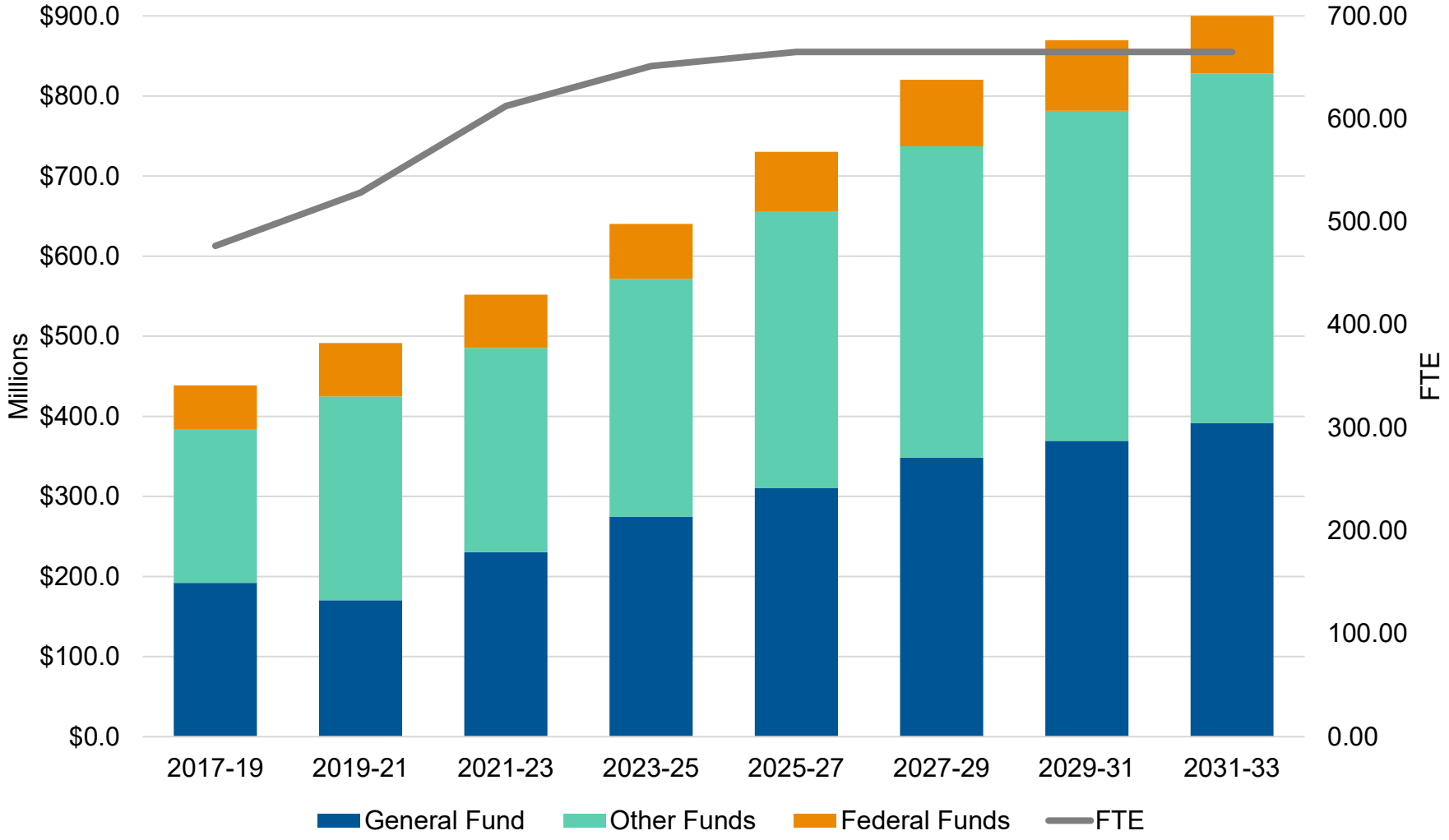
Regional Health Equity Coalition (RHEC) Expansion and Sustainability, POP 411, includes funding for expansion, by increasing resources to existing RHECs, adding three new RHECs for statewide representation, and new OHA positions for grantee support. This expansion will increase the ability of community members to participate in the policy making process to address health inequities across the state.

Operationalizing Health Equity, POP 412 requests funding to build infrastructure through strategic investments in the Traditional Health Worker (THW) program to address maternal child health inequities and measure effectiveness of THWs within CCOs.

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



Executive Summary

Expenditures by fund type, positions and full-time equivalents

Shared Services & SAEC	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
2023-25 LAB	$274.73	$290.74	$68.52	$640.19	664	651.37
2025-27 GB	$310.14	$345.95	$74.08	$730.17	669	664.99
Difference	$35.41	$55.21	$5.56	$89.97	5	13.62
Percent	13%	19%	8%	14%	1%	2%

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. The mission of OHA | ODHS Shared Services is to provide critical business services that are data-informed, accountable, and transparent. ODHS and OHA govern their shared services through a board composed of operational leaders from the two agencies who ensure that shared services are prioritized and managed to support program needs. The board and its subgroups have established service level agreements and performance measures for each service, implemented recent budget cuts, moved staff in and out of shared services to rationalize service delivery, and begun implementing more integrated systems to support the performance of all our employees.

The OHA Shared Services budget contains the Office of Information Services. The Governor's Budget of $289.0 million Total Funds continues funding for the Office of Information Services for 2025-27 at the current service level, as well as the policy packages listed below.

- **POP 201: Mainframe Modernization.** Over a million people in Oregon depend on an aging mainframe platform supported by a dwindling number of technical specialists. POP 203 was approved in 2023-25 to start moving from the mainframe to a more modern, flexible, and supportable technology that can meet the needs

Executive Summary

of constituents who expect and rely on ODHS to provide services reliably and securely. Moving off a 50-year-old platform requires a multi-biennium effort, and this POP continues work that has already begun.

- **POP 202: Improve Information Technology Privacy and Security.** The Information Security and Privacy Office supports both OHA and ODHS programs by providing assurances in the protection of agency regulated data, risk identification and mitigation, and the confidentiality, integrity, and availability of information for the communities whom OIS serves. ODHS|OHA remain responsible for the protection of their regulated data including the breadth, volume, scope, and associated governance, risk, and compliance of that data. Information, security, and privacy standards are much greater than most other state agencies; as the human impact of information security and privacy risks in government health and human services data is substantial, encompassing compromised privacy, financial harm, emotional distress, potential medical mismanagement, and erosion of public trust. ODHS|OHA must proactively invest in resources and tools to strengthen these essential areas, address Secretary of State audit gaps and mitigate privacy risks and vulnerabilities impacting both agencies.

OHA State Assessments and Enterprise-wide Costs (SA&EC) includes the budget for costs that affect the entire agency including statewide assessments that include Department of Administrative Services charges such as the State Government Service Charge, Risk Assessment and State Data Center Charges. Rent for all of OHA is in the Facilities budget. IT Direct is for all computer replacement needs. The Shared Services funding is the revenue for the OHA portion of ODHS | OHA Shared Services and Debt services is to pay off Certificates of Participation or Q-Bond loans taken for major OHA projects. Each service, both shared and assessed, are important for OHA to attain its programmatic outcomes. The Governor's Budget for SA&EC is $359.8 million Total Funds.

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

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- 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

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 desk phone budget and DAS financing charges for the telecommunications system. Expenditures for work contracted to the IT phone contractor for phone system adjustments is paid out of this budget as well.

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Facilities

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

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

Executive Summary

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 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.

Executive Summary

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 1,700,000 clients, 60,000 agency and partner staff at 140 local offices, Oregon State Hospital locations, and the public health laboratory.

OIS provides support for more than 51,000 devices and 80 mission critical applications. The Service Desk responds to more than 14,000 service requests each month.

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.

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Executive Summary

Program justification and link to long-term outcomes

OHA Shared Services provides critical business supports necessary for OHA programs to achieve the agency's overarching mission to eliminate health inequities by 2030. OHA Shared Services - Office of Information Services (OIS) – performs Quarterly Target Review meetings where managers review metrics and outcomes that align with OHA's Health Equity goals. In addition, OIS reports to the ODHS/OHA Shared Services Budget Committee (SSBC), which is made up of OHA and ODHS leaders, on the OIS metrics and Service Level Agreement components.

OIS aligns with the ODHS and OHA Strategic plans.

ODHS|OHA Strategic Technology Plan Goals

- Cultivate IT Workforce - Cultivate a highly skilled, diverse, and customer focused organization.
- Strengthen Cybersecurity, Risk and Privacy - Strengthen cybersecurity and consider the risk in the decision-making process.
- Accelerate Technology Modernization - Enhance and augment IT infrastructure, systems, cloud capabilities, and processes to address pressing human services and health care challenges.
- Increase Data Insights - Consider community involvement in data that is collected, and used in a way that does not perpetuate or exacerbate existing inequities ensuring accuracy and completeness.
- Optimize Technology Management - Provide inclusive, customer-focused collaboration.

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 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.

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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 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.

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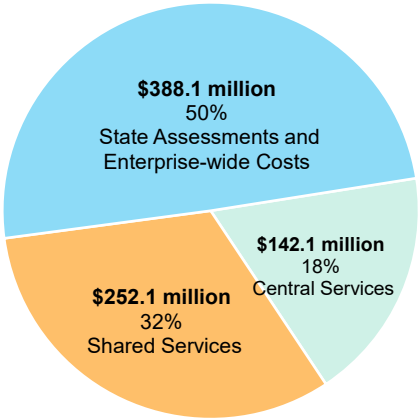
Significant program changes from 2023-25

- Telecom Contact Center Support
- Technology Modernization
- Health and Service Equity (REALD-SOGI Implementation)
- Oregon Eligibility (Including Legacy Systems) Maintenance and Operations
- Building consolidation

Oregon Health Authority
2023-25 Legislatively Approved Budget

Central & Shared Services, State Assessments & Enterprise-Wide Costs by Program
$782.3 million Total Funds



Central & Shared Services, State Assessments & Enterprise-Wide Costs by Program
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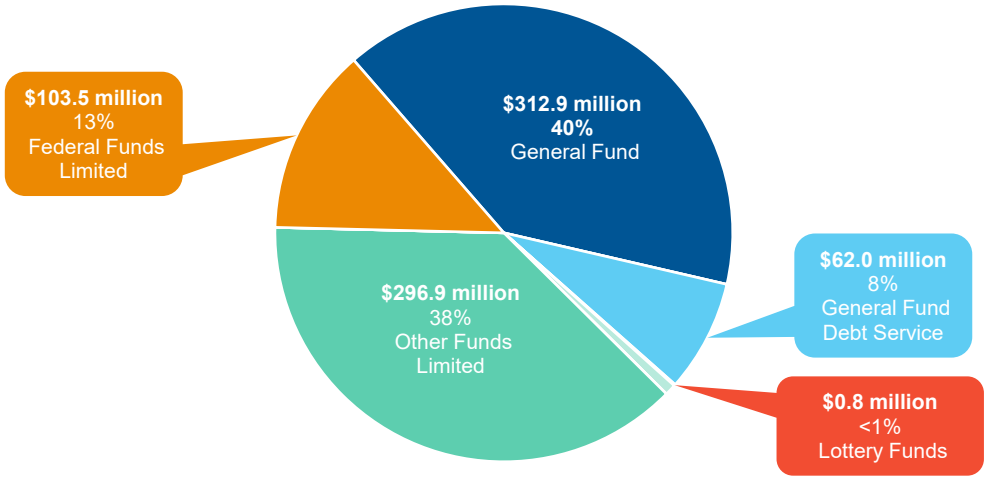
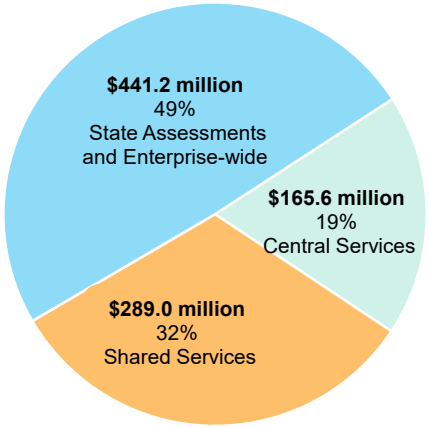


Oregon Health Authority
2025-27 Governor's Budget

Central & Shared Services, State Assessments and Enterprise-Wide Costs by Program
$895.8 million Total Funds



Central & Shared Services, State Assessments and Enterprise-Wide Costs by Program
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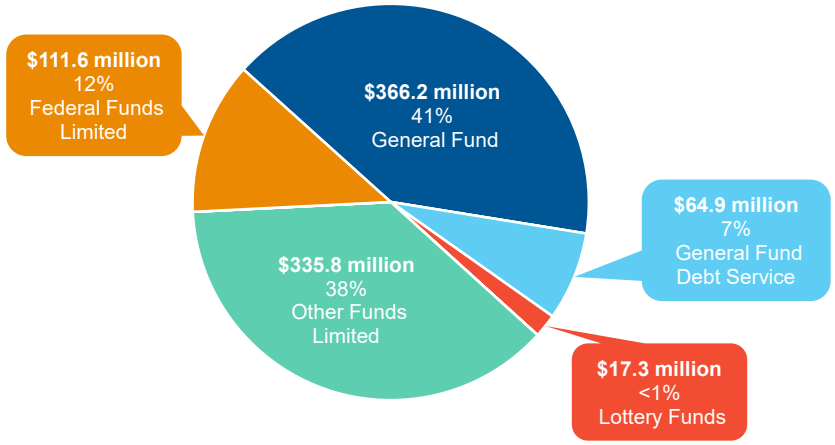
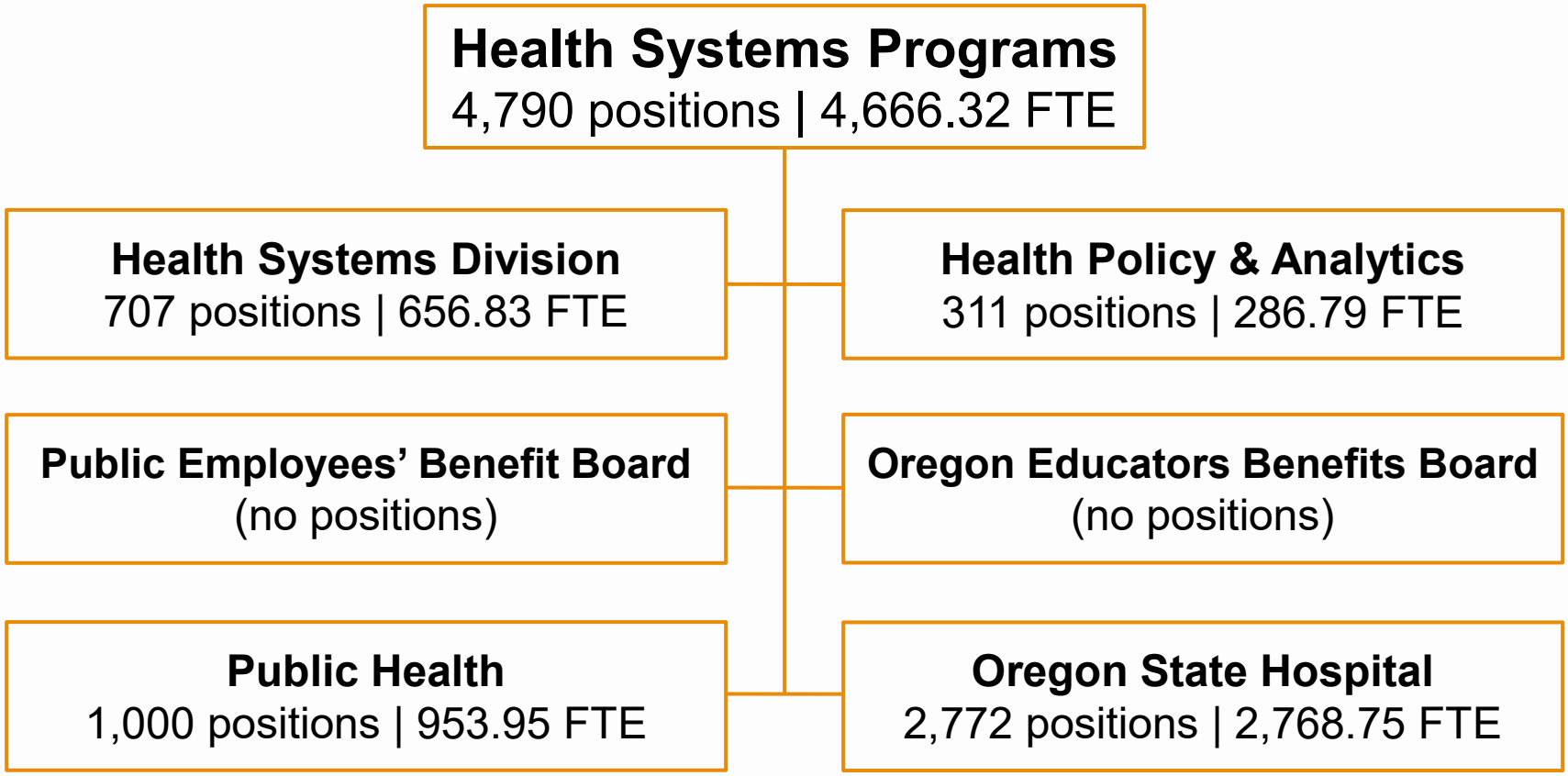
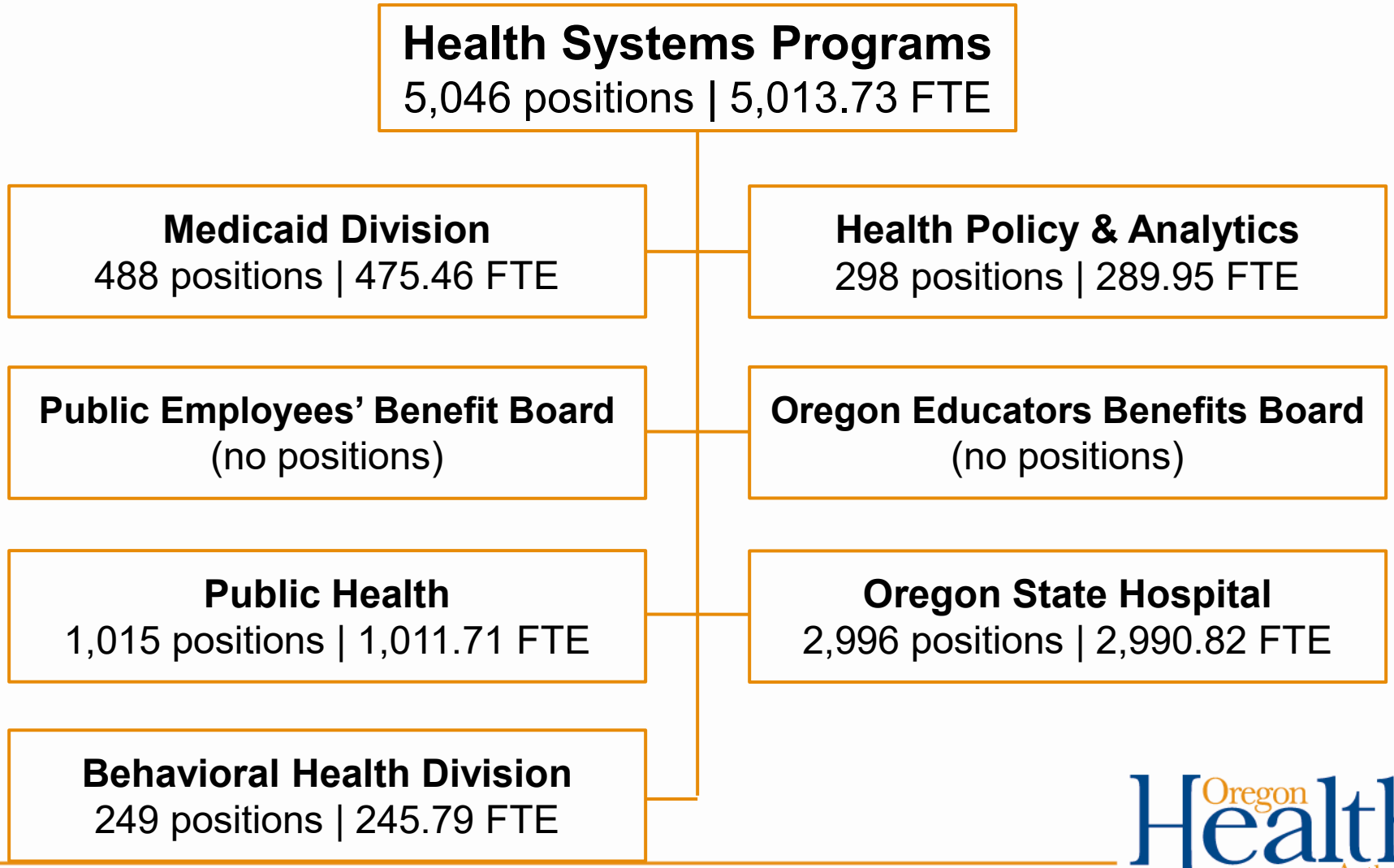


2023-25
Legislatively Approved Budget



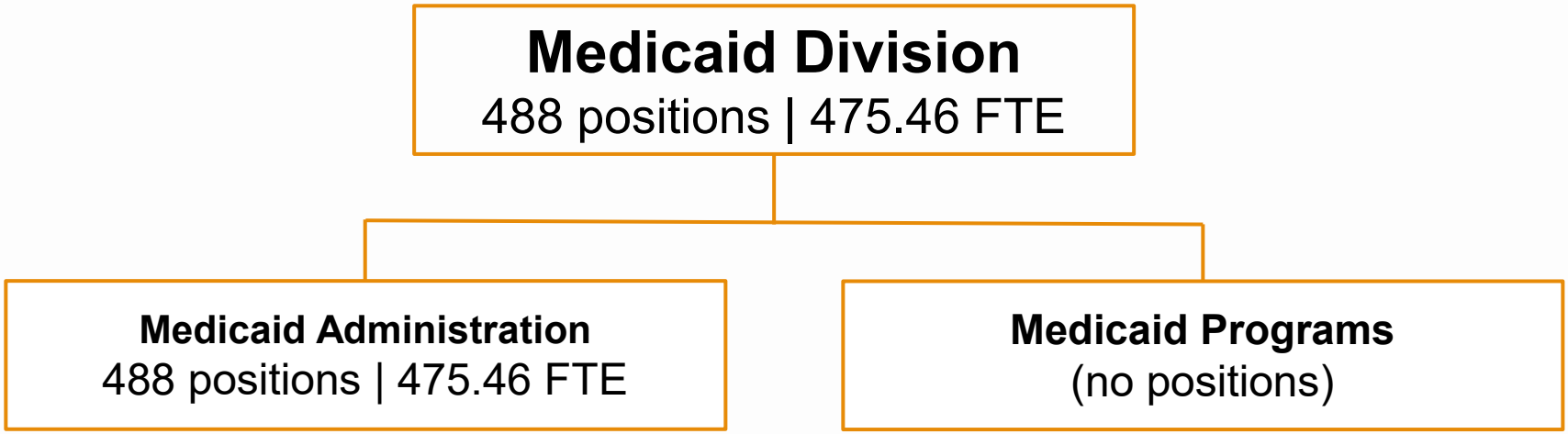
Oregon Health Authority

2025-27
Governor's Budget



Oregon Health Authority

2025-27
Governor's Budget

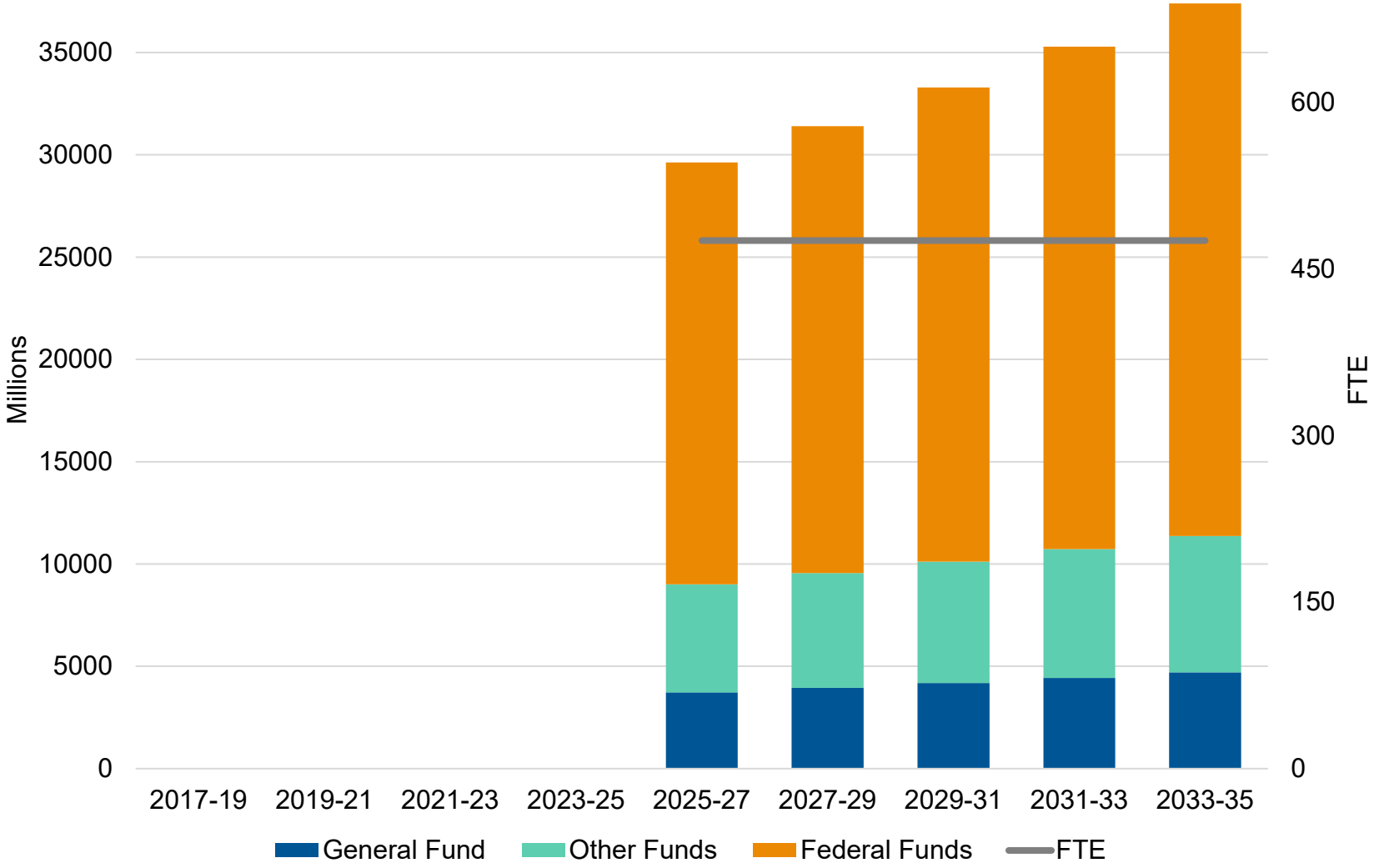


Oregon Health Authority

Oregon Health Authority: Medicaid

Executive Summary

Program Contact: Emma Sandoe, Medicaid Director 971-673-1222



Executive Summary

Division overview

The Medicaid Division of OHA manages the comprehensive lifecycle of publicly funded Medicaid programs, including design, development, implementation, monitoring, evaluation, and improvement. The Division encompasses Medicaid State Plan components, CCO contracts, the 1915(i) Home and Community-Based Services, and 1115 waiver authorities, while also serving as the federally recognized Medicaid authority and providing administrative oversight for all Medicaid-funded programs, including those under the Oregon Department of Human Services (ODHS), such as Long-Term Services and Supports and services for individuals with intellectual and developmental disabilities. The Division also administers and oversees a number of state-funded health coverage programs that have been established by the legislature, including Healthier Oregon and the Veteran Dental program. By administering these programs and partnerships, the Medicaid Division supports OHA's goals of strengthening access to affordable care for all, fostering healthy families and environments, and building OHA's capacity to eliminate health inequities by 2030.

Recommended funding

OHA’s Governor’s Budget of $29.6 billion Total Funds for Medicaid to continue funding for key Medicaid programs above the current service level for the 2025-27 biennium. The Governor’s Budget includes the expansion of the Healthier Oregon program to all adults, regardless of age, who would qualify for Medicaid except for immigration status. A reduction of $1.5 million to administrative service and supplies is included in this budget. Additionally, OHA proposes the following policy packages to decrease health inequities:

- **POP 408 – Medical Benefits for Incarcerated Individuals:** This policy package transforms health care access and support within Oregon’s carceral system by funding the service delivery of the 1115 Waiver carceral benefit package. It ensures adequate OHA staffing, technical assistance, and best practices for implementation, enhancing service delivery and equity. Funding also includes building a similar benefit

package for Tribal members who may not opt into CCO enrollment for 1115 coverage to create parity of benefits offered. Total funds allocated equals $64,015,530. This includes seven positions at 5.75 FTE.

- **POP 556 – CCBHC Expansion:** This policy package implements House Bill 4002, which mandates OHA to secure federal approval via a State Plan Amendment (SPA) for Certified Community Behavioral Health Clinics (CCBHC) program funding before the current demonstration expires, ensuring federal financial support statewide. OHA plans to integrate fifteen additional clinics in 2026, expanding beyond the existing twelve to meet the statewide requirement. Funding for this POP is needed to provide services at these 15 new clinics, and contains staff positions essential for supporting statewide expansion. Total Funds allocated equals $47,805,217. This includes two positions at 1.5 FTE.

- **POP 417 – Healthier Oregon: Reinvesting OHP Bridge Savings:** This POP transitions qualifying individuals from Healthier Oregon to OHP Bridge. By transitioning this population to OHP Bridge with a Healthier Oregon wraparound benefit, this POP ensures we continue to prioritize coverage for the Healthier Oregon population while also maximizing federal funds and promoting health equity. It seeks to secure $75 million per year in federal funds and reinvests 60.3$ million in savings after offsetting the $2 million cost for IT system updates to facilitate the transition. The timing of this transition remains unknown, but the target effective date is July 1, 2026. In the absence of this policy package, the state would forgo $130-160 million in Federal Funds per biennium. Reduces General Fund expenditures by $18,131,796. Total funds allocation for this POP equals $24,731,607. There are no positions associated with this POP.

- **POP 418 – Child Medicaid Behavioral Health: Home and Community-Care Based Services:** This policy package provides initial resources to develop and implement CMS requirements to deliver Home and Community-Based Services (HCBS) for children and youth with behavioral health needs. The POP provides resources and addresses CMS compliance by implementing key steps: selecting assessment tools,

developing case management systems, establishing provider networks, and refining eligibility processes. The POP provides access to HCBS for children and youth with behavioral health needs, ensuring equitable service delivery and compliance with federal requirements while enhancing health outcomes and reducing disparities. Total Funds allocated equals $919,708. This includes three positions at 2.25 FTE.

- **POP 421 – Hospital Tax Renewal:** This policy package aims to extend the hospital assessment program administered by the Oregon Health Authority. The hospital assessment is a foundational piece of the Medicaid OHP funding package. When the collected funds are matched with federal dollars, it provides for approximately a third of the total funds for OHP. OHP offers essential medical, behavioral, oral health, and Health-Related Social Needs services to individuals at or below 138 percent of the federal poverty level, regardless of citizenship status, ensuring equitable health access and outcomes for low-income Oregonians. Offsets General Fund need by $1,091,000,000. The total funds allocated for this POP equals $1,985,000,000. There are no positions associated with this POP.

- **POP 422 – Insurers' Tax Renewal:** The insurers' assessment is set to expire on December 31, 2026. This program provides funding for the Oregon Health Plan (OHP) and commercial reinsurance pool. Without extending the insurers' assessment program, these critical health care programs risk losing funding. Offsets General Fund need by $133,891,664. The total funds allocated for this POP equals $123,965,962. There are no positions associated with this POP.

Other POPs that impact Medicaid, but are sponsored by other divisions include:

- **POP 201 – Mainframe Modernization**: The payments and remaining eligibility COBOL-based IT systems are amongst the oldest applications in OHA|ODHS. Limited staff capacity and technical flexibility in the mainframe area create risks including delays in providing services, failure to pay some benefits, and prioritization of one

community's needs over another's due to limited ability to support multiple initiatives in parallel. The OIS Mainframe Migration POP enables OIS to continue the work started in the 2023-25 biennium to modernize payments processing, incorporates fully moving the remaining benefits eligibility determination applications from the mainframe to ONE, and supports creation of migration and archiving plans for remaining mainframe systems and data.

- **POP 427 Equitable Enforcement of Commercial Tobacco:** Reduces youth access to harmful emerging synthetic nicotine products by ensuring all nicotine products are covered by the minimum legal sales age and other tobacco sales regulations. Removes criminal penalties for persons who sell tobacco products or inhalant delivery systems. It also eliminates loopholes that allow for tobacco product access through home delivery and giveaway change machines. The bill could generate a small amount of revenue if it closes the tax loophole for synthetic oral nicotine products. This policy package includes Other Funds from new revenues in the Tobacco Use Reduction Account and a General Fund reduction to offset the additional Other Funds available for Medicaid, resulting in total funds allocated of $900,000. There are no positions associated with this POP.

Non-POP investments in Medicaid:

- **BRS Compliance (01a and b):** Allows the BRS program to operate in alignment with federal Medicaid requirements as described in Oregon's Medicaid State Plan by funding 10 new staff positions at 7.5 FTE to ensure compliance with federal policies and support the expansion of the program and expanding BRS services statewide to all eligible OHP members, per CMS expectations, improving access to critical services. This package also includes funding to research specialty types of care including Treatment Foster Care (TFC), Sexual Abuse Specific Treatment (SAST) and Commercially Sexually Exploited Children (CSEC).
- **DRG Effective 6% (02):** CMS allows a health care related assessment program that includes a calculation of the 6% rate cap on net patient revenues (NPR) that includes all the hospitals that provide a class of services, even if they don't pay the assessment. This effectively increases the assessment rate for the hospitals that actively pay

the assessment to greater than 6% and increases the total state funds available for Federal Financial Participation. OHA will begin operating with this change beginning July 1, 2025.

- **FFS Inflation Reductions 3.4 percent to 2.9 percent (03):** The proposed reduction in Medicaid Fee For Service's annual inflation rate will limit the program's ability to increase provider rates over the next biennia. This will continue the disparity between rates paid by CCOs and FFS. Low FFS rates will continue to negatively impact network adequacy, further limiting the ability of Open Card clients to receive health care they need in a timely manner. This issue has a disproportionate impact on providers and clients living in rural areas and on our American Indian/Alaska Native members.
- **Out of State Hospital Rate Reduction (04):** Updates the Out-of-State Contiguous and Non-contiguous payment methodology for outpatient hospital services. The new methodology will be consistent with the in-state reimbursement methodology for outpatient DRG hospitals instead of a percentage of billed charges.
- **Quality Incentive Pool Reduction (05):** The CCO Quality Incentive Program (QIP) provides financial incentives to CCOs for year-over-year performance improvements on a set of quality metrics. Over its ten-year history, the QIP has incentivized 32 different metrics, most of which are incentivized for several years. This reduction option would decrease the incentive funds, which would reduce the intended effect of the program. Many CCOs use these incentive payments to reinvest in resources and programs that facilitate achievement of the quality metrics, including pass forward to their providers through value-based payments. So fewer incentive dollars may also impact the scale, scope or effectiveness of the efforts that CCOs have in place for pursuing these quality outcomes.
- **Placeholder for HOP Risk Corridor Payments for 2024 (06):** CCOs' CY24 capitation rates are subject to a "risk corridor", wherein CCO revenue for HOP is compared with actual claims expenses, and a portion of the difference is recovered. Particularly for the state-funded portion of benefits, early indications are that CCO spending is much lower than capitation rate revenue, meaning that a sizeable refund to the state will be due.
- **Maximize Disproportionate Share Hospital (DSH) 3 Program (08):** Allows OHA to reimburse hospitals proportionately based on their low-income shortfall. Increased state funding allows OHA to access additional

federal financial participation to support larger payments to hospitals that experience low-income shortfall from serving populations with insufficient reimbursements.

- **Enhanced Graduate Medical Education (GME) (09):** States have the flexibility on how to use Medicaid funds for GME, OHA would expand current GME policy to include specialty and numbers of interns/residents required in Oregon eight teaching hospitals.
- **Enhanced Hospital Maternity Rates (10):** Funding will allow OHA to design an increase in payments to hospitals providing maternity care with special focus to rural hospitals that are needed for providing maternity coverage throughout Oregon where utilization would otherwise make these services cost prohibitive.
- **Office of Payment Accuracy and Recovery (OPAR) Medicaid Audit Response (11):** Four recommendations—(1) develop a process to triage PARIS matches, (2) request an additional 4 full-time employees (FTE) for the Data Match Unit (DMU), (3) collaborate with the U.S. Treasury's Do Not Pay Center on a Washington/Oregon (WA/OR) concurrent enrollment pilot project, and (4) implement a process to recoup duplicate enrollment payments made to Coordinated Care Organizations (CCOs)— are currently being worked on by the Office of Payment Accuracy and Recovery (OPAR), specifically within the DMU. The DMU performs many bodies of work, one of which is the PARIS interstate matches. This is when there are potentially open benefits for Medicaid recipients in more than one state. The Data Match team receives the PARIS report on a quarterly basis, which typically includes approximately 24,000 to 28,000 cases for review. Each quarter, the team successfully processes an average of 31% of the report. Currently, the PARIS team is staffed with 2.5 full-time employees (FTE) and generates an average of $2.2 million in cost avoidance each month, resulting in a $91:1 return on investment (ROI).
- **Medicaid: Staff to Administer Expanded DRG Assessment (12):** Provides funding for two positions as follows: a) FA3 – FOD/Budget to monitor financial impact and b) OPA3 – MED to support increase in operation work.
- **Essential Healthcare Worker Trust Investments (13):** The Essential Workforce Healthcare Trust (EWHT) is a strategic investment in Oregon's long-term care workforce, addressing critical challenges in healthcare affordability and workforce stability. Currently, EWHT delivers high-quality health benefits to 4,800 long-term care

workers and their families, with projected growth to 6,500 covered lives in 2025. This model, featuring self-insured and fully insured options, significantly reduces premiums, deductibles, and out-of-pocket costs—covering up to 90% of workers' healthcare expenses. By improving access to affordable care, EWHT not only enhances the well-being of essential workers but also strengthens recruitment and retention in an industry vital to supporting Oregon’s growing aging population and the state’s broader healthcare system.

Program description

The scale, scope, and urgency of recent legislative investments and program commitments for both Medicaid and Behavioral Health are highly visible and relevant for community, policymakers, partners and Oregon Governor’s Office. In April 2024, OHA implemented an organizational restructuring that dissolved the Health Systems Division, and two distinct yet interconnected divisions were created within OHA: Medicaid and Behavioral Health. This change allowed for expansion, growth and focus within the respective areas of work, while prioritizing continued partnership and collaboration

The Medicaid Division is comprised of two different Program Units – Administration and Medicaid. Medicaid's 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.

The scope of services provided, and the number of enrollees play a significant role in determining the overall costs of the Oregon Health Plan (OHP), particularly impacting the specific cost drivers associated with the Health Oregon Program (HOP). These factors are central to understanding and managing the financial aspects of Medicaid, as the quantity and types of services affect expenditure levels.

Executive Summary

The Medicaid division of OHA works collaboratively with the federal government, the Nine Federally Recognized Tribes of Oregon, health care providers, community partners, public health programs, community behavioral health programs, Urban Indian Health Programs, and other state agencies to maintain and improve access to physical, behavioral, and oral health care. Medicaid 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 figure largely sustains the increases observed during the Public Health Emergency by extending coverage to several groups: Oregonians joining through the Healthier Oregon Program, who would have qualified for Medicaid if not for their immigration status, and individuals with incomes between 138 percent and 200 percent of the Federal Poverty Line (FPL), who are transitioning to the Basic Health Plan (OHP-Bridge).

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

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 health outcomes. The Medicaid program incentivizes preventive practices and quality care through quality payments to CCOs and hospitals.

Medicaid 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: applying the race, ethnicity, language and disability (REALD) and sexual orientation and gender identity (SOGI) data collection standards

Executive Summary

mandated by House Bill 2134 (2013) and the Data Justice Act, and 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 groups that have historically been economically and socially marginalized.

The recent passage of H.B. 4002 (2024) includes provisions to expand Certified Community Behavioral Health Clinics (CCBHCs) statewide. With the support of POP 556, this expansion will increase comprehensive care for mental health and substance use disorders and increase access to coordinated and inclusive care by adding an additional 15 clinics, benefiting communities with insufficient resources and infrastructure by removing barriers to critical health care services. House Bill 3396 (2023) addresses challenges in hospital discharge processes through community engagement initiatives. By investing in clinical education, apprenticeships, and collaborative partnerships, this legislation enhances continuity of care from hospital settings to community-based health care services, ultimately improving health outcomes and reducing disparities influenced by social determinants of health. House Bill 4052 (2024) establishes a pilot for culturally specific mobile health units funded to better serve priority populations with histories of poor health outcomes. These units are a step toward overcoming health care gaps by offering tailored services that meet the unique cultural and linguistic needs of diverse communities.

Together, these initiatives emphasize Oregon's proactive approach to reducing health care disparities, promoting health equity, and ensuring that all residents have access to quality health care services that address their individual and community-specific needs. Through strategic partnerships and targeted investments, Oregon aims to build a cohesive and inclusive health care system that supports the well-being of all Oregonians.

Program performance

Currently, Oregon is actively progressing on several health care initiatives. In terms of waiver implementation, proposals for measures to CMS regarding the Healthier Oregon waiver are under development. Approval from CMS is necessary before tracking and reporting on these measures can begin. On July 1, 2024, the OHP-Bridge Plan

was successfully launched, with initial monitoring focusing on transition to OHP-Bridge and enrollment. As the program matures, a comprehensive monitoring plan will be developed. Efforts to transform Fee-For-Service (FFS) delivery are also ongoing, with the exploration of potential measures to improve FFS delivery.

As of June 2024, approximately 1.4 million individuals are enrolled in the Oregon Health Plan (OHP). Among those in OHP, 91.7 percent are in a coordinated care organization, 8.2 percent have FFS coverage and 0.1 percent are in a Program of All Include Care for the Elderly (PACE). Of the almost 1.4 million individuals enrolled in OHP, almost 89,000 are enrolled in Healthier Oregon. Initial numbers from the first month of implementation show that approximately 23,000 people now have coverage through OHP Bridge. OHP Bridge launched at the same time the two years of continuous eligibility was implemented for OHP members. We therefore anticipate that more people will receive their coverage through OHP Bridge once they meet the two-year mark on OHP.

Enabling legislation/program authorization

Chapters 409, 413, 414, 426, 427, 428 and 430 of the Oregon Revised Statutes authorize the Oregon Health Authority to administer Oregon's medical assistance program. 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 2025-27 biennium, Medicaid's budget comprises 70 percent Federal Funds, 13 percent General Fund, 17 percent Other Funds, and less than 1 percent of Lottery Funds. Federal revenue sources include Medicaid and the Children's Health Insurance Program for approximately 1.4 million OHP members. State General Fund or Other Funds must be used to match federal Medicaid dollars. This cost sharing rate is dependent upon the nature of the expenditure and determined by applying the appropriate Federal Medical Assistance Percentage (FMAP).

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Medicaid's Other Funds include a hospital assessment, insurers' assessment, 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.

Significant proposed program changes from 2023-25

In the 2025-27 biennium, Medicaid plans to expand a robust system of care that is culturally and linguistically appropriate, including:

- Continue transitioning of individuals from Healthier Oregon to OHP Bridge, expanding no-cost health care coverage to individuals with incomes between 138 percent and 200 percent of the FPL.
- Expand health care access through the full implementation of Healthier Oregon, a 2021 legislative authorized program to provide Oregon Health Plan (OHP) services to Oregonians who would qualify for Medicaid except for immigration status.
- Transform health care delivery for Oregonians with complex health needs who receive Medicaid benefits through Fee-for-Service model to person-centered, quality care with a focus on improved health outcomes.
- Expand community-based behavioral health services with clear outcome metrics and goals.
- 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 individuals transitioning from institutional settings 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 during climate change events.

Medicaid Administration and Support

The Governor's Budget continues funding for Oregon's Medicaid Administration and Support for the 2025-27 biennium and includes investments of $10 million for policy option package 408 to administer medical benefits for incarcerated individuals, $2 million for OHP bridge savings investments, $900,000 for policy package 418 to administer home community based services and $47.8 million for policy package 556 to expand certified community behavioral health clinics in Oregon, $2.4 million for behavioral rehabilitative services compliance, $650,000 to support increased needs to administer hospital programs as well as savings of $1.5 million for reduced services and supplies.

Activities, programs and issues in the program unit base budget

The Program Support and Administration budget includes funding for administrative support, services and oversight of the Medicaid program. Specialized units and teams support the division to ensure comprehensive health care delivery and program integrity. This includes managing the Oregon Health Plan (OHP) through the coordinated care organization (CCO) Operations unit, which oversees policy implementation and quality assurance across managed care entities. The Fee-for-Service (FFS) Operations unit maintains policies and operations for over 120,000 Medicaid members through the Open Card health care system. The 1115 Medicaid Waiver Strategic Operations team focuses on implementing innovative health-related social needs services and expanding benefits. Administrative oversight extends to the Integrated Eligibility Policy unit, Federal Policy unit, and Office of Data Strategy and Operations (ODSO), which manage policy development, compliance with federal regulations, and data integration to enhance service delivery and equity. The Office of Actuarial and Financial Analytics (OAFA) ensures financial integrity through rate development and oversight, while the Office of Program Integrity (OPI) safeguards against fraud and misuse of Medicaid resources. Funding also supports staff for information systems, including the Medicaid Management Information System (MMIS) and the Community Outcome Management and Performance Accountability Support System (COMPASS). Together, these entities collaborate to support, monitor, and enhance

the efficiency and effectiveness of Oregon's Medicaid program, ensuring equitable access and quality care for all beneficiaries.

Oregon Health Plan (OHP) Medical Leadership team is comprised of the Medicaid Medical Director, with expertise in physical health and family medicine, the Behavioral Health Medical Director, and the Dental Director. This is a newly formed team with the recent creation of the Behavioral Health Medical Director position and the first time the OHA Dental Director will be in the Medicaid division. The Dental Director will continue to have primary responsibilities with both Health Policy and Analytics initiatives and Public Health Division programs as well.

Coordinated Care Organization (CCO) Operations section is responsible for implementing policy and program priorities for the Oregon Health Plan for the Medicaid, Healthier Oregon and OHP-Bridge Programs. Through contract administration and quality assurance, this unit provides operational and administrative oversight for Medicaid Division policies, programs and processes. Their development and implementation of Medicaid strategic priorities and initiatives ensures equitable access and quality of health services for OHP members served by CCOs. This unit ensures compliance with legal and contractual requirements, advocates for member needs, integrates and coordinates interdivision and interagency activities, and engages with CCOs and community partners to ensure the successful provision of quality health care services.

The CCO Operations section consists of four units that play crucial roles in managing Oregon's CCOs. The CCO Quality Assurance unit oversees quality improvement efforts and regulatory compliance across CCOs through its three sub-teams: the CCO Quality of Care and Quality Assurance team focuses on federal regulations and quality management; the CCO Performance Analytics team develops data infrastructure for monitoring performance and process improvement; and the CCO Engagement and Collaboration team promotes health equity and stakeholder communication. The CCO Contracts and Rules unit manages contractual relationships between OHA and CCOs,

including procurement and alignment with state and federal rules. The CCO Services unit supports CCOs in service delivery by assisting with eligibility issues, member/provider complaints, and system improvements. Lastly, the Claims and Encounter Data unit handles encounter data submissions, provider enrollments, and electronic data interchange issues related to claims and remittance advices.

Medicaid Policy & Fee-For-Service (FFS) Operations section is responsible for developing and maintaining Medicaid policies for access to services. The unit also maintains Fee-for-Service (FFS) operations and the Open Card health care system for over 120,000 Medicaid members. This unit provides direct oversight for FFS contracts, maintains FFS rate schedules and works with community partners to identify gaps in policy and services and collaborate on solutions. Medicaid is transforming FFS to create a statewide, person-centered system of care to aid in eliminating health inequities by 2030, including convening the Lived Experience Advisory Panel (LEAP) comprised of FFS members and their families as well as community advocates to provide input and feedback on FFS policies and operations.

The Medicaid Policy & FFS Operations section has three systems focused teams: The Strategy and Initiatives unit supports policy and operational initiatives, coordinating with OHA experts to improve FFS services statewide. The OHP Community Engagement unit emphasizes community and partner involvement in Medicaid policies, collaborating closely with OHA and state agency teams. The FFS Quality Assurance and Operations unit oversees health care rate standardization, access and quality for the Open Card system, managing care coordination and quality assurance strategies.

In addition, there are four policy and program units that are responsible to write administrative rules (OAR), direct coverage policy, direct provider enrollment and provider billing policy, issue guidance, lead rate setting and provide subject matter expertise: Hospital & Professional Services Policy; Medicaid Behavioral Health Policy; Children and

Family Policy; and Safety Net Policy. The Medicaid Behavioral Health Policy unit focuses on the full continuum of behavioral health services, including Behavior Rehabilitation Services, Crisis Respite, Home and Community Based Services 1915(i) State Plan Option, Institutions for Mental Diseases, and Personal Care Attendant and HCBS in home PCA programs (including Agency with Choice). The Safety Net Policy unit ensures compliance and supports operations for federally funded health safety net clinics, including FQHCs, IHCs, and CCBHCs, with a focus on expanding CCBHCs statewide.

1115 Medicaid Waiver Strategic Operations team is responsible for implementing and operationalizing initiatives authorized in the five-year 1115 OHP Demonstration Waiver in order to further the goals of the Oregon Medicaid Program and advance health equity. Specifically, the team leads the implementation of the 1115 Health-Related Social Needs (HRSN) Services and expansion of OHP benefits to individuals experiencing critical life transitions, such as individuals being release from carceral settings. The team leads policy development, contract, and rule development, facilitates system enhancements, and changes, and ensures operations are in compliance with state and federal regulations. In facilitating program and policy design, the team collaborates with community, CCOs, state agencies, federal partners, tribes, and program governing bodies. In addition to implementation, the team focuses on identifying the need for strategic improvements in Oregon's Medicaid Program, ensuring these strategies are reflected in the planning and coordination of future 1115 OHP Demonstration Waivers.

- **Health-Related Social Needs** team develops Medicaid policies for housing, climate, nutrition, and outreach to aid members in critical transitions, including those released from incarceration or mental health facilities, involved in child welfare, transitioning to dual Medicaid-Medicare eligibility, experiencing houselessness or at risk, and young adults with special health needs, ensuring comprehensive service support and operational oversight.

Medicaid Administration and Support

- **Waiver Transition Populations** unit focuses on integrating Medicaid benefits as individuals transition from carceral settings, including care coordination, case management, clinical consultations, peer services, medication assistance, and ensuring medications upon release. They prepare Oregon facilities for 2026 waiver benefits and support the 2025 implementation of care coordination mandates for youth and former foster care under the Federal Consolidated Appropriations Act. Additionally, they address Dr. Pinals' Medicaid Mink Bowman recommendations for enhanced care coordination from Oregon State Hospital to community or jail transitions.

Integrated Eligibility Policy unit is responsible for developing and maintaining policy, administrative rule, and ONE system functionality related to Oregon Health Plan/Medicaid eligibility. This includes the maintenance of federal contracts, reporting, budget, and compliance. The integrated eligibility policy unit ensures alignment with federal regulation, state statute, and the 1115 Medicaid Waiver.

Medical Eligibility Policy unit ensures OHP eligibility policies are compliant and up to date with federal regulation, state statute, and initiatives related to the 1115 Medicaid Waiver. Medical eligibility policy staff coordinate updates in state policies, programs, and information, payment, and eligibility systems when changes to Medicaid/CHIP eligibility policy occur due to changes in federal regulation, legislative session, and 1115 waiver initiatives. The eligibility policy team works closely with ODHS policy and operations units to ensure that OHA objectives are represented and met and provides subject matter expertise across OHA and ODHS.

- **Federal Policy** unit coordinates Oregon's Medicaid State plan, Health-Related Services, and HCBS Waivers under ODHS, ensuring compliance with federal regulations and providing technical support for CMS negotiations and waiver applications. Responsibilities include managing the 1115 OHP Waiver, SUD waiver,

contraceptive care waiver, and HCBS waivers, as well as compiling required reports and supporting CCO contracts, rulemaking, and other strategic initiatives.

Provider and Clinical Support Services unit supports OHA FFS utilization management through the operationalization of prior authorization requirements, Medical Management Committee reviews, claim-denial appeal reviews, testimony in fair hearings, and active participation in OAR development. The unit also helps in-state and out-of-state FFS providers to identify prior authorization requirements, navigate prior authorization process, interpretate OARs, validate medical code pairing for requested services, and advocate for providers wishing to seek approvals for unique health service requests. Timely and accurate provider engagement and prior authorization responses enable OHA to partner with providers to support the health care needs of the FFS population and promote optimal health outcomes.

Strategic Operations & Improvement focuses on three main areas to support the agency's mission. The Workforce Development, Equity and Administrative Services unit within this division concentrates on design and delivery of workforce development (recruitment, onboarding, training) activities, workforce equity strategies, and core administrative services such as facilities management, equipment procurement, and travel coordination. The Contracts and Fiscal Operations unit oversees financial management and contractual aspects of the Medicaid program. Responsibilities include contract administration, financial oversight, compliance monitoring, and policy implementation to promote health equity and ensure efficient resource allocation. This unit plays a crucial role in maintaining the fiscal integrity and operational efficiency of Oregon's Medicaid program, supporting equitable access to health care for all beneficiaries. The Governance & Process Improvement team supports all Medicaid functions through audit management, performance metrics coordination, project management for complex initiatives, and process documentation to ensure operational continuity and efficiency across the division.

Medicaid Administration and Support

Provider and Member Services includes several specialized units: Provider Enrollment, which handles screening, enrollment, maintenance, and revalidation of Medicaid providers, ensuring their access to Oregon Health Plan (OHP) members and the Medicaid Management Information System (MMIS). The unit manages provider sanctions, terminations, and audits. Provider Services offers support to health care providers, assisting with claims reviews, payment approvals, and technical inquiries via phone and email, while also addressing billing issues with Medicaid members. Client and Enrollment Services assists OHP members by facilitating access to care, explaining coverage, connecting members with their Coordinated Care Organizations (CCOs), and resolving billing concerns and complaints. The Hearings team processes appeals for denied medical services, coordinating contested case hearings with members, CCOs, and administrative bodies to ensure fair representation and resolution under the Oregon Health Plan.

Office of Data Strategy and Operations (ODSO) The Office of Data Strategy and Operations (ODSO) under OHA and ODHS aims to enhance equity in service delivery through modernized data and technological systems. It focuses on improving transparency and accountability of managed data, supporting equitable data use, and promoting system integration and efficiency across OHA and ODHS divisions. The office comprises three units: Data Strategy and Partnerships, which facilitates strategic data projects and collaborations to minimize silos and enhance data sharing; Medicaid Management Information Systems (MMIS), responsible for managing benefit programs, claim processing, and system enhancements in collaboration with Gainwell Technologies; and Community Outcome Management and Performance Accountability Support System (COMPASS), which oversees data environments like the Oregon Health Authority Data Environment (ODE) and various behavioral health data systems to support outcomes-based reporting and client interaction insights. ODSO aligns with state policies on data governance and transparency to advance OHA's goal of eliminating health inequities by 2030.

Medicaid Administration and Support

The Innovator Agent team collaborates extensively with coordinated care organizations (CCOs), providers, community partners, and OHA programs to drive health system transformation in Oregon. Their mission is to facilitate local implementation of statewide health priorities and promote health equity. Innovator Agents are legislatively empowered to bridge communication between OHA, communities, and CCOs, advocating for regional health needs and resource gaps to inform statewide initiatives. They play a crucial role in advising Medicaid teams on policy and program development, enhancing access to care, amplifying OHP member voices within CCO operations, and supporting initiatives such as housing, behavioral health, language access, and health equity. They are integral partners across OHA Medicaid efforts, ensuring local insights shape equity-focused implementation statewide, particularly in response to emergent issues like COVID-19, wildfires, and heat events.

Office of Actuarial and Financial Analytics (OAFA), overseen by OHA's Fiscal Division of Central Services, plays a pivotal role in Oregon's health care financial landscape. OAFA is responsible for developing capitation rates for Coordinated Care Organizations (CCOs), Program of All-inclusive Care for the Elderly (PACE), and Healthier Oregon (HOP), ensuring these rates reflect the cost of care provided per member per month. They collaborate with external actuarial vendors to certify CCO rate development and oversee financial reporting, fiscal solvency, and risk-based capital measurement for CCOs under NAIC standards since 2020. OAFA also has the authority to design reinsurance programs for CCOs and monitors their contract compliance. Beyond rate development, OAFA supports OHA and CCOs through data analysis, budgetary impact assessments, financial incentives calculation, cost-containment strategies, reimbursement rate reviews, and policy development to advance Oregon's health system transformation. They consolidate and publish CCOs' financial reports to ensure transparency and accountability in Medicaid managed care.

Office of Program Integrity (OPI), housed within OHA's Fiscal and Operations Division, ensures the integrity of Oregon's Medicaid program by investigating, auditing, and reviewing services billed by providers in both Fee-for-Service (FFS) and Coordinated Care Organization (CCO) networks. OPI's efforts aim to detect and prevent

Medicaid Administration and Support

Medicaid fraud, waste, and abuse (FWA) while ensuring compliance with federal and state regulations. The office is structured into four units: Surveillance and Utilization Review Subsystem (SURS) conducts data analytics to monitor service utilization and identify potential FWA patterns; the Special Investigations Unit (SIU) investigates fraud referrals and collaborates with law enforcement; the Policy Unit provides policy direction and ensures regulatory compliance; and the Program Integrity Audit Unit (PIAU) conducts provider audits to verify services and recover overpayments through various audit types. OPI's comprehensive approach enhances oversight, promotes fiscal responsibility, and safeguards Medicaid resources in Oregon.

The **Communications** team focuses on creating strategic plans and content to effectively communicate with external audiences about Medicaid programs, benefits, and urgent issues. Their primary objective is to connect people with health care, coverage, and services, addressing social determinants of health. Key responsibilities include proactive engagement with the media to disseminate crucial information and respond to inquiries, ensuring clarity and cultural responsiveness in all communications. The team develops various content such as web pages, fact sheets, FAQs, and flyers, emphasizing accessibility and appropriate language use. Additionally, they organize public campaigns, manage public service announcements, and issue news releases to inform community groups, providers, and Oregon Health Plan (OHP) members about new resources and benefits.

The **Strategic Action Team** (SAT) was designed to provide high-level resources to complex priorities and initiative requiring various parts of the agency or inter-agency collaboration, and which focus on bringing the agency closer to the strategic goal of eliminating health inequities by 2030. Since the inception of the office in 2022, the SAT has been leveraged for large-scale initiatives and improvement projects such as improving access to quality and timely translations for both OHA and ODHS, improving access to services for OHP members receiving care through HOP by establishing a cross-program workgroup, 1115 waiver implementation, implementing HB 2665, development of the strategic plan, and transitioning the Prioritized List out of the Medicaid Waiver. SAT staff are able to partner both

in project management and change management, as well as be strategic partners in developing project scope, deliverables, and sustainability planning. This team has been critical in both integrating equity into large initiatives in partnership with subject matter experts, and ensuring key bodies of work are supported at the agency level. These staff partner with project leads to develop project structures which include all necessary parties and center voices of those most impacted by the work, leading to both better outcomes and cost savings from failed projects and use of costly contractors.

Background information

The Oregon Health Authority (OHA) is actively managing several pivotal projects to enhance health care accessibility and quality across the state. One key initiative involves the phased transition from the Prioritized List of Health Services to the State Plan under the 1115 Medicaid Waiver, focusing on aligning service delivery with federal requirements by January 2027. Another critical project is laying the groundwork for the future development of an integrated, cloud-based data environment to support Health-Related Social Needs (HRSN) services, fostering improved coordination and scalability in health care provision. In addition, OHA continues the Certified Community Behavioral Health Clinic (CCBHC) Demonstration project to broaden mental health and substance use services and seeks to expand these services with 15 more clinics. These projects underscore OHA's commitment to modernizing health care systems, enhancing service delivery, and increasing health care access to communities with insufficient health resources or infrastructure. Navigating these projects effectively requires careful consideration of external factors that can influence their progression and impact.

Several external factors shape the future work of the Oregon Health Authority (OHA). Federal mandates from entities like the Centers for Medicare and Medicaid Services (CMS) direct OHA’s policies, regulations, and funding allocations. Compliance with mandates such as the Patient Access and Interoperability final rule drives initiatives to enhance data accessibility and transparency in health care delivery. Community needs and feedback are pivotal in

shaping OHA's initiatives. Engaging with health care providers, patients, and advocacy groups allows OHA to gather insights that inform decision-making, program development, and practical efforts to address health care inequities and disparities across Oregon. Partnerships and collaborations with federal agencies, county entities and other partners in the health care ecosystem significantly impact OHA's strategies. These collaborations are crucial for improving care coordination, reinstating benefits for individuals transitioning from institutional settings and addressing health care disparities effectively at a local level. In addition, OHA monitors emerging health care trends and innovations to adopt advancements that could improve service delivery and patient outcomes. Innovations in telehealth, data analytics, and integrated care models are of particular interest and influence OHA's approach to service delivery and system modernization. Moreover, changes in health care policies and legislative initiatives at the state and federal levels necessitate adjustments in OHA's operations and service delivery models. These changes include shifts in Medicaid eligibility, benefits coverage, and reimbursement rates, requiring OHA to adapt policies accordingly. Lastly, public health emergencies and crises, such as pandemics, severe weather events and natural disasters, significantly impact OHA's workload and priorities. These events often require rapid response efforts, resource reallocation, and the implementation of emergency health care protocols to safeguard public health. By navigating these external influences, OHA can align its strategies and initiatives with evolving health care needs, advancing its mission to enhance health care access, quality, and equity throughout the state.

Revenue sources and changes

OHA's 2025-27 Governor's Budget Medicaid Administration and Support budget is comprised of 38 percent General Fund, 2 percent Other Funds Limited and 59 percent Federal Funds.

General Fund is used for administrative support, staffing, services and supplies, and the maintenance and operations of the information technology systems for the Medicaid Division.

Medicaid Administration and Support

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 50:50 match on staff and administrative expenditures that support the Medicaid program and a 75:25 match for administrative expenditures directly related to eligibility determinations and enrollment. The Medicaid program (OHP) receives Federal Funds for services provided to Medicaid-eligible individuals. 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).

Proposed new laws that apply to the program unit

Please see the Medicaid Programs narrative for new laws impacting this program unit.

Medicaid Programs

The Governor's Budget continues funding for Oregon's medical assistance programs for the 2025-27 biennium and makes additional investments and reductions. $17.9 million is invested for Behavioral Rehabilitative Services Compliance, $52 million for DSH-3 payments to hospitals, $9 million for Graduate Medical Education, $125 million for enhanced hospital maternity rates, $12.5 million for an essential healthcare worker trust. Policy package investments include package 408 of $58.3 million for medical benefits to incarcerated individuals, and package 417 reinvests $22.7 million from bridge savings. The budget reflects savings of $41 million for reduced fee-for-service inflation, $810,000 for rate reductions to out-of-state hospitals, $148 million in quality incentive pool reductions, $60 million from the Healthier Oregon Program risk corridor.

Activities, programs and issues in the program unit base budget

The Medicaid Division 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 Program (HOP), Basic Health Plan (BHP), the Medicaid 1115 Demonstration Waiver, and related services. Payments are made to individual health care providers as Fee for Service (FFS) and to 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.

The Oregon Medicaid budget is affected by the 1115 Medicaid Waiver, enabling the state to expand coverage to address health-related social needs (HRSNs) for Oregon Health Plan (OHP) members. These needs include critical services such as nutritional support, transitional housing, and climate-related resources, which have a positive effect on individual health and well-being. The waiver also extends OHP eligibility criteria, introducing provisions like continuous Medicaid enrollment for children up to age six years old and two years for older members while covering HRSNs such as housing and nutrition. Beginning in 2024, the Oregon Health Authority (OHA) further expanded

these services under the waiver, targeting disproportionately affected populations like young adults with special health needs, those transitioning from institutional settings and those experiencing houselessness. In July 2024, OHA started taking applications for the OHP Bridge – Basic Health Program (BHP), which provides a pathway for adults with incomes between 138% and 200% of the Federal Poverty Line (FPL) to receive essential health services. These initiatives reduce the percentage of uninsured Oregonians by allowing continued access to comprehensive healthcare coverage and continuity for eligible populations.

The Medicaid budget is determined based on caseload forecasts and cost estimates projected for the next two years. Due to the budget's scale, even minor deviations between forecasted and actual caseload numbers can lead to significant adjustments in the projected budget—resulting in either shortfalls or savings.

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, 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:

- Improve the lives of individuals who face historic and contemporary injustices.
- Increase individual, family and community resilience.
- Reduce health disparities for groups most affected by injustice and discrimination.

Medicaid Programs

As part of Oregon's CMS 1115 waiver negotiations, OHA is working toward furthering this goal. In July 2012, the Centers for Medicaid and Medicare 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 initial waiver was for a five-year period, running from July 2012 through June 2017. Oregon's Medicaid Demonstration renewal request was approved by CMS and ran from January 12, 2017, through June 30, 2022. Oregon applied for and received another renewal, which runs from October 1, 2022, through September 30, 2027.

Revenue sources and changes

OHA's 2025-27 Governor's Budget Medicaid Programs budget is comprised of 70 percent Federal Funds, 18 percent Other Funds and 12 percent General Fund. 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. Effective January 1, 2024, the Enhanced FMAP rates expired, with FMAP rates returning to normal. State General Fund or Other Funds must be used to match federal Medicaid dollars for direct service payments.

- The Medicaid Title XIX entitlement provides a 59:41 match on health care services to Medicaid members. This means for every dollar OHA spends on health care services to Medicaid members, the federal Centers for Medicare & Medicaid Services (CMS) funds 59 cents and OHA funds the rest.
- The Children's Health Insurance Program (CHIP) Title XXI entitlement provides a 72:28 match on health care services to CHIP members.
- Medicaid Title XIX provides a 90:10 match for health services for low-income adults (expansion population).

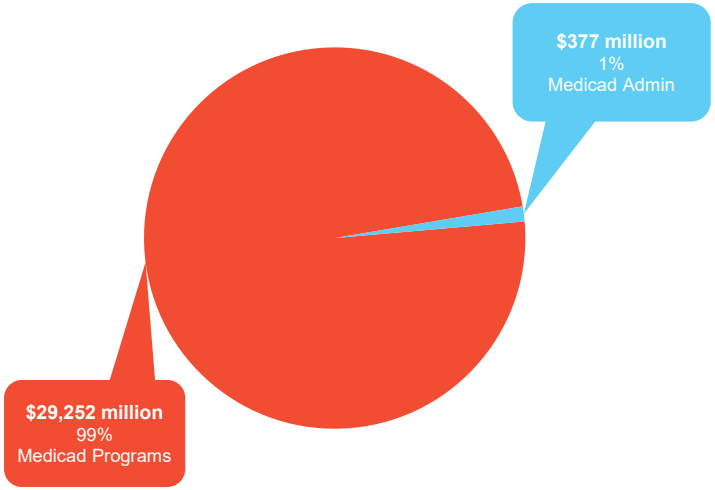
- Other Funds revenues include tobacco tax revenues, hospital assessments, an intergovernmental transfer agreement with the Oregon Health & Science University (OHSU), insurers assessments, grants, third party recoveries, pharmaceutical rebates, and the Tobacco Master Settlement Agreement (TMSA).

Proposed new laws that apply to the program unit

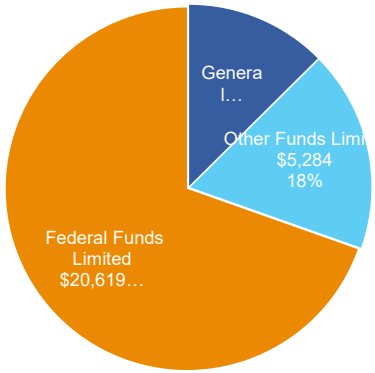
Legislative Concept #44300-006: This legislative concept makes statutory changes needed to achieve compliance with Oregon's most recent 1115 waiver agreement with CMS. The prioritized list will become part of the state Medicaid plan through use of a State Plan Amendment and some changes will be made to the FFS appeals and review process for covered benefits. In addition, issues community members have brought forward regarding HERC processes and barriers to accessing covered services due to utilization management tools such as prior authorization are undergoing review. This legislative concept is sponsored by the Health Policy and Analytics Division but is related to the 1115 Waiver Implementation – Benefit Update Project (BUP) POP sponsored by the Medicaid Division.

Oregon Health Authority
2025-27 Governor's Budget

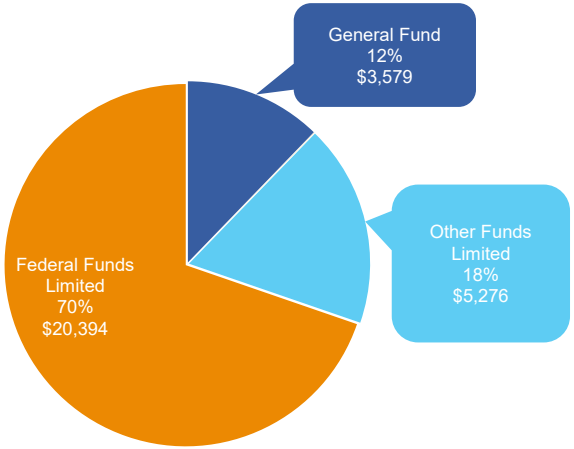
Medicaid Division
$29,629 million Total Funds



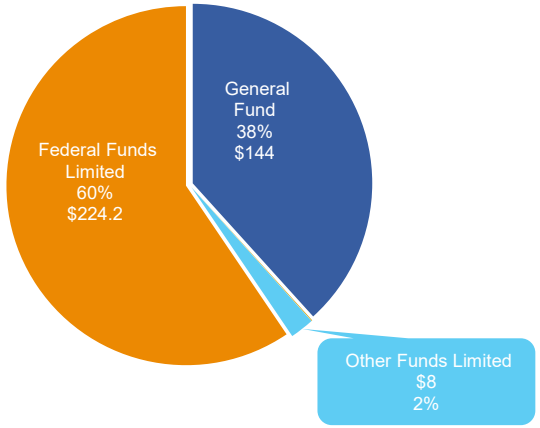
Medicaid Division by Fund Type
$29,629 million Total Funds



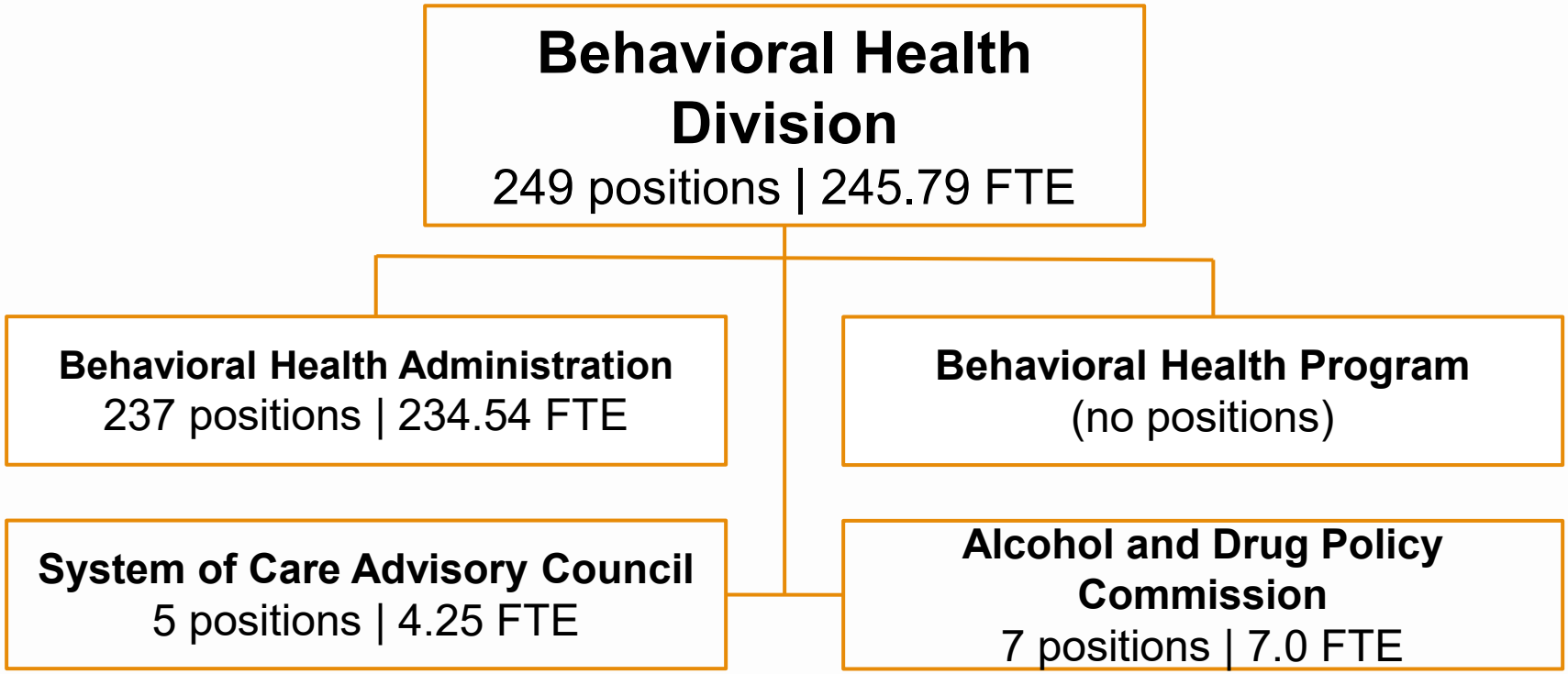
Medicaid Programs by Fund Type
$29,252 million Total Funds



Medicaid Admin and Support by Fund Type
$377 million Total Funds



2025-27
Governor's Budget

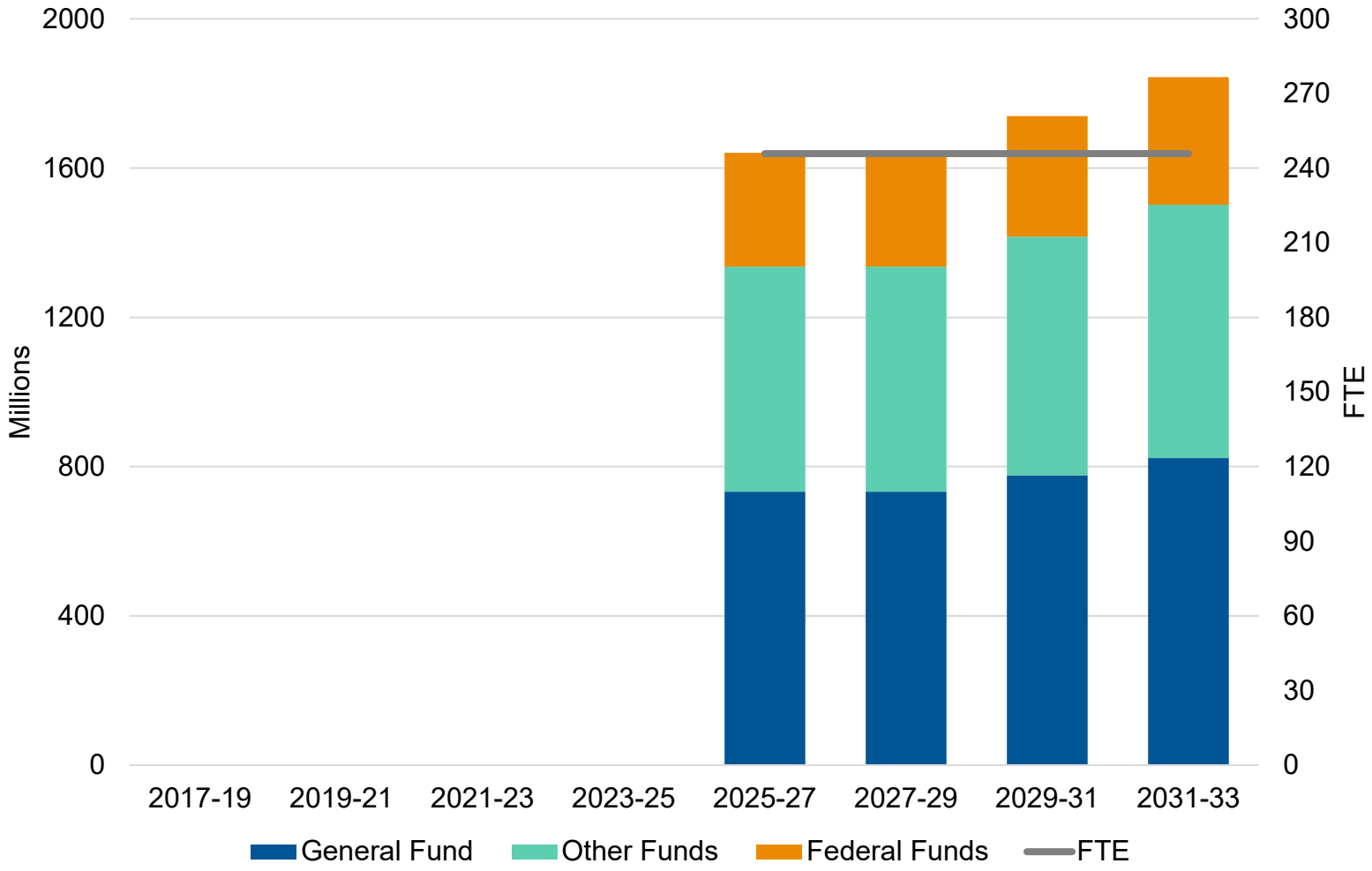


Oregon Health Authority

Oregon Health Authority: Behavioral Health Division

Executive Summary

Program Contact: Ebony Clarke, Director
503-428-7385



Executive Summary

Division overview

OHA's Behavioral Health Division's (BHD) mission is to support individuals, families, and communities to heal and thrive through a community-led, culturally responsive, evidence-based approach that prioritizes advocacy, prevention, and access to quality, affordable behavioral health care. BHD is responsible for developing and maintaining a statewide system of integrated behavioral health care. This includes working with partners statewide to provide funding, oversight, technical assistance and expert guidance to facilitate a comprehensive, accessible and integrated system of behavioral health care. Key Division activities include:

- Developing business and operational policies for addiction services and behavioral health delivery systems
- Contracting with behavioral health programs and other partners to support community-based health services and oversee compliance with state and federal regulations
- Reducing behavioral health inequities and elevating quality and accountability
- Facilitating community-centered engagement and person-directed services
- Increasing overall capacity and integration across settings and services
- Incentivizing trauma-informed, culturally responsive and linguistically specific services
- Improving workforce diversity and increasing staff retention

In support of the Oregon Health Authority's (OHA) mission to eliminate health inequities in Oregon by 2030, BHD is committed to establishing a behavioral health system that ensures all people can reach their full health 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 application, this means that health equity is a central consideration in all BHD programs and administrative efforts. Likewise, BHD collaborates with all regions and sectors of the governments of the Nine Federally Recognized Tribes of Oregon to address the equitable distribution or redistribution of resources and power, as well as recognizing, reconciling and rectifying historical and contemporary injustices.

Executive Summary

Recommended funding

OHA's Governor's Budget recommends $1.6 billion Total Funds to continue funding for the BHD programs at the current service level for the 2025-27 biennium and includes funding to support several policy packages for Behavioral Health. Included in the $1.6 billion are $24.3 million for policy package 550 behavioral health workforce investments, $10.4 million funding for policy package 551 to provide harm reduction services, $100 million for policy package 552 to increase residential capacity in behavioral health facilities, $840,000 for policy package 557 to adequately staff and serve the Alcohol and Drug Policy Commission, $570,000 funding for policy package 559 to adequately serve the SOCAC, $2.4 million funding for behavioral health community navigators, $3.3 million to staff civil commitment, $16.3 million for deflection and jail based services, $7 million for intensive in-home behavioral health treatment for youth and families, an additional $17.5 million of funding from the 988 tax, a reduction of administrative service and supplies of $800k.

OHA's Governor's Budget includes the following policy packages to decrease health inequities:

- **POP 550 – Behavioral Health Workforce Investments**: OHA seeks to address the shortage of behavioral health professionals, particularly in rural areas and substance use disorder services, by attracting, retaining, and supporting a diverse, culturally competent workforce through tuition assistance, loan forgiveness, and peer workforce training.
- **POP 551 – Save Lives Oregon**: To address the state's continuing substance use, addiction, and overdose crisis, OHA proposes the Save Lives Oregon Initiative's Harm Reduction Supply Clearinghouse. The Clearinghouse aims to provide essential harm reduction supplies to community-based organizations, expanding access to lifesaving medications like naloxone, and supporting safer substance use practices that prevent overdose, infections and injuries. This initiative aims to reduce overdose deaths, infections, and hospitalizations, and fosters health equity. Save Lives Oregon ensures marginalized populations receive a base amount of harm reduction supplies, such as the opioid

overdose reversal medication naloxone. The Save Lives Oregon Initiative also supports integrating life-saving harm reduction strategies into programs and services throughout Oregon.

- **POP 552 – Residential+ Study:** OHA proposes expanding behavioral health residential treatment and support services to address infrastructure gaps for substance use disorders, psychiatric treatment, and co-occurring needs by increasing the capacity of residential programs for youth, young adults, and adults through new facilities and beds, with a focus on regional and mandated populations and cultural diversity. This plan includes purchasing, constructing, or renovating facilities, stabilizing current providers, and supporting culturally and linguistically diverse services to reduce youth wait times and emergency department reliance, and improve adult access to developmentally responsive treatment and housing, emphasizing equitable funding distribution to smaller, culturally specific providers and those serving the Aid and Assist population.
- **POP 557 – Alcohol & Drug Policy Commission Sustainability:** The Alcohol and Drug Policy Commission (ADPC) aims to enhance the efficiency and effectiveness of substance use disorder (SUD) services in Oregon. This policy package requests permanent funding for positions and strategic plan contracts which are critical for ADPC to maintain subject matter expertise, partner engagement, and research analysis with respect to SUD services. Please note that this policy package is an ADPC request; OHA is merely making this request on behalf of ADPC.
- **POP 559 – Strengthening the System of Care Advisory Council:** The System of Care Advisory Council (SOCAC) focuses on enhancing service coordination, promoting culturally competent practices, and ensuring equitable access to services for youth. This policy proposes sustained staffing to support SOCAC's legislative mandates. Please note that this policy package is a SOCAC request; OHA is merely making this request on behalf of SOCAC.

Program description

OHA's BHD is comprised of two program units: Behavioral Health Service Delivery and Program Support & Administration. BHD's Service Delivery unit provides oversight to ensure the development of accessible, effective,

Executive Summary

and equity-driven services within the continuums of behavioral health care to serve people in Oregon across the lifespan, from child and family services to services for adults and older adults, in addition to specific communities that intersect with the criminal/legal system and houselessness. The Program Support & Administration unit creates and maintains BHD's essential operations and strategy infrastructure, aligning service delivery with essential business, policy, project management, budget, contract and procurement, technology, and communication capabilities to achieve BHD's mission in an organized, efficient, and transparent manner.

In collaboration, both program units enable BHD to pursue its mission to build and advance a system of care to help all people in Oregon achieve optimal behavioral and mental health. This is defined by behavioral health services that are simple to access, responsive to people's needs, and result in meaningful outcomes for individuals, families, and communities. The Division conducts innovative programming and ambitious community-led efforts to change the quality of and access to behavioral health services, including approaches that eliminate health inequities in Oregon and ensure the health system serves and respects diversity, cultures, and languages across Oregon communities.

BHD works with the federal government, the Nine Federally Recognized Tribes of Oregon, health care providers, community partners, public health programs, community behavioral health programs, and other state agencies to build, maintain and improve access to behavioral health care. BHD administers state and federal funds to deliver and pay for behavioral health care services to over 1.4 million people in Oregon, primarily through the Oregon Health Plan (Medicaid). This enrollment includes a significant increase resulting from federal policies to ensure people maintained their coverage during the COVID-19 pandemic, and the recent expansion of OHA's Bridge program, which extends and continues that coverage.

BHD also guides transformational change in the behavioral health system through the historic investments made during the 2023-25 biennium by the Oregon legislature. In the 2023 legislative session, Oregon made significant strides in enhancing its behavioral health and addiction treatment systems. Senate Bill 5525 was a pivotal part of this effort, particularly through Package 404, which allocated substantial funds to support the 988 Behavioral Health

Executive Summary

Crisis System. This funding was critical for handling increased call, text, and chat volumes, as well as covering technological and operational costs. The package also funded the statewide rollout of mobile crisis response teams to provide timely interventions in behavioral health crises. Package 429 addressed payer parity within the 988 system, enhancing administrative support and resources for jail diversion through Community Mental Health Programs. Other key legislative actions included House Bill 2235, which established a workgroup to tackle workforce recruitment and retention challenges, and House Bill 2421, which expanded the roles of behavioral analysts to include substance abuse treatment and mandatory child abuse reporting. Additional measures focused on opioid crisis prevention and education, such as Senate Bill 238, which mandated a curriculum on synthetic opioids, and House Bill 2395, which expanded access to naloxone and other overdose reversal drugs.

In 2024, Oregon continued to focus on behavioral health improvements with new legislative actions. House Bills 4002 and 5204 aimed to address addiction and public safety comprehensively by replacing the Class E violation for possession of small amounts of controlled substances with a misdemeanor offense and promoting deflection programs. These bills also included provisions for Medicaid, allowing pharmacists to prescribe opioid use disorder medications and establishing the Opioid Medication Grant for treatment in correctional facilities. A statewide expansion of the Certified Community Behavioral Health Clinic (CCBHC) program was initiated, requiring collaboration between OHA and Community Mental Health Programs (CMHPs). Task forces were created to address youth substance use disorder treatment, behavioral health system governance, and worker safety, with over $200 million appropriated to fund these initiatives. These legislative efforts aimed to enhance accountability and effectiveness in the behavioral health system.

Additional legislative actions in 2024 further emphasized Oregon's commitment to improving behavioral health services. House Bill 4092 required OHA to study funding for CMHPs and assess administrative burdens on providers. House Bill 4129 established agency-with-choice services for personal care under a self-directed model, while House Bill 4151 created a subcommittee within the System of Care Advisory Council to strengthen youth behavioral health workforce career pathways. Senate Bill 1506 allowed pharmacists to manage COVID-19 treatments, and Senate Bill 1530 provided funds for housing assistance and the Air Conditioner and Air Filter

Executive Summary

Deployment program. Senate Bill 1557 directed the OHA to seek federal funding to support individuals under 21 living at home, ensuring access to services and collaboration with the Oregon Department of Education. These comprehensive measures highlight Oregon's dedication to addressing addiction, enhancing system accountability, and expanding care access for vulnerable populations.

BHD's cost drivers can be understood through two primary lenses – sustaining a high-quality workforce and operational infrastructure and responding to emerging issues and crises in behavioral health. These include:

- Increased substance use and swelling overdose crisis, exacerbated by a sharp increase in opioid and stimulant-related fatalities, with overdose rates nearly tripling since 2016.
- Rising hospitalizations due to serious bacterial infections from injection drug use.
- Significant shortage of mental health and substance use disorder residential treatment beds for all age groups, with even more profound shortages for culturally and linguistically specific residential treatment services.
- Substantial behavioral health workforce shortages at all levels of care.
- Need for expanded staffing capacity within BHD to address and meet the demands of a rapidly changing and more complex behavioral health landscape in Oregon, including increased data management, policy development and implementation, and stronger service coordination.

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. BHD works in partnership across systems collaborating to solve systems challenges and coordinate care across the behavioral health continuum of care – from prevention to recovery.

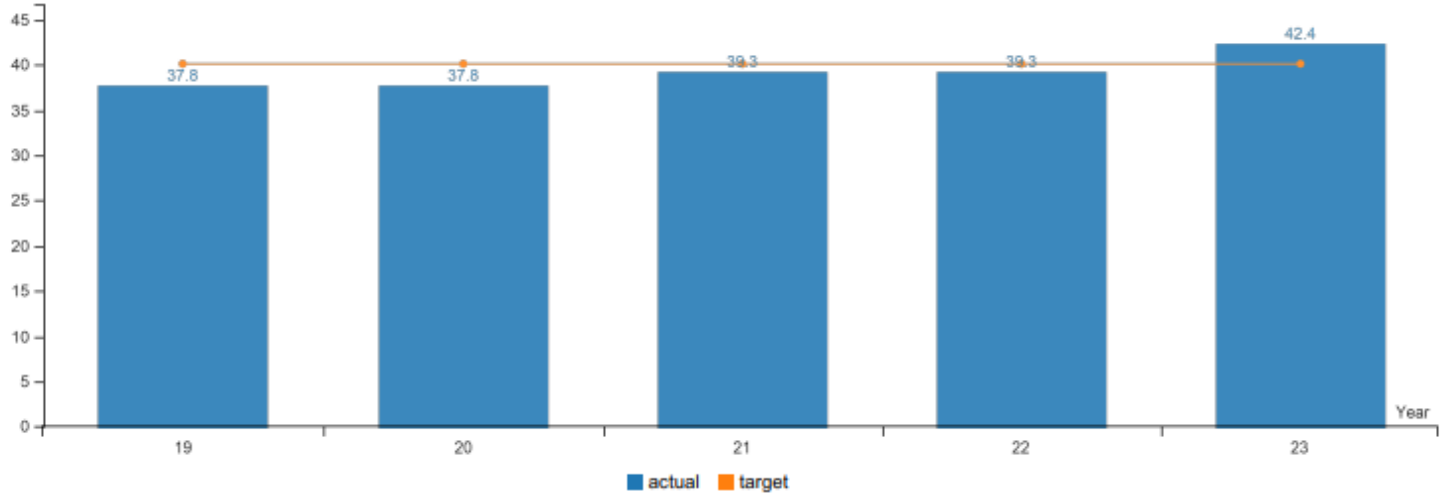
Executive Summary

OHA's BHD 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 those populations.

Program performance

OHA tracks more than 30 Key Performance Measures (KPM) to assess the progress and impacts of the Agency's work. Of those, seven apply directly to OHA's Behavioral Health Division's mission and scope of work. An overview of each KPM relevant to BHD and most recently available data on progress since 2019 follows below.

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.

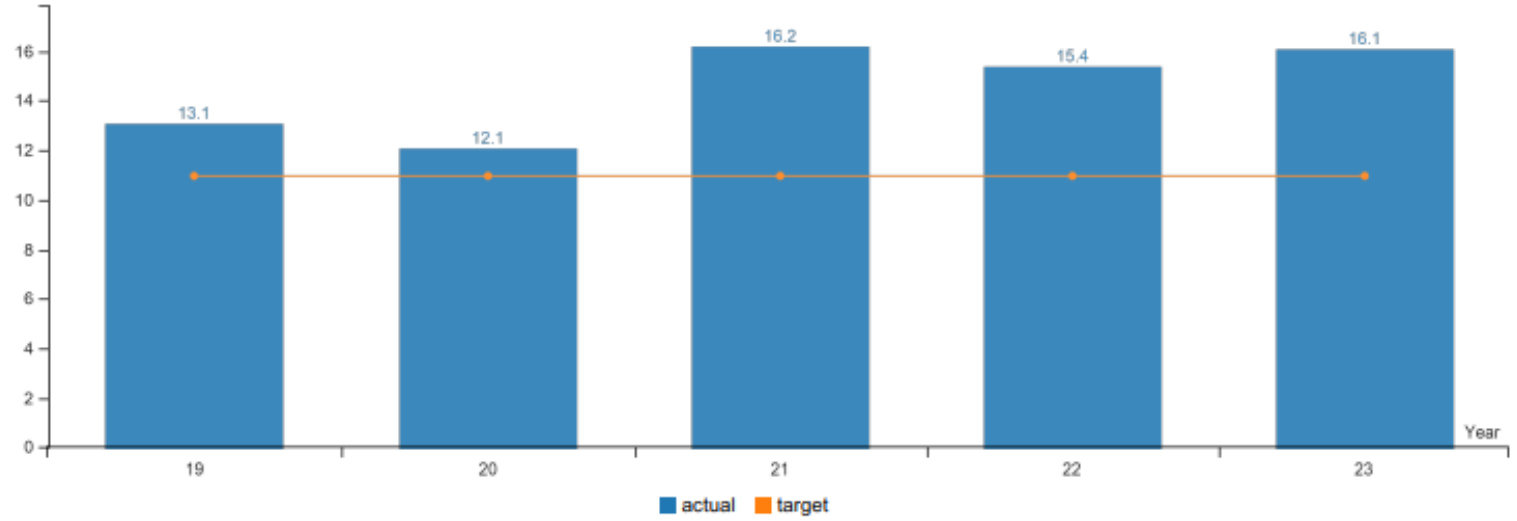


**Upward trend indicates positive result*

Executive Summary

The percentage of members ages 13 and older newly diagnosed with alcohol or other drug dependencies who initiated treatment within 14 days stayed was 42.4 percent in 2022. Data prior to 2022 are not directly comparable due to a methodology change. It is possible that the increased statewide emphasis on alcohol and drug use screening 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 receive two or more services within 30 days of initiation visit

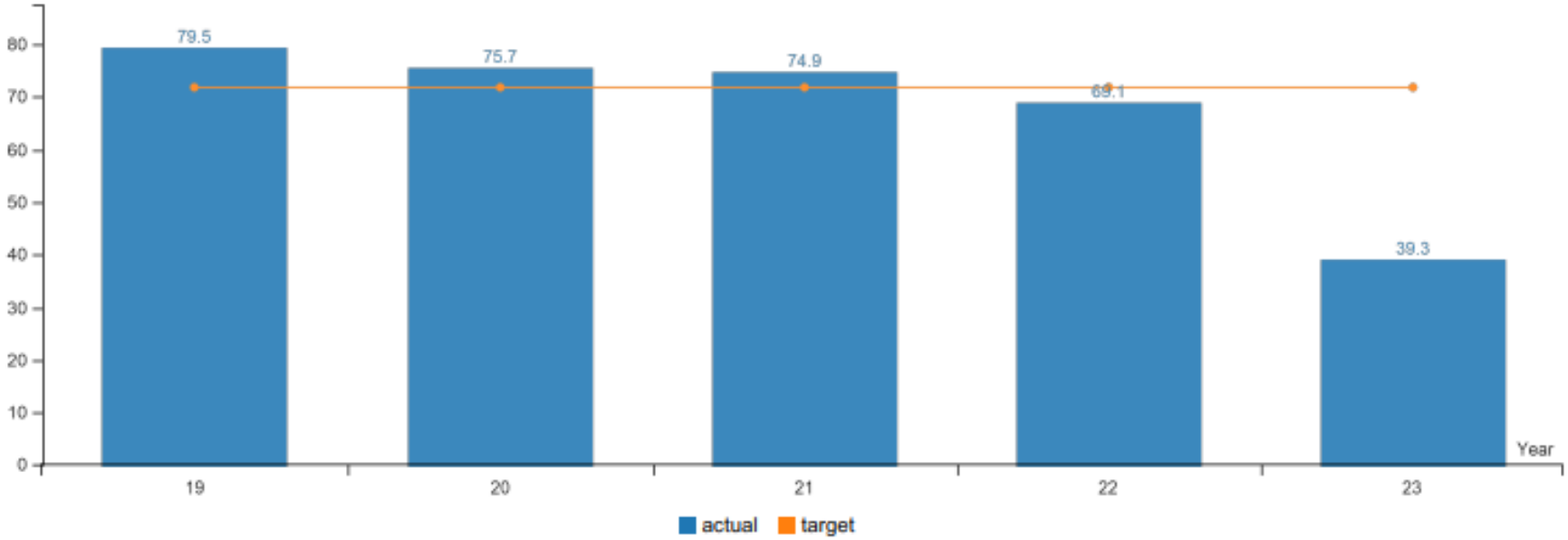


**Upward trend indicates positive result*

The percentage of members who continued their treatment was 16.1 percent in 2022. Data prior to 2022 are not directly comparable due to a methodology change. 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.

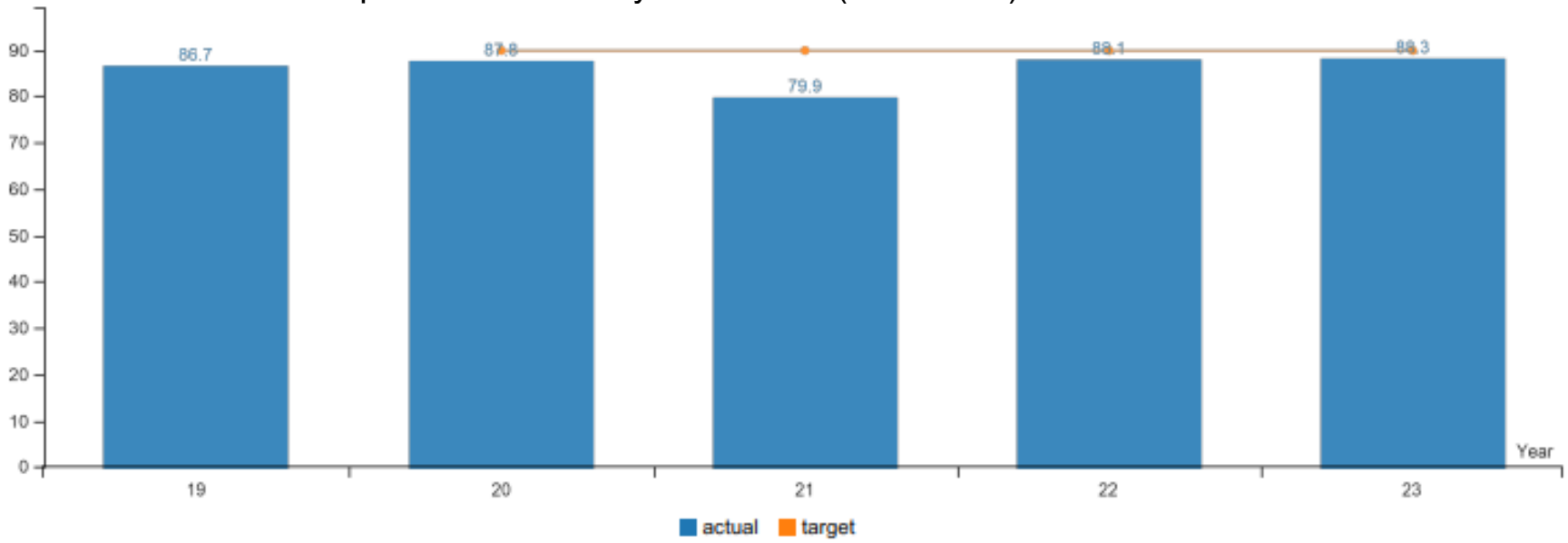


**Upward trend indicates positive result*
***Performance on this measure cannot be compared to past years due to changes in specification requiring service is provided by a mental health professional.*

The specifications for this measure changed to require that the service be provided by a mental health professional. This change aligns the measure with Healthcare Effectiveness Data Information Set (HEDIS) specification.

Executive Summary

KPM 4: Mental, physical, and dental health assessments for children in ODHS custody – percentage of children in ODHS 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 ODHS (foster care).



**Upward trend indicates positive result*

Data represent performance in CY 2022 and show a slight increase from CY 2021 when the percentage was 88.1 percent.

In 2023, OHA added the Key Performance Measures listed below, which will be used to measure Behavioral Health Division program performance moving forward. However, due to lack of historic data, they have been omitted from the 2025-2027 narrative.

Executive Summary

- **KPM 45: Quality of life – poor mental health.** This measure shows the average number of self-reported mentally unhealthy days in the past 30 days for respondents who are age 18+. Measuring health-related quality of life helps build an understanding around people's lived experience with disabilities and chronic diseases across the population.
- **KPM 46: Premature death – number of years of potential life lost 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 is 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.
- **KPM 47: 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.

Enabling legislation/program authorization

The statutory framework for the programs administered by the BHD 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.

Executive Summary

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- 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.

Funding streams

OHA's Behavioral Health Division budget includes General Fund, Federal Funds, and Other Funds. General Fund revenue is utilized for administrative support, staffing, services and supplies, and the maintenance and operations of the information technology systems for the division's behavioral health programs.

Executive Summary

Federal funding sources include:

- Medicaid administrative match
- Federal block grants, including, Center for Mental Health Services block grant (CMHS) previously known as Mental Health Block Grant
- Substance Use Prevention Treatment Recovery Services (SUPTRS grant) previously known as Substance Abuse Prevention and Treatment (SAPT grant)
- Medicaid (Title XIX)
- Children's Health Insurance Program (Title XXI)
- Other federal grants

Other Funds include:

- The Tobacco Master Settlement Agreement
- Tobacco taxes
- Lottery Funds/Bonds
- Marijuana taxes
- Drug Treatment and Recovery Services Fund (M110)
- Law Enforcement Medical Liability Account (LEMLA)
- Beer and Wine Taxes
- American Rescue Plan Act (ARPA)
- Opioid Settlement funds
- A portion of court fines, fees and assessments related to ORS 813.270, for the Intoxicated Driver Program Fund

Executive Summary

Significant proposed program changes from 2023-25

In April 2024, OHA implemented an organizational restructuring which absolved the Health Systems Division, and two distinct yet interconnected divisions were created within OHA: Medicaid and Behavioral Health. This change allows for expansion, growth and focus within the respective areas of work, while prioritizing continued partnership and collaboration. BHD therefore, restructured its work to maximize collaboration and resources for the continued implementation of more than $1.35 billion in behavioral health system investments made by the Legislature in 2021. These investments represent a turning point for behavioral health in Oregon, enabling BHD to meet OHA's goal of achieving health equity by 2030 by:

- Expanding and improving services
- Addressing the impact of the pandemic on our community and the behavioral health workforce
- Investing in infrastructure, planning, and workforce development

Program Support and Administration

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Governor's Budget 2025-27	$68.03	$63.84	$36.61	$168.48	237	234.54

OHA's Governor's Budget continues funding for Program Support and Administration of Behavioral Health Division for the 2025-27 biennium and includes $390,000 for policy package 551 to staff and administer a larger harm reduction investment, $360,000 for behavioral health community navigator investment, and $3.3 million for staffing related to civil commitment.

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 Behavioral Health Division. The division is supported by:

- The Director's Office, which includes the Deputy Directors overseeing core functional areas, the Office of Strategic Operations and the Tribal Liaisons and administration of the following areas:
  - The Equity, Community Partnerships & Quality Assurance area, which includes Equity and Community Partnerships unit, Office of Recovery and Resilience unit, Quality Assurance and the Behavioral Health Metrics and Committees unit.
  - The Operations & Strategy area, which includes Business Operations, Contracts, Behavioral Health Investments, Behavioral Health Workforce Investments and Licensing and Certification.
  - The Behavioral Health Service Delivery area, which includes Child and Family Behavioral Health and Adult Behavioral Health.

Division Administration and Support

Program Support and Administration

In April 2024, Oregon Health Authority's Behavioral Health Division restructured its operations to improve collaboration and expand behavioral health services statewide, focusing on culturally responsive, evidence-based approaches that emphasize advocacy, prevention, and affordable access. The Oregon Health Authority's 2025-27 Strategic Plan outlines five goals: transforming behavioral health, enhancing access to affordable care, fostering healthy families and environments, achieving healthy Tribal communities, and eliminating health inequities. These objectives will be pursued through initiatives in policy, partnerships, workforce development, data modernization, and the behavioral health continuum of care, with services delivered across various settings in collaboration with diverse community partners. With the recent restructure to form the Behavioral Health Division, the Program Support and Administrative functions have been enhanced and expanded to better promote strategy, operations, and accountability. The Behavioral Health Division's Program Support and Administrative areas are comprised of:

1. Behavioral Health Director's Office (Overseen by the Director)
2. Behavioral Health Equity, Community Partnerships & Quality Assurance
3. Behavioral Health Operations & Strategy
4. Behavioral Health Service Delivery

The units that fall within these areas and respective directors and managers provide overall vision, direction and leadership for all of Oregon's publicly funded behavioral health activities, as described below.

The Behavioral Health Director's Office consists of the Behavioral Health Division Deputy Directors, the Office of Strategic Operations, the Measure 110 Unit, and the Behavioral Health Tribal Affairs. The Director's Office ensures coordinated administration and collaboration across the Behavioral Health Division to ensure the Equity, Community Partnerships & Quality Assurance, Operations and Strategy, and Service Delivery areas are strategically and operationally connected to best meet behavioral health needs for individuals in Oregon. The Behavioral Health Division has three full time tribal liaison positions that work to uphold OHA's Tribal Consultation Policy and to maintain government-to-government relationship, advocate for funding and Tribal inclusion in programs and policies

that impact Tribal communities. OHA Tribal Affairs Director matrix manages all three positions in partnership with the Behavioral Health Division. Together, they work regularly with elected Tribal officials, Tribal health directors and behavioral health staff across all Nine Federally Recognized Tribes in Oregon, as well as Indian Health Services, Oregon's Urban Indian Health Program (NARA Northwest), the Northwest Portland Area Indian Health Board, and other state agencies focusing on Tribal health priorities. Additionally, they ensure Tribal inclusion and collaboration within the agencies' top priorities which include partnering with counties, CCOs and other community-based organizations.

The Office of Strategic Operations supports the work and positioning of the division Director and the Behavioral Health Division. By facilitating standards coupled with strategy, the unit builds scaffolding for successful positioning with internal and external partners. The unit is comprised of staff supporting behavioral health policy, communications strategy, legislative coordination and tracking, budgetary tracking, workforce development and equity strategy, and project management. The unit works across agency divisions to collaborate and coordinate systems planning and operational needs.

The Measure 110 Unit is dedicated to implementing and advancing the Drug Addiction Treatment and Recovery Act, commonly known as Ballot Measure 110. This initiative aims to transform Oregon's approach to substance use disorders by prioritizing health-focused interventions. Funded through Oregon's cannabis tax revenue, the unit oversees grants distributed by the Measure 110 Oversight and Accountability Council to private, non-profit, government, and Tribal agencies. These grants support the expansion of culturally and linguistically specific substance use treatment and recovery services statewide. Key services funded include screening and referral, case management, individualized intervention plans, peer addiction support, harm reduction services, low-barrier treatment options, various housing supports, and supported employment initiatives. The unit's responsibilities extend to establishing Behavioral Health Resource Networks in each county, ensuring comprehensive service availability and wrap-around support tailored to client needs.

Additionally, the unit manages a 24/7 phone line to provide immediate access to screening and referrals for individuals with substance use concerns, enhancing accessibility to critical services across Oregon.

The Behavioral Health Equity, Community Partnerships & Quality Assurance area consists of the Behavioral Health Equity and Community Partnerships Unit, the Office of Recovery and Resilience, the Behavioral Health Metrics and Committees Unit, and the Behavioral Health Quality Assurance Unit. These units focus on accountability to individuals in Oregon most impacted by behavioral health inequities through community engagement, partnerships, and quality management. The units in this area partner with culturally and linguistically specific service providers and organizations, peer-led and peer delivered service providers and organizations, and internal agency equity-focused teams and analytics teams to promote accountability through partnership and progress reporting. The area serves the whole Behavioral Health Division.

The Behavioral Health Equity and Community Partnerships Unit leads OHA's efforts to reduce disparities in behavioral health services, aiming to achieve health equity for all individuals in Oregon by 2030. The unit's mission aligns with the strategic goal of eliminating health inequities, defined as creating a health system where all individuals can reach their full potential without being disadvantaged by race, ethnicity, language, disability, age, gender, or other socially determined factors. Achieving this requires collaboration across all state sectors, including Tribal governments, to equitably distribute resources and rectify historical and contemporary injustices. The unit's vision is to amplify the voices of communities most affected by health inequities and build partnerships that enable everyone to achieve behavioral health and wellness.

To accomplish this, the team uses community relationships to guide their work through five key strategies related to data, policy, workforce, technical assistance, and communications. They focus on sharing data to highlight systemic inequities and inform best practices identified by communities. They promote policy initiatives advocated by those most impacted by health inequities and support workforce development to

create a culturally responsive, trauma-informed behavioral health workforce. Additionally, they provide technical assistance to enhance the capacity of internal staff and community partners, and they work to increase community awareness and access to information about behavioral health inequities and equity strategies.

The Office of Recovery and Resilience consists of policy and program analysts with lived experience in behavioral health, acting as a crucial link between the agency and the community. Their role is to ensure that the perspectives of individuals with lived experience, including youth, families, and adults, are integral to shaping Oregon's behavioral health system. The unit oversees, strategizes, and supports peer-delivered services statewide by applying their lived experiences to analyze, develop, and implement programs and policies that foster a more person-directed, equitable, and effective behavioral health system. They facilitate the meaningful involvement of those with lived experience at every level of policy creation, service delivery, and program evaluation, providing training and technical assistance to agency and division colleagues, community partners, and people with lived experience.

Additionally, this unit promotes the growth and integration of Peer Delivered Services (PDS) within Oregon's behavioral health system by overseeing programs such as youth support, family support, and adult peer support. They provide technical assistance to the PDS workforce and other system partners, collaborate on strategic planning for peer services and workforce development, and work to secure sustainable funding for PDS. The unit invests directly in the PDS workforce through community partners and Peer Run Organizations to deliver training, develop curriculum, establish standards of practice, and implement workforce wellness initiatives. They also focus on building partnerships and community connections to reduce stigma and discrimination against individuals with mental health or addiction issues and their families, fostering culture change within OHA and the communities they serve. In collaboration with the behavioral health equity team,

the unit aims to advance an equitable behavioral health system that provides individualized, person-directed, and culturally and linguistically appropriate services and supports.

The Behavioral Health Metrics and Committee Unit plays a pivotal role in advancing Oregon's behavioral health system transformation by supporting the Behavioral Health Committee, established under House Bill 2086 (2021). This unit takes a transformative approach to ensure that all efforts align with health-based, equitable, and effective behavioral health practices. They facilitate the committee's mission to establish quality metrics for behavioral health services provided by coordinated care organizations, health care providers, counties, and other government entities, and develop incentives to enhance service quality. These metrics and incentives aim to improve the integration of physical and behavioral health care, ensure timely access to care, support individuals in the least restrictive environments, reduce hospitalizations, and decrease overdoses. Additionally, in collaboration with OHA's Health Policy and Analytics Division, the unit gathers, analyzes, and utilizes federal, state, and community data to monitor and lead efforts to improve behavioral health outcomes in Oregon and address disparities. They provide support and guidance to the Behavioral Health Committee to ensure that the agency's efforts are effectively directed.

The unit also coordinates the review of existing administrative rules and regulations related to behavioral health metrics across various settings, ensuring alignment with policy and advising on system changes to meet the agency's mission, vision, values, and goals. Their work includes improving behavioral health outcomes, reducing disparities, promoting trauma-informed approaches, and advancing equity as directed by the community and individuals with lived experience. They promote and execute policy initiatives to strengthen the impact of OHA programs on behavioral health equity and increase awareness and access to information about behavioral health inequity. Additionally, they develop and implement strategies to promote equity and advocate for trauma-informed approaches that recognize the impact of structural racism and oppression, focusing on community-centered healing and sustainable structural change.

Program Support and Administration

The Behavioral Health Quality Assurance Unit plays a crucial role in advancing equity within the administration of Oregon's behavioral health system, especially amid the ongoing challenges posed by the COVID-19 pandemic. This unit, newly established by the Behavioral Health Division, focuses on addressing behavioral health priorities through expertise in quality management, compliance, evaluation, monitoring, and continuous quality improvement. In response to multiple audits of the behavioral health system and the services funded by the agency, the team fosters a culture of quality improvement and accountability to the public. They maintain a system-wide perspective on quality assurance, encompassing statutory requirements, community partner implementation of new legislation and rule-making, and corrective action planning and monitoring.

By organizing and synthesizing updates across various quality activities related to Oregon's behavioral health system, the unit provides a framework for accountability at both the state and local levels. Their efforts ensure that the behavioral health system not only meets statutory and regulatory requirements but also prioritizes equity by addressing the complex and diverse needs of individuals in Oregon. The unit's work advances equity by ensuring that quality improvements and compliance measures are applied consistently and equitably across all communities, promoting fair access to high-quality behavioral health services for all individuals, regardless of their background or circumstances.

The Behavioral Health Operations & Strategy area encompasses several units: the Business Operations Office, the Contracts Strategy and Coordination Unit, the Behavioral Health Workforce Incentives Unit, the Behavioral Health Investments Unit, the Mental Health Licensing and Certification Unit, and the Behavioral Health Licensing and Certification Unit. This area provides oversight and support for mental health and substance use disorder funding, promoting a collaborative community approach to addressing systemic and institutional health inequities. It supports community-based licensed residential services, supportive housing, treatment facilities, rental assistance, and program contracts/grants while enhancing the behavioral health workforce through incentives. Additionally, this

section is responsible for workforce support, position management, expenditures, and general administrative functions.

The Business Operations Office serves as a crucial hub within the Behavioral Health Division, providing comprehensive operational, administrative, contracting, and fiscal support. Comprising units such as the Business Office Unit, Contracts Strategy and Coordination Unit, Position and Fiscal Management, Behavioral Health Investments Unit, and Behavioral Health Workforce Incentives Unit, it plays a pivotal role in ensuring the division's smooth functioning and effective service delivery.

The Business Office and Administrative Support Unit within the Business Operations Office handles a wide array of operational tasks essential for the division's daily operations. This includes managing recruitment processes, facilitating employee onboarding, overseeing facilities management, coordinating software and hardware needs, arranging travel logistics, managing mail services, ensuring security protocols, and overseeing records management. Meanwhile, the Position and Expenditure Management Unit provides critical technical support and analytical insights to Behavioral Health Executive Leadership and managers. Their responsibilities include managing positions within the workforce through platforms like Workday, overseeing budget actions, and handling payments such as invoices and stipends. Together, these units perform core functions of administrative and operational support essential for maintaining efficiency and compliance across the Behavioral Health Division.

The Contracts Strategy and Coordination Unit serves as the pivotal hub responsible for managing a significant volume of contract action requests—over 1,500 annually—while strategically planning biennial contract renewals in strict adherence to timelines. Contract specialists within the unit leverage their expertise to coordinate the development of contracts, grants, agreements, and solicitations that align precisely with program expectations, service requirements, and desired outcomes, all while ensuring compliance with

established processes, statutes, rules, and regulations. This includes overseeing agreements that fund behavioral health services provided by Community Mental Health Programs, Nine Federally Recognized Tribes in Oregon, Tribal organizations, and local service providers statewide. The unit meticulously tracks utilization data, evaluates actual versus budgeted expenditures, and monitors funding commitments to prevent over-obligation of state resources, identifying trends that inform future funding needs and compiling Continuing Service Level requirements for upcoming contract terms.

The unit plays a critical role in maintaining the integrity and quality of contracts by offering guidance in writing Statements of Work using clear language and standardized processes, ensuring alignment with statutory requirements. They facilitate effective program and treatment service delivery by bringing together the necessary parties promptly and ensure fair payment for services rendered. Additionally, the unit educates and supports users of contracting systems, facilitating remote work capabilities through automated workflows, approvals, and real-time status updates from initial request through final execution. They also manage contract retention via DocuSign CLM, customizing processes as needed and providing comprehensive support for all division contracting needs, including compliance with the Oregon Public Contracting Code and federally mandated reporting requirements. Through centralized communication and coordination efforts, the unit optimizes contracting processes to minimize costs while maximizing outcomes for the benefit of program staff, service providers, and the broader community.

The Behavioral Health Workforce Incentives Unit, established under House Bill 2949 (2021), plays a crucial role in enhancing the recruitment and retention of behavioral health providers from diverse backgrounds, including people of color, American Indian/Alaskan Native, Tribal members, and rural residents. This initiative aims to bolster the capacity of Oregon's behavioral health system to deliver culturally responsive care that integrates equity-centered practices, destigmatizes services, promotes restorative healing, and empowers communities. The unit oversees funding for scholarships, loan repayment programs, and grants to support the

development of a diverse behavioral health workforce across licensed and non-licensed professions, emphasizing supervised clinical experience to facilitate licensure or certification attainment.

Aligned with the goals of House Bill 2949, the unit focuses on investing in culturally specific providers and organizations to expand access to culturally responsive services and interventions, particularly for communities disproportionately affected by health inequities. It also prioritizes initiatives to reduce barriers for historically underserved individuals in accessing training and educational opportunities within the behavioral health field. Additionally, the unit collaborates closely with communities in shared decision-making processes to establish frameworks, resources, and supports that enhance the recruitment and retention of a culturally specific behavioral health workforce, particularly in rural areas of the state. These efforts are designed to build a workforce that reflects and meets the diverse needs of Oregon's population while advancing equity and inclusivity in behavioral health care delivery.

The Behavioral Health Investments Unit operates with a community-centered approach, emphasizing shared leadership and collaborative decision-making to address systemic health inequities. The primary focus is on expanding community-based licensed residential and supportive housing services, aimed at enhancing stability, improving access to appropriate care, and promoting overall health and wellbeing. Responsibilities of the unit include developing and implementing policies and procedures for administering funding to community partners, particularly for the creation of these essential housing services. The unit oversees a Delegation Agreement authorized by the Office of Contracts and Procurement to issue Requests for Grant Funding and provide technical assistance to other units within the Behavioral Health Division to ensure effective delivery of funding.

Additionally, the unit administers rental assistance programs for individuals experiencing serious and persistent mental illness, including co-leading the Housing and Urban Development 811 Project Rent

Assistance program in collaboration with Oregon Housing and Community Services. The unit manages the Community Mental Health Housing Fund, a substantial Trust Fund exceeding $5 million, and oversees a diverse housing portfolio of forgivable loans and grants to ensure compliance with occupancy and program requirements. The unit actively engages with communities to share funding opportunities, gather insights into local needs, remove barriers to access, provide technical assistance, and facilitate networking among Community-Based Organizations. The unit also drives pilot projects such as the Temporary Assistance to Needy Families (TANF) Behavioral Health Pilot, which aims to broaden access to mental health and substance use disorder services for TANF families. Additionally, staff in this unit administer the Birth Certificate program, assisting individuals experiencing and at risk of homelessness in obtaining their birth certificates to facilitate access to essential services and benefits.

The Mental Health Licensing and Certification Team plays a pivotal role in overseeing the licensing, certification, registration, and monitoring of more than 350 programs serving nearly 2,000 individuals across Oregon. These programs encompass a diverse range, including the newly introduced Behavioral Health Agency with Choice and Crisis Stabilization Centers, as well as Adult Foster Homes where the team actively engages in labor management for bargaining. The team also oversees Residential Treatment Facilities, Residential Treatment Homes for both adults and young adults in transition, Secure Residential Treatment Facilities (SRTFs) with various levels of care, and SRTFs located on Oregon State Hospital campuses. Additionally, the team manages hold rooms in emergency departments and SRTFs, 5-day hold hospitals, transport custody hospitals, inpatient psychiatric units, psychiatric emergency services, regional acute care psychiatric services, secure transport services, and community-based structured housing.

Regulatory responsibilities are comprehensive, involving the assessment of compliance through various measures such as administering application processes, reviewing policies, procedures, personnel records, client records, and conducting interviews with providers, staff, individuals receiving services, and system

partners. Site inspections are conducted regularly to ensure adherence to standards, and findings are documented in detailed Site Review Reports (Statements of Deficiency). The team reviews and approves Plans of Correction to address identified deficiencies, provides technical assistance to support program compliance and improvement, and conducts investigations into complaints and critical incidents as they arise. The issuance, revocation, or conditioning of licenses, certificates and registration is conducted in accordance with regulatory requirements, including compliance with the Collective Bargaining Agreement for Adult Foster Homes and active participation in labor management and bargaining forums to ensure fair and effective oversight of mental health services across the state. Through these comprehensive activities, the team plays a crucial role in maintaining substantial compliance and high standards of quality care across Oregon's behavioral health system.

The Behavioral Health Licensing and Certification Team is responsible for the oversight, licensing, certification, and registration of over 400 programs at more than 950 locations, with 358 provider certifications. The programs and providers under its purview include Community Mental Health Providers, civil commitment processes, and the training of civil commitment examiners and investigators. The team also oversees crisis systems, including Mobile Crisis Intervention Services, and Certified Community Behavioral Health Clinics. Intensive Treatment Services such as Psychiatric Residential Treatment Facilities, sub-acute psychiatric residential treatment, integrated psychiatric residential treatment, Secure Children's Inpatient Program, and psychiatric day treatment are also regulated by the unit. Other services include Children's Emergency Safety Intervention Specialists, substance use disorder residential treatment, withdrawal management facilities, problem gambling residential programs, sobering facilities, and various outpatient programs. These outpatient programs encompass mental health, Tribal mental health, substance use disorder, Tribal substance use disorder, corrections-based substance use disorder, opioid treatment programs, DUII treatment and education, problem gambling, and Alcohol and Other Drug Screening Specialists.

Program Support and Administration

The team conducts a range of regulatory activities to assess compliance and ensure quality standards are met. These activities include administering application processes, reviewing policies and procedures, personnel records, charts, and conducting interviews with providers, staff, individuals receiving services, and system partners. The team also performs site inspections, develops Site Review Reports (Statements of Deficiency), and reviews and approves Plans of Correction. Additionally, the team provides technical assistance, conducts investigations into complaints and critical incidents, and issues, revokes, or places conditions on licenses and certificates as appropriate. Through these comprehensive activities, the team plays a crucial role in maintaining high standards of care and service delivery across Oregon's behavioral health system.

The Behavioral Health Service Delivery area is responsible for providing oversight to ensure the development of accessible, effective, and equity-driven services within the continuums of behavioral healthcare to serve people in Oregon across the lifespan, from child and family services to services for adults and older adults, in addition to specific communities that intersect with the criminal/legal system and houselessness. Additionally, Service Delivery is responsible for collaborating with Medicaid for Certified Community Behavioral Health Clinic (CCBHC) statewide expansion as well as leading other initiatives to support legislative initiatives.

Background information

In April 2024, the Behavioral Health Division restructured to enhance collaboration and resource utilization, aiming to implement system investments and expand behavioral health services in Oregon. The division's mission is to support individuals, families, and communities through a community-led, culturally responsive, evidence-based approach that prioritizes advocacy, prevention, and access to affordable behavioral health care. Under the Oregon Health Authority’s 2025-27 resource request, the division is committed to five strategic goals: transforming behavioral health, strengthening access to affordable care, fostering healthy families and environments, achieving healthy Tribal communities, and building OHA’s capacity to eliminate health inequities. These resources will enable

the division to lead Oregon's behavioral health system transformation through policy development, partnerships, workforce enhancement, data modernization, and care continuum improvements. The system's success relies on strong partnerships with consumers, Community-Based Organizations, coordinated care organizations, county governments, service providers, families, and local partners, ensuring service delivery across various settings.

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

- Administrative support for approximately 190 permanent full-time employees.
- Oversight and support for behavioral health services and administrative budget and invoices.
- Development and support for over 1,500 contracts and grants.
- Managing and monitoring the implementation of legislative initiatives.
- Monitoring and improving division operations, compliance and performance.
- Development and maintenance of behavioral health data and reporting systems.

Revenue sources and changes

OHA's 2025-27 ARB Behavioral Health Program Support and Administration budget is comprised of 40 percent General Funds, 22 percent Federal Funds, 36 percent Other Funds, and 2 percent Lottery Funds.

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

Program Support and Administration

Program Support and Administration receives Federal Funds through a Medicaid administrative match, small amounts of federal block grants to meet administrative requirements, and other federal grants to fulfill the grant obligations.

Other Funds include Lottery Funds and allocations from funding sources for admin, including:

- The Tobacco Master Settlement Agreement
- Tobacco taxes
- Lottery Funds/Bonds
- Marijuana taxes
- Drug Treatment and Recovery Services Fund (M110)
- A portion of court fines, fees and assessments related to ORS 813.270, for the Intoxicated Driver Program Fund

Federal Funds include:

- Center for Mental Health Services block grant (CMHS) previously known as Mental Health Block Grant
- Substance Use Prevention Treatment Recovery Services (SUPTRS grant) previously known as Substance Abuse Prevention and Treatment (SAPT grant)
- Medicaid (Title XIX)
- Children's Health Insurance Program (Title XXI)

Proposed new laws that apply to the program unit

OHA's Behavioral Health Division is not proposing new laws for the Program Support and Administration unit.

Behavioral Health Service Delivery

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Governor's Budget 2025-27	$653.37	$521.59	$266.47	$1,459.70	0	0.00

** Behavioral Health Division did not exist budgetarily until the 2025-27 Current Service Level*

OHA's Governor's Budget continues funding for Behavioral Health Service Delivery for the 2025-27 biennium and includes $24.3 million for policy package 550 to invest in Oregon's behavioral health workforce, $10 million for policy package 551 to fund harm reduction services, $100 million for policy package 552 to increase residential capacity for youth and adult psychiatric services.

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 individuals, families, and communities. Oregon continues to face a severe substance use and overdose crisis, exacerbated by a sharp increase in opioid and stimulant-related fatalities, with overdose rates nearly tripling since 2016. The state must address rising hospitalizations due to serious bacterial infections from injection drug use, which has significantly strained healthcare resources. Thus, the need for enhanced and expanded behavioral health services and supports continues into 2023-2025.

Oregon's behavioral health system is a community-based continuum that relies on numerous partnerships including, but not limited to, consumers and people with lived experience, Community-Based Organizations (CBOs),

coordinated care organizations (CCOs), county governments, service providers, families, and local community partners. These strong partnerships are integral to the delivery of services through outpatient, residential, school, acute, hospital, and criminal justice and community settings.

OHA's Behavioral Health Division's Service Delivery area is responsible for providing oversight to ensure the development of accessible, effective, and equity-driven services within the continuums of behavioral healthcare to serve people in Oregon across the lifespan, from child and family services to services for adults and older adults, in addition to specific communities that intersect with the criminal/legal system and houselessness. OHA's Behavioral Health Division Service Delivery area is comprised of the following units:

- Child and Family Behavioral Health;
- Adult Behavioral Health;
- Addiction Treatment, Recovery, and Prevention;
- Adult Mental Health;
- Intensive Services;
- 988 & Behavioral Health Crisis System; and
- Certified Community Behavioral Health Clinic Program.

Additionally, Service Delivery is responsible for collaborating with Medicaid for statewide expansion of the Certified Community Behavioral Health Clinic Program as well as leading other initiatives to support legislative initiatives.

The Child and Family Behavioral Health unit is committed to delivering equitable and effective behavioral health services for individuals aged 0-25 and their families, utilizing a System of Care approach that integrates developmental science and trauma-informed practices. This approach focuses on providing community-based services tailored to the needs of children and youth facing mental health challenges or at risk, aiming to improve their functioning across various life domains. Key initiatives include participation in the Governor's System of Care

Advisory Council, which influences policy to enhance Oregon's behavioral health system. The unit coordinates care across multiple systems, such as juvenile justice and education, emphasizing community-based interventions and peer-delivered services. It resources a helpline for parents and caregivers to reduce crisis incidents by offering support and resource connections.

Suicide prevention is a major focus of the unit, aligning with Oregon's Youth Suicide Intervention and Prevention Plan. The unit manages prevention program contracts, collaborates with school districts, and evaluates intervention effectiveness. It also invests in interventions for parent-child relationship issues, trauma responsive treatment, and addiction through evidence-based programs like Parent-Child Interaction Therapy and Collaborative Problem Solving. Prioritizing community-based treatment and early identification, the unit supports initiatives such as the Early Assessment Support Alliance and the Oregon Psychiatric Access Line. It funds school-based mental health services and programs addressing the commercial sexual exploitation of children. Additionally, the unit provides Juvenile Fitness to Proceed services for youth and has introduced a new crisis response model, Mobile Response and Stabilization Services, to offer community-based alternatives to psychiatric hospitalization. Intensive In-Home Behavioral Health Treatment is available for children with complex needs, aiming to prevent out-of-home placement. Through advisory groups, the unit actively engages youth and families in policy development and oversight, providing funding and technical assistance to local communities to promote mental wellness and reduce stigma, emphasizing the importance of social and emotional determinants of health. Overall, the unit's comprehensive approach is designed to help children, youth, and families throughout Oregon effectively navigate behavioral health challenges.

Accomplishments: Oregon's Child and Family Behavioral Health Unit has achieved significant accomplishments and additional investments for the continuum of care, including securing two Transformation Transfer Initiative Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance suicide prevention efforts for Black and Latinx youth. The unit introduced innovative initiatives such

as a dedicated program for Black youth suicide prevention, participation in SAMHSA's inaugural cohort on this issue, and organizing the first annual symposium on substance use disorders for youth and young adults. Additionally, the unit added two new Parent-Child Interaction Therapy programs for young children and launched Mobile Response and Stabilization Services for youths aged 0-20, key components of Oregon's System of Care. The unit also funded three new Young Adult in Transition residential homes, expanded residential facilities for youth affected by mental health and substance use challenges, and secured additional residency slots for child psychiatrists and developmental pediatricians, demonstrating a comprehensive approach to enhancing mental health services and support systems for Oregon's youth and families.

Challenges: Oregon's behavioral health treatment continuum of services are vital for addressing substance use disorders, psychiatric treatment, and co-occurring needs across all age groups, but the current infrastructure is inadequate to meet the state's demands. For youth and young adults, the availability of residential treatment beds is significantly lacking, with a recent study recommending increased capacity due to long wait times and reliance on emergency departments for crisis situations. Despite system improvements such as additional providers and added beds, challenges persist, including a 6 – 10 week wait time for psychiatric residential treatment facilities and insufficient options for young adults age 18 – 21. The services are concentrated along the I-5 corridor, posing accessibility issues for families in other regions. For adults, priorities include ensuring equitable access to culturally and linguistically diverse services and addressing bureaucratic funding processes that disadvantage smaller organizations. The unit received $10M from the Governor’s recommended budget to expand psychiatric and substance use disorder residential services for youth. The unit will focus on residential capacity for youth in smaller, home-like settings, adding programs for co-occurring mental health and substance use treatment, and improving funding distribution to support culturally specific providers and smaller organizations. In addition, the unit is focusing on ways to support youth in the community through intensive in-home supports to proactively manage youth needs before residential treatment is needed. The unit received $7M in the Governor’s recommended budget to enhance

the Intensive In-home Behavioral Health Treatment (IIBHT) supports currently required through CCO contracts. These funds will be used to support centralized training for existing programs through CCOs, a mental health campaign to build awareness of the services and supports available, culturally specific teams and partnership with Child Welfare, and building increased capacity for co-occurring substance use treatment supports through this community treatment model.

In addition, the ambiguity in Oregon's juvenile fitness to proceed laws affects health equity among youth, as these laws dictate whether a youth is mentally fit to participate in legal proceedings and access mental health services. Inconsistencies in these statutes lead to health disparities, especially for vulnerable populations, by limiting access to behavioral health services, creating treatment disparities, and denying legal advocacy and support, particularly affecting communities that have been economically and socially marginalized, including Tribal youth.

The Adult Behavioral Health unit is dedicated to developing and managing the infrastructure, programs, and services for adults aged 18 and up, focusing on mental health, substance use disorder services and a comprehensive crisis system. This includes building the state's behavioral health crisis system and ensuring services range from community-based outpatient care to secure treatment settings. The unit emphasizes equity and community involvement by partnering with equity teams within the Oregon Health Authority (OHA) and collaborating with community-based organizations. Their approach prioritizes harm reduction and patient-centered treatment planning, aiming to provide whole-person care across the behavioral health continuum in the least restrictive settings possible.

The Adult Behavioral Health unit plays a critical role in planning and administering federal behavioral health block grants and the State Opioid Response grant for non-Medicaid services. They coordinate the County Financial Assistance Agreements and the substance use disorder Medicaid waiver, working to fill service gaps through federal grants and partnerships with CCOs. The unit ensures that consumer input is integral to service planning and

delivery through the Office of Recovery and Resilience, and it focuses on eliminating health inequities by advancing equity and consumer voices in policy decision-making.

This unit also coordinates the efforts of the Saves Lives Oregon/Salvando Vidas Oregon (SLO) and the harm reduction clearinghouse. SLO is a community led initiative that partners experts in harm reduction across the care continuum and OHA. The purpose of SLO is to support agencies across the state move from awareness of harm reduction to partnership in harm reduction efforts, enabling provision of equitable access to life saving supplies and resources for organizations directly serving people at highest risk of overdose, infection, and injury due to substance use. The clearinghouse offers free naloxone and harm reduction supplies to community-based organizations who serve people who use substances. Additionally, it develops policies for integrating behavioral and physical health care, oversees the expansion of Certified Community Behavioral Health Centers, and supports the integration of behavioral health services through CCOs to enhance the system's effectiveness. The section also manages administrative rulemaking for Behavioral Health programs, provides technical assistance to CCOs, and analyzes behavioral health funding streams to inform policy decisions and drive transformation.

Accomplishments: OHA continues to use federal funds to improve the behavioral health system. The State Opioid Response grant continues to fund peer programs, Opioid Treatment Program, and Outpatient Based Opioid Treatment services throughout the state. The Mental Health Block Grant funds Community Mental Health Programs and community-based organizations to increase and improve crisis service, early intervention services for youth experiencing psychosis for the first time, and outpatient mental health services to those who are uninsured or underinsured. The Substance Use, Prevention, Treatment, Recovery Services grant (SUPTRS) funds outpatient and residential treatment service to those who are uninsured or underinsured. Additionally, SUPTRS funds peer mentor programs, trainings, housing and Tribal specific substance use treatment services. The unit works with each CCO to ensure they develop their comprehensive

behavioral health plans and progress in implementation. OHA and the CCOs collaborate to ensure that the needs of the members and communities were understood, and actions are being taken to improve services.

Challenges: Oregon faces a severe substance use and overdose crisis, exacerbated by a sharp increase in opioid and stimulant-related fatalities, with overdose rates nearly tripling since 2016. The state also must address rising hospitalizations due to serious bacterial infections from injection drug use, which has significantly strained healthcare resources. Despite the success of harm reduction efforts and the expansion of programs like the SLO Harm Reduction Supply Clearinghouse, which provides essential supplies such as naloxone, the need for increased treatment facilities and resources remains critical. Current gaps include a shortage of substance use disorder residential treatment facilities and withdrawal management beds, highlighting the urgent need for expanded and culturally specific services.

In response, OHA is focusing on two main initiatives: continuing and expanding the SLO Harm Reduction Supply Clearinghouse to increase access to lifesaving supplies and hosting Opioid Treatment Innovation Listening Sessions to develop and implement new strategies for addressing the crisis. These efforts aim to enhance harm reduction, improve treatment access, and foster community collaboration to effectively tackle the substance use crisis and its associated challenges.

The Addiction Treatment, Recovery, and Prevention Unit partners with communities to develop and oversee an equitable system of care for addiction treatment, recovery, and prevention across Oregon. The unit manages the statewide substance use disorder system, including state initiatives for opioid misuse, Driving Under the Influence of Intoxicants (DUII) related services, problem gambling programs, veterans' behavioral health, integrated co-occurring disorder services, and Tribal substance use prevention. It administers funding from various sources such as the General Fund, taxes, and the lottery, supporting a range of programs from outpatient and residential treatment to crisis services and enhanced payment rates for co-occurring disorder services.

Behavioral Health Service Delivery

The unit's responsibilities include overseeing problem gambling treatment and prevention in all 36 counties, addressing opioid, stimulant, and polysubstance use through enhanced services, as well as ensuring compliance of licensed opioid treatment programs. It also provides training and education on Medication Assisted Treatment (MAT) and collaborates with stakeholders and federal agencies to expand MAT, improve community awareness of opioid misuse, and support evidenced-based treatment approaches. Because issues related to substance use disorders are addressed in multiple units and divisions throughout the OHA, the unit collaborates with other partners and coordinates substance use disorder related work. The Tribal Alcohol, Tobacco and Other Drug Prevention Specialist works closely with the prevention specialist and community members in each of the Nine Federally Recognized Tribes of Oregon. This collaboration supports the planning, policy and program development and implementation of specialized services designed for American Indian and Alaska Natives.

Accomplishments: The Addiction Treatment, Recovery, and Prevention Unit has achieved significant accomplishments in promoting culturally specific and effective substance use disorder prevention and treatment across Oregon. The unit has partnered with the Nine Federally Recognized Tribes of Oregon to create and implement community-focused prevention plans, and it is currently running a culturally specific tribal prevention training cohort, which will certify approximately 25 tribal prevention specialists. Additionally, the unit supports tribal participation in the Cross-State Prevention Leadership Academy and is sponsoring the State Tribal Opioid and Fentanyl Summit. These initiatives demonstrate a strong commitment to integrating culturally specific approaches into prevention efforts and strengthening partnerships with tribal communities.

Beyond tribal-focused efforts, the unit has led initiatives to combat substance use disorders more broadly. By collaborating with the University of Washington and the Northwest Addiction Technology Transfer Center, the unit has implemented contingency management programs to reduce stimulant use and expanded tobacco cessation programs with local tribes and urban Indian health programs. The launch of the Adult Suicide Intervention and Prevention Plan further reflects the unit's commitment to comprehensive suicide prevention.

Additionally, the unit has opened four transitional housing beds offering culturally specific services for BIPOC and LGBTQIA2+ individuals with gambling disorders and launched free financial counseling for those affected by gambling disorders. The unit has also expanded support for individuals who are pregnant or parenting and experiencing substance use disorders through initiatives like Nurture Oregon and flexible spending options for outreach and recovery supports. By changing contracting processes to reduce administrative burdens and ensuring alignment with the American Society of Addiction Medicine levels of care, the unit has effectively enhanced access to services for individuals who are uninsured or underinsured, while providing technical assistance to treatment providers and staff at Oregon State Hospital to increase access to Medication Assisted Treatment.

Challenges: The DUII service system is in urgent need of comprehensive reform due to persistent challenges such as inefficient screening, referral, and monitoring processes, unclear roles among partners, disparities in outcomes, and insufficient support for evidence-based practices to prevent DUII recidivism. Oregon's current DUII service system, established in 1981, is fraught with inefficiencies and inconsistencies across various agencies and services. Disparities in the representation of communities of color among individuals cited for DUII reflect broader inequities, while the current focus on identifying substance use disorders overlooks key risk factors for DUII recidivism. Additionally, insufficient oversight has led to predatory financial practices by program providers, and limitations in the Intoxicated Driver Program Fund impede access to essential services for indigent defendants.

The Adult Mental Health Unit manages a comprehensive array of services designed to support adults in accessing behavioral health care across different stages of need. Key programs include Acute Inpatient Care, which focuses on stabilizing psychiatric symptoms and transitioning individuals back to less restrictive environments such as licensed residential treatment facilities or homes, and Adult Foster Care, which offers stabilization and personal care in a licensed, home-like setting. The unit also oversees adult suicide prevention efforts through the Adult Suicide

Intervention and Prevention Plan and is part of Oregon's Suicide Prevention Team comprised of various OHA programs. This team provides intensive, 24/7 wraparound services through the Assertive Community Treatment model to aid in community reintegration and operates three centers for excellences: the Center for Excellence for Aging and Behavioral Health to address the needs of older adults, Oregon Center of Excellence for Assertive Community Treatment, and Oregon Supported Employment Center of Excellence.

Additional initiatives include the Choice Model for coordinating mental health services, Community Mental Health programs for individuals who are uninsured or underinsured, and Complex Needs Behavioral Health Consultation to tackle service access barriers. Enhanced Care and Enhanced Care Outreach support individuals with complex medical and psychiatric needs administered with the Aging and People with Disabilities division of the Oregon Department of Human Services, while Guardianship services assist those legally unable to make health decisions. The Older Adult Mental Health Initiative improves access to services for older adults, and Projects for Assistance in Transition from Homelessness work to reduce homelessness. Pre-admission Screening and Resident Review assess nursing facility needs, residential services support individuals at risk of hospitalization or requiring stability, and Individual Placement and Supports Supported Employment offers job placement and support through the Individual Placement and Support model. The team facilitates and administers the Rate Review Committee. This committee is comprised of representatives from several OHA programs, with the intent to determine exceptional service needs requests above covered services.

Accomplishments: The unit launched the Center for Excellence in Aging and Behavioral Health through Portland State University which is the first research-based center specializing in older adult and behavioral health in Oregon. Several resources for older adults such as the ECHO Network pilot with the Aging and People with Disabilities division of the Oregon Department of Human Services and webinar caregiver trainings for mental health through Comagine were implemented via federal block grants. Through Enhanced Care Services, capacity expansion occurred in two facilities, one in Hood River and one in Portland. Several key

changes occurred in the Assertive Community Treatment and Independent Placement and Supported Employment system of care. The rules were updated and beginning in July 2024, the fidelity review process was paused to allow for a transition to the Tools for Measurement of Assertive Community Treatment. The Adult Mental Health Unit continues to be Subject Matter Expert evaluators for the Transformation Quality Strategy project. The team leads the Rate Review Committee Process Improvement Plan, mitigating and resolving a backlog of service requests. The team also continues to be active partners and collaborators on various OHA projects including Medicaid's Independent Qualified Agent Assessment Tool Replacement, Medicaid's Home and Community Based Services Expansion, Medicaid's Residential Rates Review, and Intensive Service Unit's Mink/Bowman Project. Additionally, the Tribal Mental Health team's work has grown over the last five years by expanding funding to three times as many programs.

Challenges: Residential and complex needs care coordination have been an ongoing challenge for the unit. The team does not have the staffing capacity to fully support the increasing residential and care coordination needs for those needs that do not fit the current system's model of care which are based on different Medicaid plans (fragmented between OHA, ODHS Aging and People with Disabilities, and Office of Developmental Disability Services). The team seeks to disrupt the pipeline of acute care hospitalization and carceral setting placements by focusing on prevention, safety, and wellness through improving community-based services and residential treatment services founded on a whole-person care principle. Residential services would need to be developed beyond the current administration of service elements by implementing ongoing provider support and revising rules to define treatment requirements. Young adult services specializing in ages 18-26 remain minimal throughout the state within the adult system of care. Services are either within the children system or with the adult system. Although funding is available for the age group, the systems do not currently work together to allow for joint support for this age group.

Behavioral Health Service Delivery

The Intensive Services Unit is dedicated to advancing a justice-centered behavioral health care system in Oregon by ensuring access to high-quality resources for all residents. The unit manages and evaluates behavioral health systems specifically designed for individuals mandated by the court to receive services under ORS Chapters 161 and 426. This includes overseeing programs related to Aid and Assist, Civil Commitment, Jail Diversion, and cases involving the Psychiatric Security Review Board (PSRB). The unit focuses on policy creation and refinement, aiming to reduce hospitalizations and recidivism while improving outcomes by coordinating services in the least restrictive and most clinically appropriate settings.

In addition to policy and program development, the unit provides contracting, technical assistance, and collaboration with various partners, including Community Mental Health Programs, CCOs, the Oregon State Hospital, and other state and local entities. It oversees statewide policies, programs, and contracts related to Aid and Assist, Civil Commitment, PSRB, and Jail Diversion. The unit is also responsible for overseeing and implementing recommendations from the federal Mink/Bowman case, managing jail diversion services, and ensuring data collection and analysis for its program areas. Through these efforts, the Intensive Services Unit supports the standardization of civil commitment programs and the integration of behavioral health services within the criminal justice system.

Accomplishments: There have been major strides with the expansion of jail diversion and deflection across the state, and the intentional efforts to help individuals transition back into community. Jail Diversion Services expanded to seven additional counties, aiming to steer individuals with mental health needs away from carceral settings. Community Mental Health Programs received $9.8 million to coordinate jail diversion and deflection efforts, along with $6 million to bolster civil commitment programs. Additionally, the team implemented a new CFAA Plan of Resolution (POR) process to facilitate smoother transitions for court-mandated individuals from Oregon State Hospital to community care settings. The POR process provides complex systems coordination and support, assists contractors in resolving coordination challenges and

barriers with other systems partners to ensures contractual compliance for the transition of court mandated people in the Oregon State Hospital and acute care settings to lower levels of care. This unit launched a pilot Community Navigator Team in five Oregon Community Mental Health Programs to include Clackamas, Deschutes, Lane, Marion, and Washington, and one Oregon Certified Community Behavioral Health Clinic, with Cascadia Health covering the Multnomah service area. These teams support individuals sent for restoration as they transition from the Oregon State Hospital into community settings with peer support and case management services. Lastly, updates were made to the Aid and Assist Community Restoration rules, aligning them with expert recommendations.

Challenges: Behavioral health residential capacity for court mandate populations remains a challenge, along with the increase in the Community Restoration census. Placement needs continue to outpace the capacity. A recent challenge was the establishment, recruitment, hiring and onboarding of eight new positions that were essential to support the growing forensic population and system changes required through the Mink Bowman and Mossman Federal Orders.

Currently, the lack of age criteria in Oregon's mental health civil commitment laws allows for the inappropriate involuntary inpatient detention of minors without adequate consideration of parental or guardian rights, raising concerns about the adequacy of protections for young individuals with mental health issues. This gap in Oregon's civil commitment laws contrasts with other states that have specific statutes for minors, resulting in inadequate support and treatment for youth facing mental health crises. Advocates emphasize the need to address this deficiency to ensure all individuals, regardless of age, receive appropriate care and protection under the law. The absence of age-specific provisions also raises concerns about the suitability of civil commitment for minors, given that the current system is primarily geared toward adults. Although some programs like Aid and Assist and the Psychiatric Security Review Board have youth-focused initiatives, civil commitment lacks tailored guidelines for minors. This is compounded by limited access to intensive mental

health treatment for youth in Oregon, where minors subject to civil commitment often end up in suboptimal treatment environments. Furthermore, communities of color are disproportionately represented in civil commitment cases across the state, highlighting the impact of inequitable policies. Restricting civil commitment to adults would align with principles of youth rights and parental authority, ensuring minors are not subjected to inappropriate legal processes. Implementing age-specific criteria would promote consistency and clarity in civil commitment laws, enhancing fairness and equity in the mental health care system.

The 988 & Behavioral Health Crisis System unit is dedicated to establishing and overseeing Oregon's comprehensive crisis response system, ensuring that care is trauma-informed and culturally, linguistically, and developmentally appropriate. The unit manages three key programs: the 988 helpline for behavioral health crisis intervention, Mobile Crisis Intervention Services for adults, and Mobile Response and Stabilization Services for youth and families. Additionally, it is responsible for setting up Crisis Stabilization Centers to provide immediate, local support and prevent emergency department and jail admissions.

The unit's responsibilities include designing and implementing a statewide 988 system that operates 24/7/365, as mandated by federal law and House Bill 2417 (2021). This includes developing a comprehensive state plan amendment to secure Medicaid funding for mobile crisis services and ensuring uniform standards across all insurance types. The unit also focuses on creating a statewide network of crisis stabilization centers, collecting and evaluating data on program effectiveness, and conducting public education and marketing for 988. Other key tasks involve budgeting, establishing new administrative rules, and providing centralized training through the Crisis System Training Academy for behavioral health crisis staff.

Accomplishments: The 988 & Behavioral Health Crisis System Unit has achieved significant milestones in enhancing Oregon’s behavioral health crisis response infrastructure. Celebrating its two-year anniversary in July 2024, the 988 call centers continue to operate around the clock, handling an average of over 4,400 calls

and 1,200 texts and chats monthly, with an impressive average wait time of just 20 seconds. The passage of House Bill 2757 (2023) has established a sustainable funding model through a $0.40 telecommunications fee, ensuring ongoing support for these centers. The Behavioral Health Crisis System Advisory Committee, launched in March 2024, plays a crucial role in overseeing the state's crisis system implementation. Additionally, Oregon's participation in the federal Substance Abuse and Mental Health Services Administration Crisis System Response Training & Technical Assistance State Policy Academy and the $3 million secured by U.S. Senators Jeff Merkley and Ron Wyden for a 988 public awareness campaign, alongside a three-year federal Improvement Grant from the Substance Abuse and Mental Health Services Administration, underscores the state's commitment to crisis support.

In mobile crisis services, the unit has introduced new Oregon Administrative Rules to enhance Mobile Crisis Intervention and Stabilization Services, mandating a two-person, 24/7 behavioral health response team. Furthermore, the unit has engaged in a seven-month community outreach initiative to understand the needs for Crisis Stabilization Centers, with new rules and regulations for these centers expected to be implemented by January 2025. These efforts reflect a robust and forward-thinking approach to crisis management and stabilization across the state.

Challenges: The implementation of the 988 Crisis Line faces significant challenges, including low public awareness, with only 23 percent of Americans familiar with the service. Efforts are underway to understand public perception in Oregon. In the realm of mobile crisis services, Community Mental Health Programs encounter workforce challenges, particularly in staffing overnight shifts, which are critical for ensuring a 24/7 response capability. Additionally, crisis stabilization centers face financial hurdles, as there is currently no dedicated funding stream to sustain their operations, hindering the ability to provide continuous support for individuals in crisis. These challenges highlight the need for increased public awareness, workforce development, and secure funding to enhance Oregon’s behavioral health crisis response system.

The Certified Community Behavioral Health Clinics Unit is a cross-division team dedicated to implementing Oregon's current Certified Community Behavioral Health Clinics (CCBHC) demonstration program, enhancing the CCBHC model, and expanding the program statewide under a forthcoming state plan amendment. BHD primarily oversees administrative functions, compliance, provider and community partner engagement, and coordinating overall program and policy planning. The CCBHC team includes subject matter experts from a multitude of OHA programs. This collaborative approach aims to strengthen the CCBHC model and improve access to comprehensive, coordinated behavioral health services across Oregon.

Accomplishments: Research on Oregon's CCBHC program has revealed that the model has been successful in improving access to care, addressing health disparities, and reducing emergency department and hospital use across the state. For example, a 2023 evaluation of Oregon's program found that CCBHCs increased access to treatment by 4.3 percent overall, with even greater gains in rural and remote areas (23.4 percent and 18.3 percent, respectively.) The same evaluation noted that rural adults and urban children and youth reported higher satisfaction with access to care, with Black and African American adults reporting the most significant improvements in care. Clinics have reported that the CCBHC model has enabled them to increase access to services, improve their ability to hire and retain workers, support the build out of a stronger administrative and quality improvement infrastructure internally, and strengthen their partnerships with providers and organizations across the continuum. In spite of funding lapses and agency turnover over the years, all 12 clinics that joined the demonstration are in operation today. Two additional clinics have opened with direct funding from the federal Substance Abuse and Mental Health Services Administration, and one of these two clinics is taking immediate steps to prepare for full participation once the state plan amendment is effective in 2025. Other recent programmatic accomplishments include:

- OHA successfully completed rebase of all CCBHC sites for the first time in 3 years; and

- OHA submitted CCBHC state/clinic led metrics to the Substance Abuse and Mental Health Services Administration for first time ever.

Challenges: OHA has experienced extreme staffing shortages that have hindered its ability to support CCBHCs and effectively administer the CCBHC demonstration program. This has been alleviated, in part, through funding allocated through House Bill 5204 (2024), but some key positions remain unfunded and are the subject of POP 556 – CCBHC Expansion, a collaborative POP with OHA's Medicaid Division. Presently, OHA has no additional funding to support expansion of CCBHCs once the state plan amendment is effective. This renders the agency incapable of meeting its statutory mandate to pursue a state plan amendment, due to requirements for statewide coverage. Some CCBHCs have struggled with certain parts of implementation, including meeting the state's requirement for 20-hours of on-site primary care services per week. This requirement may need to be reconsidered for Oregon's state plan amendment. Some clinics in the current demonstration faced challenges at start-up, especially with securing and implementing electronic health records and developing the quality improvement culture and infrastructure that is necessary for success in the CCBHC model. This will likely be a challenge for some providers who participate in the model when Oregon goes statewide. Some clinics have experienced challenges with determining the roles and responsibilities CCBHCs versus CCOs have around care coordination.

Background information

In April 2024, the Behavioral Health Division restructured to enhance collaboration and resource utilization, aiming to implement system investments and expand behavioral health services in Oregon. The division's mission is to support individuals, families, and communities through a community-led, culturally responsive, evidence-based approach that prioritizes advocacy, prevention, and access to affordable behavioral health care.

Behavioral Health Service Delivery

Under the Oregon Health Authority's 2025-27 resource request, the division is committed to five strategic goals: transforming behavioral health, strengthening access to affordable care, fostering healthy families and environments, achieving healthy Tribal communities, and building OHA's capacity to eliminate health inequities. These resources will enable the division to lead Oregon's behavioral health system transformation through policy development, partnerships, workforce enhancement, data modernization, and care continuum improvements. The system's success relies on strong partnerships with consumers, Community-Based Organizations, coordinated care organizations, county governments, service providers, families, and local partners, ensuring service delivery across various settings.

Revenue sources and changes

General Funds are used to support Behavioral Health Programs.

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

- The Tobacco Master Settlement Agreement
- Tobacco taxes
- Lottery Funds/Bonds
- Law Enforcement Medical Liability Account (LEMLA)
- Marijuana funds
- Drug Treatment and Recovery Services Fund (M110)
- A portion of court fines, fees and assessments related to ORS 813.270, for the Intoxicated Driver Program Fund
- Beer and Wine Taxes
- American Rescue Plan Act (ARPA)
- Opioid Settlement funds

Federal Funds include:

- Center for Mental Health Services block grant (CMHS) previously known as Mental Health Block Grant
- Substance Use Prevention Treatment Recovery Services (SUPTRS grant) previously known as Substance Abuse Prevention and Treatment (SAPT grant)

Proposed new laws that apply to the program unit

- **Legislative Concept 44300-016: Taskforce to Study and Modernize Juvenile Restoration Statutes** – OHA recommends forming a Taskforce on Restorative Services for Youth to propose reforms to clarify statutes, update terminology, and incorporate evidence-based practices. The task force should define roles, reevaluate service lengths, and ensure equitable treatment, with diverse representation to address the needs of all communities, aiming to enhance fairness and access to care for youth involved in delinquency matters.
- **Legislative Concept 44300-027: Ensuring Youth are Protected from Civil Commitment** – The proposed legislative change aims to amend Oregon's mental health civil commitment criteria to specify that only individuals aged 18 and older are eligible for civil commitment, addressing concerns about the inappropriate detention of minors and the preservation of family rights in healthcare decision-making. By restricting civil commitment to adults, this change seeks to align with principles of youth rights and parental authority, promote consistency and clarity in the law, and enhance fairness and equity in the mental health care system, especially given the disproportionate impact on communities of color and the limited access to appropriate mental health treatment for minors in Oregon.
- **Legislative Concept 44300-028: DUII Modernization** – To address challenges in Oregon's DUII service system, four policy proposals are suggested: establishing a legislatively mandated workgroup with representatives from various agencies to clarify roles and propose solutions for enhancing system effectiveness and equity; transferring monitoring responsibilities to a more suitable entity for better supervision

and rehabilitation support; amending statutory language to allow individuals facing DUII charges in Oregon to complete equivalent programs in their home state; and expanding the Intoxicated Driver Program Fund to cover screenings and education for those unable to afford these services, ensuring equitable access to intervention programs. These reforms aim to improve system efficiency, promote treatment protocol uniformity, and enhance access to necessary services for vulnerable populations, with the overall goal of reducing DUII recidivism.

System of Care Advisory Council

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Governor's Budget 2025-27	$8.21	$0.00	$1.04	$9.24	5	4.25

** Behavioral Health Division did not exist budgetarily until the 2025-27 Current Service Level*

OHA's Governor's Budget continues funding for the System of Care Advisory Council for the 2025-27 biennium and funds $570,000 for policy package 559 to allow adequate staffing to meet the council's mandates.

Activities, programs and issues in the program unit base budget

The program and services in this budget seek to create a more integrated, responsive, and equitable system of care that supports the well-being of youth across Oregon, aiming to reduce barriers to accessing essential services and promoting positive outcomes for young people and their families. SOCAC's proactive approach to policy development, assessment, collaboration, advocacy, and continuous improvement contributes to building a more integrated, responsive, and equitable system of care. Oregon continues to face fragmented service delivery across multiple sectors such as juvenile justice, child welfare, and health systems, resulting in disjointed care experiences for vulnerable youth. SOCAC aims to centralize and streamline policy development, ensuring a cohesive approach to service planning and implementation, and the need to incentivize systemic changes, address gaps in current service provisions, and promote equitable access to comprehensive care that meets the diverse needs of Oregon's youth population continues into 2025-2027.

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

System of Care Advisory Council

- Improve System Integration: Enhanced coordination and integration of services across sectors such as public health, child welfare, education, juvenile justice, mental and behavioral health, and support for individuals with disabilities.
- Ensure Equitable Access to Services: Ensured equitable access to high-quality services and supports for all youth and families, regardless of background or geographic location within Oregon.
- Reduce Disparities: Reduction of disparities in access to care and outcomes among youth, particularly those from marginalized or underserved communities.
- Increase Culturally Competent Practices: Promotion and implementation of culturally competent practices in service delivery, ensuring services are responsive to diverse cultural beliefs, practices, developmental stages, and linguistic needs.
- Develop Effective Policy and Planning: Development and maintenance of comprehensive, long-range plans and policies that address the evolving needs of youth with specialized needs and their families.
- Enhance Oversight and Accountability: Improved oversight and accountability mechanisms to monitor service delivery, outcomes, and adherence to best practices across state and local systems of care.
- Strengthen Engagement with Lived Experience Experts: Increased engagement and involvement of youth, families, and community stakeholders in shaping policies and programs that affect them directly.
- Data-Driven Decision Making: Utilization of data and metrics through the Children's System Data Dashboard to drive continuous improvement and decision-making processes.
- Sustainable Resource Allocation: Sustainable funding and resource allocation to support ongoing improvements and innovations in youth service delivery and system enhancements.

Policy package 559 funds $570,000 to fully staff the SOCAC so it can meet the mandates and adequately engage with the legislature and workgroups to address the issues the SOCAC serves.

System of Care Advisory Council

Background information

In January 2018, the Children and Youth with Specialized Needs work group was formed by the Governor, the President of the Senate, and the Chief Justice of the Supreme Court, to address unique challenges faced by children with distinctive mental or behavioral health needs who come to the attention of different systems (such as the juvenile justice system, the child welfare system, or the health system). The recommendations from this work group included the formation of a statewide system of care advisory council empowered to incentivize, change, and address gaps in current state systems meant to support children and youth with complex needs. As a result, Senate Bill 1 was passed during the 2019 legislative session, establishing a 25-member System of Care Advisory Council (SOCAC) to improve state and local systems that serve youth by centralizing statewide policy development and planning.

SOCAC serves a crucial role in enhancing the efficiency and effectiveness of state and local systems that provide services to youth. Central to its mission is the development and maintenance of a comprehensive, long-range plan for a coordinated state system of care. This plan encompasses various sectors including public health, health systems, child welfare, education, juvenile justice, and services for mental and behavioral health, as well as individuals with intellectual or developmental disabilities. The council's primary responsibility lies in formulating state system of care policies that address critical aspects such as capacity, utilization, and types of services and supports available. It is tasked with integrating diverse services like in-home behavioral health, crisis intervention, and therapeutic foster care into existing residential programs, thereby ensuring a cohesive approach to service delivery.

Furthermore, the council plays a pivotal role in assessing the effectiveness of current systems and identifying gaps in coverage. It recommends strategies to reduce juvenile dependency and delinquency, emphasizing the importance of culturally competent practices in service provision. This includes establishing guidelines that promote understanding and accessibility for youth and families across different cultural backgrounds and disabilities. The council collaborates closely with state agencies like the Oregon Health Authority, the Oregon Youth Authority, and

the Oregon Department of Human Services to oversee the implementation of services, provide oversight, and recommend improvements to enhance system effectiveness.

To fulfill its mandate effectively, the council engages in joint studies with other state entities, offers recommendations for legislative action, and updates its comprehensive plan every four years. It also maintains a Children's System Data Dashboard to monitor critical metrics like youth placements and emergency care utilization. Supported by the ability to receive grants and gifts, the council adopts rules and leverages statewide agencies to access necessary information and advice. Ultimately, the council's efforts are geared towards ensuring that all youth receive equitable access to high-quality care and support, fostering their well-being and reducing barriers to service implementation across Oregon.

Revenue sources and changes

OHA's 2025-27 Governor's Budget SOCAC budget is comprised of 89 percent General Fund and 11 percent Federal Funds.

Proposed new laws that apply to the program unit

- **LC #44300-008**: **Strengthening the System of Care** – SOCAC has four core values, one of which is "youth and family are full partners in care at the individual, program and policy levels." To improve the Council's ability to center youth and family voice in strategic planning and system transformation efforts, SOCAC needs to increase the number of youth and family voices formally present as voting members on the Council. Currently, youth and family voice accounts for 16% of the total seats on the SOCAC, as defined in Senate Bill 1 (2019). This concept adds two additional youth seats and two additional family seats, to bring youth and family voice up to 27.6% of the Council's total voting membership.

Alcohol & Drug Policy Council

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Governor's Budget 2025-27	$ 2.83	$0.00	$0.36	$3.19	7	7.00

** Behavioral Health Division did not exist budgetarily until the 2025-27 Current Service Level*

The Governor's Budget of $3.2 million Total Funds continues funding for the Alcohol and Drug Policy Commission at the current service level for the 2025-27 biennium and $840,000 to fund policy package 557 which will enhance the efficiency and effectiveness of substance use disorder services in Oregon.

Activities, programs and issues in the program unit base budget

The programs and services in this budget seek to improve the efficiency and effectiveness of substance use disorder services in Oregon. The ADPC develops, disseminates, and implements the comprehensive addiction, prevention, treatment and recovery plan for the state. Given the state's prevalence of substance use disorders, rates of overdose and other substance use-related deaths, the quickly evolving illicit drug market and health disparities related to substance use disorder, the need for enhanced and expanded substance use disorder services and supports continues into 2025-2027.

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

- Reduce the prevalence of SUDs in Oregon;
- Reduce deaths related to SUDs;
- Reduce health disparities related to SUDs; and
- Reduce the economic burden to the state resulting from SUDs.

ADPC currently has limited staff support and needs stability and sustainability to continue serving its advisory and oversight role with state agencies, the Governor and the legislature. Without stable staff support, the ADPC will be unable to provide necessary subject matter expertise on substance use disorder (SUD) treatment best practices; adequate communication with community partners and policymakers on SUD trends, barriers and responses in the state; and adequate research analysis and data sharing to effectively track outcomes and indicators in alignment with the strategic plan. Furthermore, the ADPC needs consistent and stable funding dedicated for contract procurement to continue contracting subject matter experts and consultants for the development and implementation of the 2026-2030 and beyond strategic plans. Policy package 557 addresses these issues by allowing ADPC to make positions permanent that serve these roles as well as funding to contract with organizations to develop and implement the 2026-2030 strategic plan.

Given the state's SUD prevalence, rates of overdose and other substance use-related deaths, the quickly evolving illicit drug market and health disparities related to substance use disorder, there is a high need for continued contracts to study emerging issues and treatments, evaluate best practices and make recommendations to the Governor, the legislature and state agencies.

Background information

The Alcohol and Drug Policy Commission (ADPC) is an independent state agency created by the Legislature in 2009 to improve the effectiveness of substance use services for all Oregonians. ADPC does this by working with the Governor's office, partner state agencies, providers of substance use services, people with lived experience, and others to achieve four main goals:

1. Develop a coordinated statewide system of substance use services
2. Prioritize funding and use of effective prevention strategies
3. Increase Oregon's ability to provide rapid access to treatment services

4. Expand the types and use of recovery support services.

Ultimately, all of ADPC's work is aimed at reducing Oregon's substance use disorder rate, reducing substance-use related deaths and health disparities, and reducing the economic burden of substance use spending (for example, reducing the amount of money Oregon spends on the problems of substance use, such as criminal justice spending due to substance use, and redirecting that money to prevention, treatment, recovery, and other supportive services).

In 2018, the Legislature directed ADPC to develop a statewide, comprehensive strategic plan for substance use services, which ADPC completed in 2020. The plan was approved by the Governor and the Legislature and is now Oregon's Strategic Plan for Substance Use Services for 2020-25. ADPC works with 14 participating state agencies to prioritize the work contained in Oregon's Strategic Plan, develop implementation plans and track progress and outcomes. ADPC is currently developing the 2026-30 strategic plan.

Revenue sources and changes

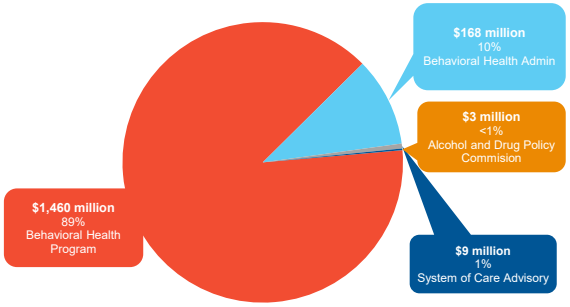
OHA's 2025-27 Governor's Budget ADPC budget is comprised of 89% percent General Fund and 11% percent Federal Funds.

Proposed new laws that apply to the program unit

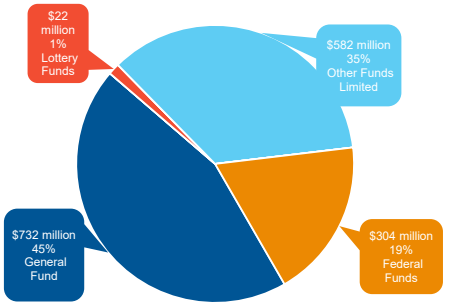
ADPC is not proposing new laws for the 2025-2027 biennium.

Oregon Health Authority
2025-27 Governor's Budget

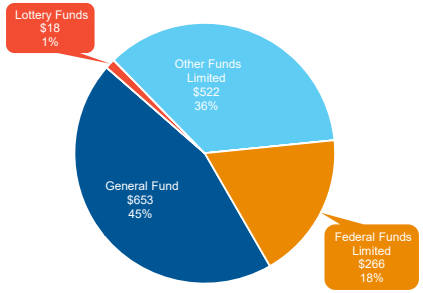
Behavioral Health Division by Program
$1,641 million Total Funds



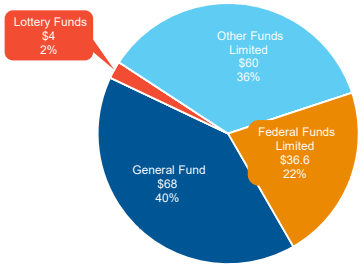
Behavioral Health Division by Fund Type
$1,641 million Total Funds



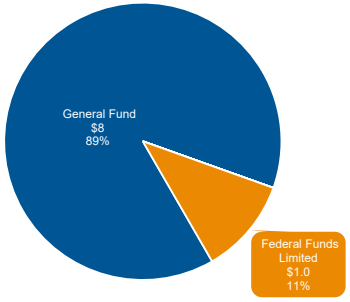
Behavioral Health Program
$1,459 million Total Funds



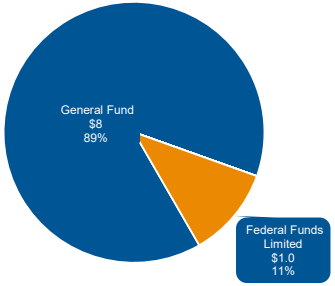
Behavioral Health Admin
$168 million Total Funds



System of Care Advisory Council
$9 million Total Funds

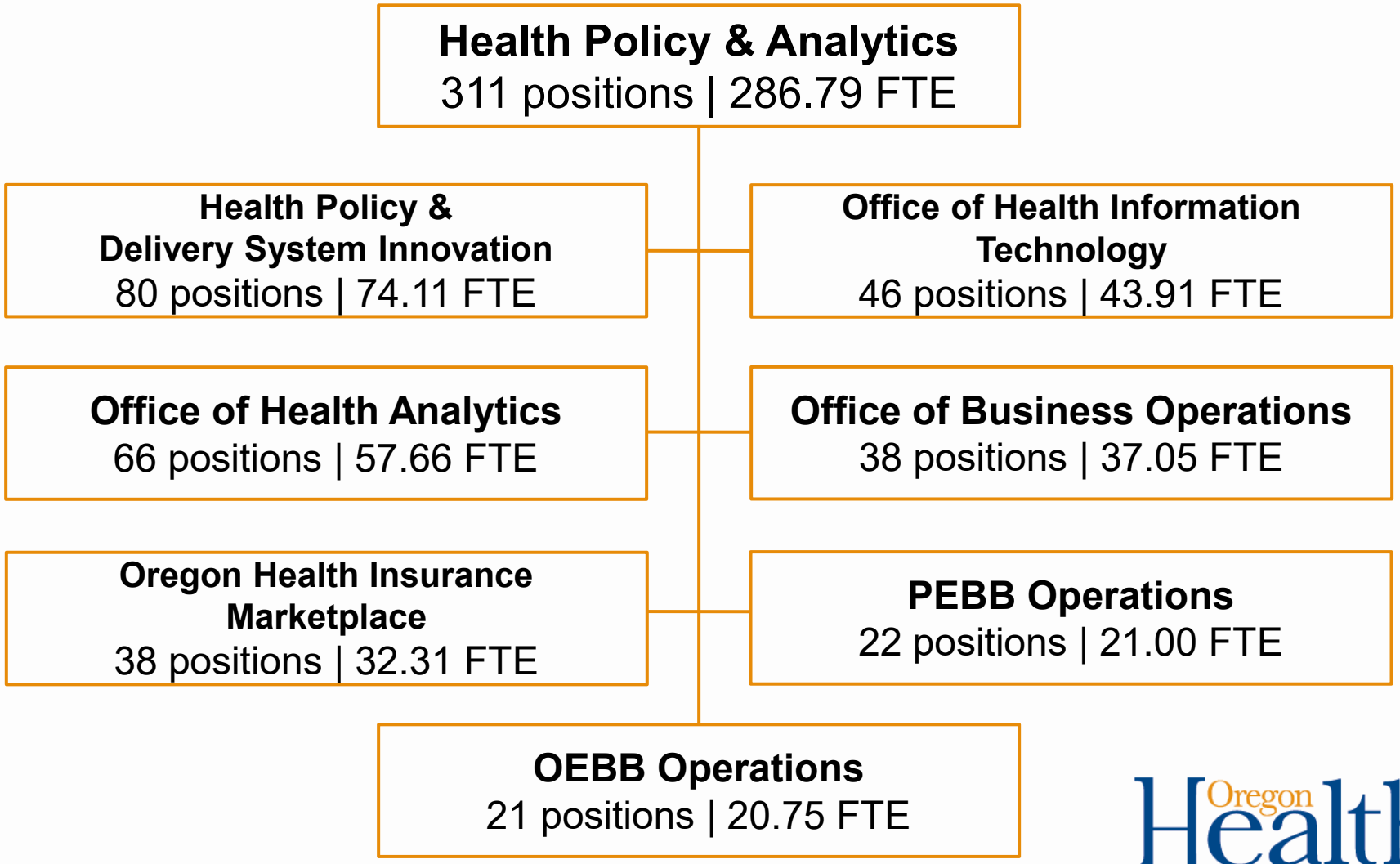


Alcohol and Drug Policy Commission
$3 million Total Funds



2023-25

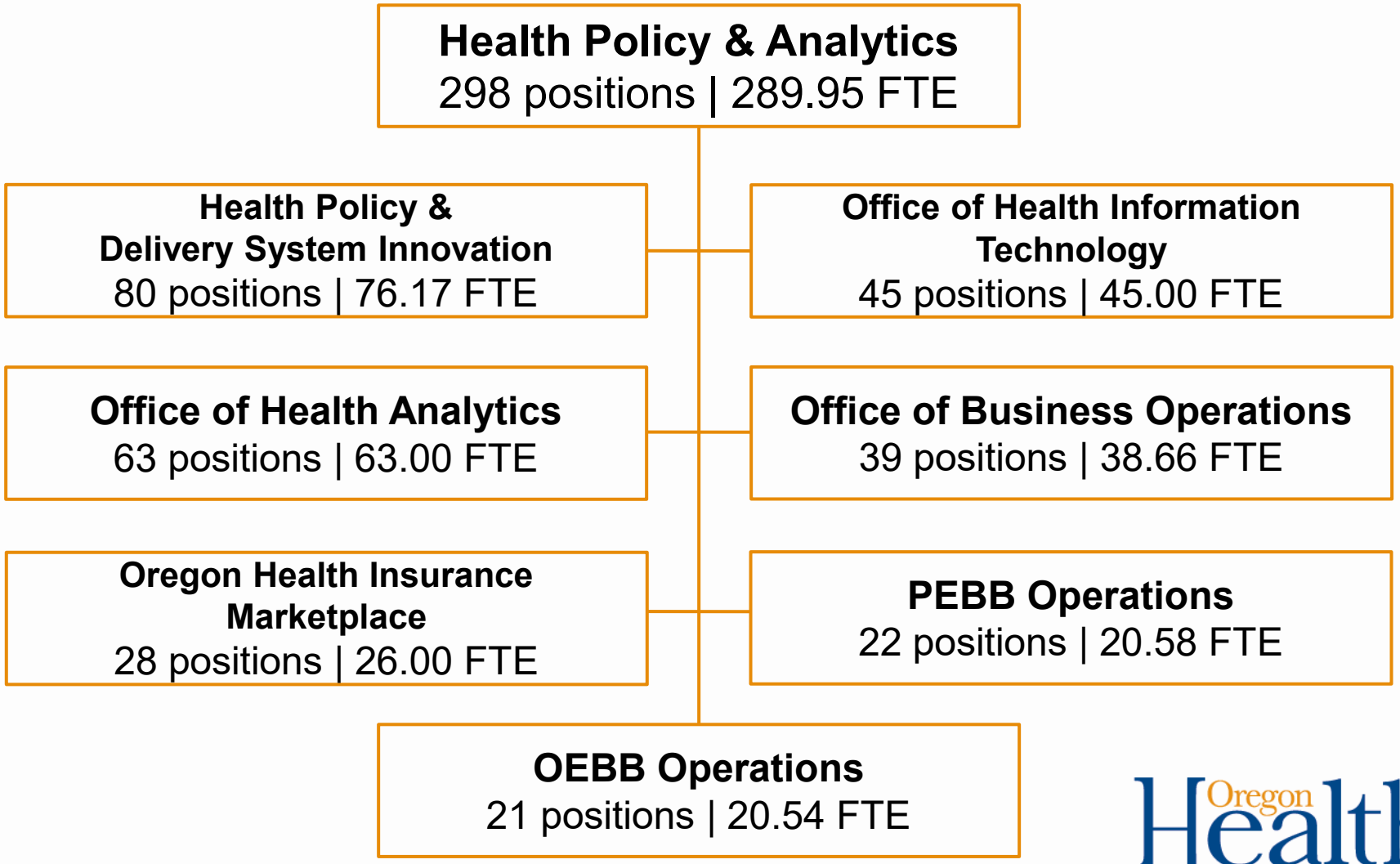
Legislatively Approved Budget



Oregon Health Authority

2025-27

Governor's Budget



Oregon Health Authority

Oregon Health Authority: Health Policy and Analytics

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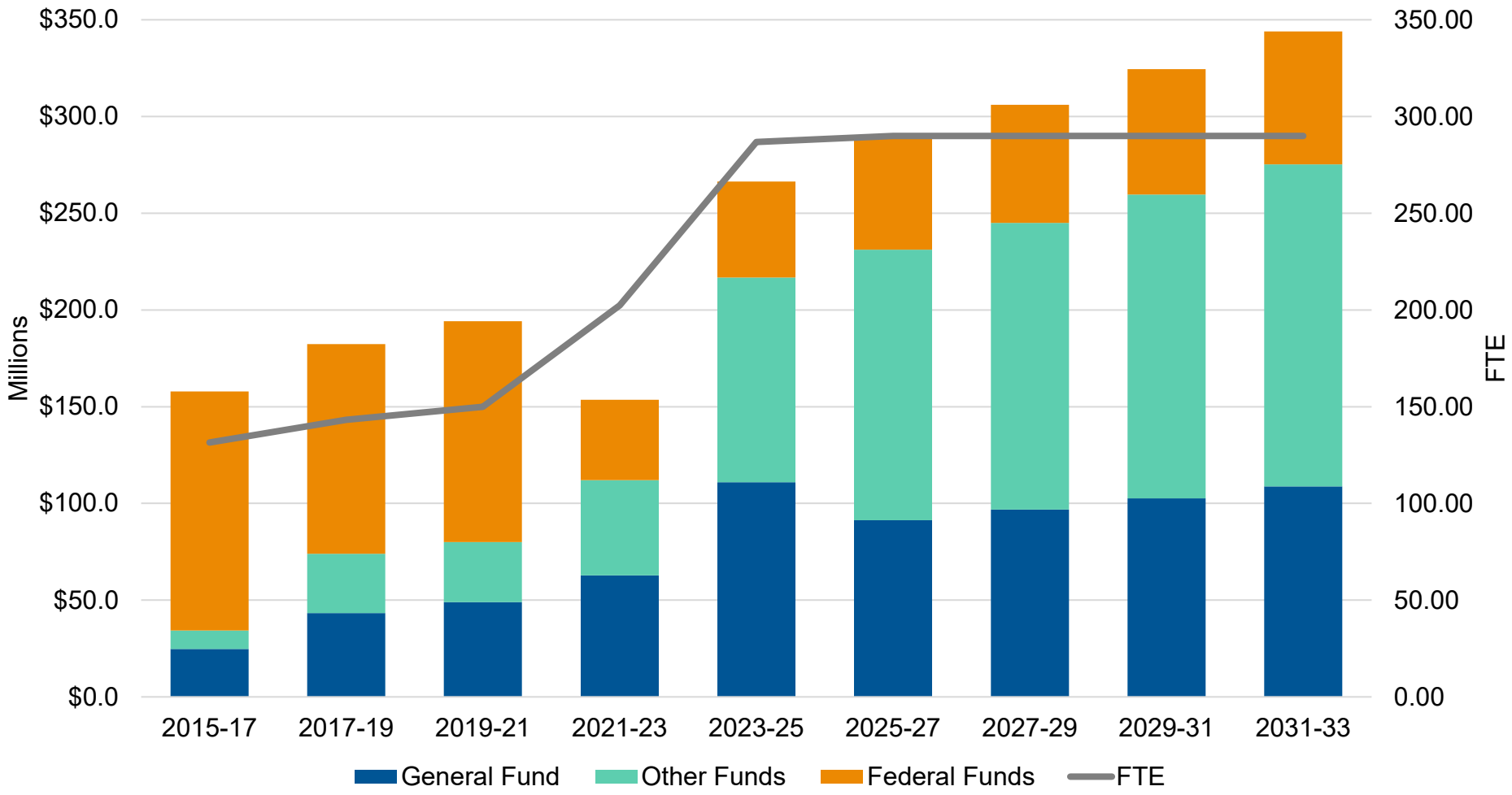
Program Contact: Clare Pierce-Wrobel Director of Health Policy and Analytics (503) 798-2714



Executive Summary

Division overview

OHA's 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 that face health inequities due to factors such as systemic racism. This is accomplished by providing expertise in agency-wide policy development, strategic planning, program design, clinical leadership, and delivery system technology tools to support care coordination, health system transformation, and health system performance. Health Policy and Analytics teams collectively provide services and support focused on achieving health equity through the triple aim of better health, better care, and lower costs.

Recommended funding

The Governor's Budget includes $288.8 million Total Funds to fund the Health Policy and Analytics division at the current service level for 2025-27, except for an administrative reduction of $600,000 in services and supplies. This budget also includes policy packages to do the following:

- POP 407 Temporarily backfills the Health Care Market Oversight (HCMO) program revenue shortfall with General Fund. 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.
- POP 423 Allows PEBB and OEBB to seek the services for RFP support, claims audits, clinical audits and support for the Joint Health Equity Workgroup (HEW), the Innovation Workgroup (IWG) and the Strategies on Evidence and Outcomes Workgroup (SEOW).
- POP 424 Funds the transition to a state-based eligibility and enrollment platform and consumer assistance center for Oregon's health insurance exchange.

Executive Summary

- POP 425 Implementing the OEBB and PEBB benefits management system replacement project. 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.

Program descriptions

OHA's Health Policy and Analytics division is accountable for leading the next phase of health system transformation and achieving OHA's 2030 goal to eliminate health inequities 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.

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

Executive Summary

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) aligns and integrates 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 (with a focus on social determinants of health and value-based payment) and related quality improvement activities; the Patient Centered Primary Care Home program and Workforce initiatives of the Primary Care Office; 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 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:

- Research, analysis, and policy development
- Coordination and tracking
- Partnerships

Current priority areas for the Office of Health Policy are health care costs, children's health care, and health care coverage.

The **Office of Health Analytics** is organized into five interconnected work units and is complemented by three analytics work units under the Office of Health Information Technology & Analytics (OHITAI) Infrastructure. OHITAI analytics teams include the Medicaid Analytics and Data Integration unit, Social Health Needs and Analytics

Executive Summary

Projects unit, and Data Equity and Engagement unit. These OHITAI teams are matrixed with Health Analytics. Together the eight health analytics teams serve these overall functions:

- Ensure the availability of high-quality reliable data through data system integration and transparent reporting;
- Analyze data, and develop strategies and tools to assess the performance of OHA programs; and
- Support OHA policy development, implementation, and evaluation.

Staff in each unit collaborate closely with analytic, policy and program colleagues across the Health Policy & Analytics Division. They also work closely with other OHA divisions such as Behavioral Health Division, the Medicaid Systems Division, the Equity & Inclusion Division, the Public Health Division, and the Oregon State Hospital, as well as other state agencies such as Oregon Department of Human Services (ODHS), and Department of Consumer and Business Services (DCBS).

The **Office of Health Information Technology & Analytics Infrastructure** is responsible for providing policy, program, partnerships, data system infrastructure, and analytics supports, including:

- Accelerating state and federal health reform goals through organized support for adoption, implementation, and integration of health information technologies, such as electronic health records, health information exchange, and community information exchange. This includes supporting patients and organizations with better access to patient information leading to better care coordination across organizations and improving quality of care.
- Working with the Office of Health Analytics to collect and analyze data on the performance of Oregon's health care system to support and inform sound policy development and decision making. This includes:
    - Ensuring the availability of high-quality reliable data through data system integration and hosting the Health Policy and Analytic division's analytics data warehouse,
    - Analyzing and reporting on Medicaid data, including reporting on new Health-Related Social Needs benefits, and

Executive Summary

- Supporting disaggregated demographic analysis (meeting Oregon's specific Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) standards), Health Analytics' data request information system, and providing other critical supports for modernizing the division's health analytics and metrics products and processes and improving customer service.

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 the Health Policy and Analytics budget while the program budgets are kept separate.

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.

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Following Oregon's transition to a state-based marketplace, the Marketplace will assume responsibility for:

- Facilitating and managing applications submitted through the state-based marketplace platform.
- Training and certifying insurance agents to guide Oregonians through the application and enrollment process.
- Providing constituent services for escalated case issues, problem solving, and handling appeals.
- Assessing enrollment data to inform health coverage policy decisions, systemic improvements, and outreach strategy.
- Training for, managing and facilitating consumer support through the state consumer assistance center.

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

Program justification and link to long-term outcomes

OHA's Health Policy and Analytics programs directly support the long-term outcomes of healthy people and health equity. Together, the seven 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

Executive Summary

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, Health Policy and Analytics 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

OHA's Health Policy and Analytics division 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. Health Policy and Analytics 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), the Oregon Health Insurance Exchange, and the Health Care Incentive Fund. By statute (ORS 243.185), PEBB can collect an amount

Executive Summary

that equals up to two 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 2023-25

None other than policy packages noted previously.

Office of Business Operations

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$4.57	$0.73	$3.62	$8.91	38	37.05
Gov. Budget 2025-27	$5.46	$1.09	$4.10	$10.65	39	38.66
Difference	$0.90	$0.36	$0.48	$1.74	1	1.61
Percent Change	20%	49%	13%	20%	3%	4%

The Governor's Budget continues funding the Office of Business Operations at the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies. It invests $200,000 to provide support in policy package 424 for the second stage of the implementation of a state-based marketplace enrollment platform and consumer assistance center.

Activities, programs and issues in the program unit base budget

OHA's Health Policy and Analytics (HPA) Office of Business Operations develops and maintains operational processes and procedures on behalf of the HPA 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.

Office of Business Operations

- 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.
- 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.

Office of Business Operations

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.

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. In addition, the Administrative Support team leverages Medicaid administrative match for eligible programs and activities that they support.

Proposed new laws that apply to the program unit

None.

Health Policy and Delivery System Innovation

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$51.51	$39.55	$20.21	$111.28	80	74.11
Gov. Budget 2025-27	$52.12	$41.40	$21.81	$115.33	80	76.17
Difference	$0.60	$1.85	$1.60	$4.05	0	2.06
Percent Change	1%	5%	8%	4%	0%	3%

The Governor's Budget continues funding the Health Policy and Delivery Systems Innovation at the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies. It invests $3.1 million for policy package 407 to offset a revenue shortfall in the Health Care Market Oversight program.

Activities, programs and issues in the program unit base budget

The Delivery System Innovation (DSI) Office and Health Policy Office provide a broad range of health system policy and program support, including policy analysis and development; technical assistance, program and development and implementation. DSI's and HP's work touches on a range of topics related to the OHA strategic plan, from strengthening access to affordable care to addressing health inequities.

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 and 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.

Health Policy and Delivery System Innovation

The Office of Health Policy includes the Sustainable Health Care Cost Growth Target Program, the Health Care Market Oversight Program, children's health policy (with a current focus on supporting implementation of 1115 waiver initiatives related to children); and expansions in health care coverage, including the Oregon Health Plan Bridge program, the Healthier Oregon Program, and the Universal Health Plan Governance Board. Policy package 407 provides $3.1 million to cover needed costs of running the Healthcare Market Oversight Program for increased workload and positions as fees do not adequately support the costs of operating the program.

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.
- 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.
- Focus the agency's clinical and delivery system knowledge and expertise on achieving transformation, quality, and cost-containment goals.

Health Policy and Delivery System Innovation

Significant cross-agency collaboration is involved in the work within the Delivery System Innovation Office. For example, the HERC partners with the Medicaid 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 delivery system policies and program strategies. The Clinical Supports, Integration and Workforce Unit partners with the Behavioral Health 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 thousands of representatives of CCOs and other payers, providers, and community partners through over 750 individual technical assistance sessions and large convenings across the entire range of OHA key health priorities, including social determinants of health, behavioral health, health equity, and value-based payment, along with providing technical assistance on the CCO Quality Incentive Metrics.

Health Policy and Delivery System Innovation

The Office of Delivery System Innovation also includes the Clinical Supports, Integration and Workforce Unit, which brings together the Patient-centered Primary Care Home Program, the Primary Care Office, and other Health Care Workforce Incentives, supporting high-quality care that minimizes health inequities through a robust primary care system and health workforce that meets patients' needs. In 2023, through House Bill 2665, the Temporary Health Care Staff Rate Setting Program was established to set the maximum reimbursement rates for temporary health care staff who provide direct care on behalf of qualifying facilities; the rates will be effective as of January 1, 2025.

In addition, Pharmacy Policy & 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.

Revenue sources and changes

OHA's Health Policy and Delivery System Innovation leverages Medicaid administrative match for eligible programs and activities, including Medicaid-related health system transformation, the Medicaid Advisory Committee, research and evaluation, and staffing. These federal funds are matched at the state level with General Fund. 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.

Health Policy and Delivery System Innovation

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

None.

Office of Health Information Technology and Analytics Infrastructure

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$9.37	$1.44	$14.82	$25.63	46	43.91
Gov. Budget 2025-27	$12.58	$1.52	$18.13	$32.22	45	45.00
Difference	$3.21	$0.08	$3.31	$6.59	-1	1.09
Percent Change	34%	5%	22%	26%	-2%	2%

The Governor's Budget continues funding the Office of Health Information Technology and Analytics Infrastructure are the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies.

Activities, programs and issues in the program unit base budget

OHA's Office of Health Information Technology & Analytics Infrastructure (OHITAI) combines HPA's health IT, data systems, and analytics infrastructure work under one reporting structure. All units play important roles in broader OHA work related to technology, data, analytics, and systems, and are integral in contributing to Oregon's 2030 goal of eliminating health inequities.

- In terms of Analytics Infrastructure, OHITAI works with the Office of Health Analytics to collect and analyze data on the performance of Oregon's health care system to support and inform sound policy development and decision making. OHITAI's analytics teams are responsible for several functions including analyzing and reporting on the Medicaid program and new Health-Related Social Needs benefits, hosting HPA's analytics data warehouse, maintaining and supporting Health Analytics' data request database and information system, support for disaggregated demographic analysis (to meet Oregon's specific Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) standards), and providing other critical supports for modernizing HPA's health analytics and metrics products and processes and improving customer service.

Office of Health Information Technology and Analytics Infrastructure

- In terms of health information technology (IT), OHITAI teams work to ensure that Oregon's transformed health care system is supported by the right health IT: that patients and organizations have better access to patient information leading to better care coordination across organizations and improving quality of care. These teams work to fulfill the vision that health IT empowers individuals and communities to reach their full health potential and well-being.[1] OHITAI's health IT teams are responsible for policies, programs, partnerships, committees, partner engagement, and more.

The Office of Health Information Technology & Analytics Infrastructure is organized into five work units – two focused on health IT-related policy and programs and three related to analytics and analytics infrastructure and supports. OHITAI's teams are complemented by five analytics work units under the Office of Health Analytics: Behavioral Health Analytics, Behavioral Health Metrics, Quality Metrics and Surveys, Research and Data, and Monitoring and Evaluation units. These Office of Health Analytics teams are matrixed with OHITAI – the full group of eight analytics teams serve the overall functions:

- Ensure the availability of high-quality reliable data through data system integration and transparent reporting;
- Analyze data, and develop strategies and tools to assess the performance of OHA programs; and
- Support OHA policy development, implementation, and evaluation.

Staff in each OHITAI unit collaborate closely with analytic, policy, and program colleagues across OHITAI and the Office of Health Analytics, and within the Health Policy & Analytics Division. They also work closely with other OHA divisions such as Behavioral Health Division, the Medicaid Division, the Equity & Inclusion Division, the Public Health Division, and the Oregon State Hospital, as well as other state agencies such as Oregon Department of Human Services (ODHS), and Oregon Housing and Community Services (OHCS).

[1] Strategic Plan for Health IT (2024-2028), Oregon's Health Information Technology Oversight Council. https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OregonStrategicPlanforHealthIT2024-2028.pdf

Office of Health Information Technology and Analytics Infrastructure

The Health IT Policy & Program Unit is working with Oregon's health care partners, communities, and consumers 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.

- Health IT includes:
  - Electronic health records (EHRs), which are used by hospitals and health care providers including physical, behavioral, and oral health providers and others.
  - Health information exchange (HIE), which is the electronic sharing of health information among health care providers, patients, health plans, or other users of health IT systems. Health information exchange may also sometimes refer to an organization that provides HIE technology services.
  - Online patient portals attached to a provider's EHR, and apps that patients can use to help manage their health conditions.
- Health IT infrastructure is needed to connect systems, increase efficiencies, and 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 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 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.

- Health IT tools can help fill gaps in care and enhance the overall wellness of people and their communities within the state.

The HIT Policy and Program unit's work is organized into three main areas:

1. Health IT policy work, which includes staffing for the legislatively mandated **Health IT Oversight Council (HITOC).**[2] HITOC reports to the Oregon Health Policy Board, and is responsible for policy, oversight, and recommendations related to health IT to support health system transformation and health equity.
   - In 2024, HITOC completed a new **Strategic Plan for Health IT (2024-2028),**[3] after significant community engagement and two workgroups on community information exchange (CIE) and HIE. The plan includes HITOC's Vision, Goals, Principles, Strategies, and Activities for health IT in Oregon. The Strategies focus on patients and consumers, electronic health records (EHRs), health information exchange (HIE), community information exchange (CIE), interoperability, and governance. The Strategic Plan is for everyone using or impacted by health IT in Oregon, including but not limited to consumers and patients, providers and clinic staff, community-based organizations (CBOs), hospitals, health systems, coordinated care organizations (CCOs) and health insurance plans (payers), technology partners, and state agencies.

   Other health IT policy work includes policy analysis, exploration and development of new initiatives, education and technical assistance, internal OHA/ODHS coordination including partnering with Medicaid, Behavioral Health, Oral Health, Public Health, and ODHS teams, and external coordination and convening. This team also supports data collection, analysis, evaluation, and reporting on the health IT landscape in Oregon.

[2] https://www.oregon.gov/oha/HPA/OHIT-HITOC/Pages/index.aspx
[3] https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/OregonStrategicPlanforHealthIT2024-2028.pdf

2. HIE programs and partnerships, which includes the **HIT Commons**,[4] a public/private partnership co-sponsored by OHA and the Oregon Health Leadership Council and jointly funded by OHA, all Oregon hospitals, all major health plans and CCOs. The HIT Commons governs two initiatives:
    - **PointClickCare Collective Medical Platform** (also known as EDIE/PreManage, hereafter referred to as PCC): PCC 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. 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. PCC brings real-time hospital event notifications to participating CCOs, health plans, providers, and OHA/ODHS programs who subscribe to receive real-time 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 PCC, adding Oregon's data to the data from Washington and other states. In 2019, Oregon's Skilled Nursing Facilities (SNFs) were able to join PCC, and today over 80 percent of SNFs in Oregon participate.
        - Today, all CCOs and major health plans are subscribed to PCC, most of whom extend this service to their key contracted physical, behavioral, and oral health partners. This includes 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.
        - OHA supports the Medicaid PCC program, which supports CCOs, dental care organizations, Tribal clinics, Medicaid fee-for-service contractors and others. OHA/ODHS programs also use PCC– 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 Agencies on Aging and Aging & People with Disability District offices, and ODHS Intellectual & Developmental Disability program staff and contractors.

[4] https://ohlc.org/partner-initiatives/hit-commons/

- **The Oregon Prescription Drug Monitoring Program (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. This HIT Commons program is managed in partnership with OHA's Public Health Division, which oversees the PDMP program.
- These programs are operational and continue to evolve and enhance services, expanding use cases and functionality. OHITAI 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.

3. CCO health IT compliance and technical assistance, which includes:
   - CCO health IT contractual compliance and reporting, including annual Health IT Roadmap and data reporting and producing CCO Health IT Roadmap summaries. **CCO Health IT Roadmaps** and other CCO contractual health IT requirements help 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 PCC), and health IT to support social determinants of health (SDOH) as well as CCO internal use of health IT for care coordination and supporting SDOH needs. All CCOs have OHA-approved Health IT Roadmaps and annually update Roadmaps and report on progress. Starting in 2022, CCOs provide OHA with annual data on EHR and HIE adoption for their contracted providers as part of their Roadmap submission.
   - Convening quarterly **CCO Health IT Advisory Group (HITAG)**[5] meetings with all CCOs, providing technical assistance and cross-CCO learning opportunities.

The Community Information Exchange (CIE) Policy & Program Unit is responsible for setting the strategic direction for the use of CIE statewide and supporting Medicaid programmatic and administrative functions. This

[5] https://www.oregon.gov/oha/HPA/OHIT/Pages/HITAG.aspx

includes managing CIE policy, partner engagement, as well as the development, implementation, and operations of the CIE program. In particular, the unit provides new CIE technology services to support Oregon's historic 1115 Medicaid Waiver (2022-2027) and support Oregon's Medicaid/Oregon Health Plan program. The work of this unit impacts community groups, policy makers, program leadership, health care and social service partners, partner agency leadership, and consumers.

- CIE[6] 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 services, health care, and other organizations. Technology functions must include closed loop referrals, a shared resource directory, and informed consent. Adoption and use of CIEs have grown rapidly across Oregon in recent years, with a focus on referrals to help address SDOH needs.
- CIE supports OHA's goal of eliminating health inequities by 2030 by connecting health care organizations and social service providers to help people in Oregon when they need safety net programs and other supports.
- This unit focuses on the use of CIE tools to manage referrals to new Medicaid Health Related Social Needs (HRSN) services such as housing, nutrition, and climate supports.

The Social Health Needs and Analytics Projects (SHNAP) Unit is responsible for providing technical and data support for OHA's work to implement Oregon's 1115 Medicaid Waiver (2022-2027), Medicaid children's services such as the Early Periodic Screening Diagnosis and Treatment benefit, and for other Medicaid special projects. This unit focuses on data collection, analysis and reporting related to new HRSN services for Medicaid members undergoing major life transitions.

This unit develops, implements, and operates new data collection, analysis, and community collaboration related to data and reporting programs. This unit develops and publicly reports HRSN services utilization and related data to community groups, policy makers, program leadership, health care and social service partners, partner agency

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

leadership, and consumers. Staff analyze and evaluate these data along with information from other sources to inform and advance programs and policies.

The Medicaid Analytics and Data Integration Unit[7] analyzes and reports Medicaid health care claims and program data to other agency partners and interested parties to support Medicaid programs, decision-making and policy. This unit also provides technology, system, and infrastructure support for health analytics teams in HPA and OHA. Specific functions include:

- Analysis, reporting, interpretation, and development of analysis for OHA'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, including data warehousing, server management, and documentation

The Data Equity and Engagement Unit supports many functions across HPA through two teams:

- The Infrastructure for Data Engagement and Access team works to advance the use of business intelligence tools and data visualization techniques throughout HPA to strengthen the connection between the data and policy/decision makers, develop report development standards, provide training and technical guidance on reporting tools, support and maintain the Data Request Tracking System used to log, track and archive all data, report and analytics requests fulfilled by Health Analytics' teams, and improve reporting and analytical processes and infrastructure.
- The Data Equity team works in partnership with the Equity and Inclusion Division and various agency partners to support the collection, analysis and reporting of REALD and SOGI data. Collecting and reporting REALD and SOGI data is vital in supporting OHA's goals of eliminating health inequities by 2030.

[7] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/medicaid.aspx

Office of Health Information Technology and Analytics Infrastructure

Background information

In the 2023-25 LAB, the new OHA OHITAI budget structure was formalized, which reflected the following major changes:

1. In December 2022, HPA made some modest structural changes between the Health Analytics and health IT offices to better align similar work and rebalance management resources. These changes meant that the previous Office of Health IT became the Office of Health Information Technology & Analytics Infrastructure. This office retained the health IT role in its Health IT Policy & Program unit, added the Medicaid Analytics and Data Infrastructure unit (which had been part of the Office of Health Analytics), and formalized the reporting structure of the Data Equity and Engagement Unit (Business Intelligence and Data Equity teams), which had been created earlier in 2022.
2. In September 2022, Oregon received federal approval for its 1115 Medicaid waiver, which included new HRSN services such as housing and nutrition supports and a focus on coordinating health care and social services for Medicaid members undergoing major life transitions. To implement the waiver requirements, the Legislature approved the necessary resources. Included in this funding were new positions for OHITAI, resulting in two new units: the CIE Policy & Program unit and the Social Health Needs and Analytics Projects unit (described above).
3. Additional positions were established in the Data Equity and Engagement team and Medicaid Analytics and Data Infrastructure teams.

During the 2023-25 biennium, OHITAI supported or implemented numerous high-priority policy, program, or analytics initiatives, including:

Behavioral Health Information Exchange

- **Reduced emergency department visits for high utilizers.** Broad use of PCC (aka EDIE/Collective Medical Platform) across Oregon has led to some astounding results. Emergency department visits by high utilizers

decreased by 37 percent in the 90 days following the initial creation of a care guideline in PCC for Q2 2023-Q1 2024 compared to Q2 2022-Q1 2023[8]. This program allows everyone working with a patient to know when they have been in the ED or hospital and coordinate their care across providers including in primary care, CCO or health plan, behavioral health, dental care organizations, and hospitals. These impacts are especially relevant for individuals experiencing mental illness and/or substance abuse disorder. In 2023, the proportion of Oregon ED visits related to mental health decreased by 23.4%, with visits related to substance use disorder decreasing by 9.9% compared to the previous year.

- **Connecting Oregon State Hospital** to PCC in 2024 to ensure that Oregon's broad care coordination network has real-time insight into transitions in and out of the Oregon State Hospital. Oregon State Hospital residents are a priority population of the 1115 Medicaid Waiver and current care coordination relies on information about Oregon State Hospital visits shared via email or other manual means. The Oregon State Hospital's connection to PCC will mean real-time Oregon State Hospital admission, transfer, and discharge data will be available in the platform and visible to those treating or caring for patients admitted to or discharged from the Oregon State Hospital, such as providers, behavioral health, and CCOs.
- **Connecting carceral settings to PCC** in 2024. OHITAI and HIT Commons have consulted with the Oregon Department of Correction (DoC) team working to implement DoC's first electronic health record, which will integrate with multiple health information exchanges and statewide solutions in Oregon including PCC. County jails are also beginning to onboard onto PCC with the support of HIT Commons staff. HIT Commons is also exploring connections to carceral settings that can contribute data to these systems but will not onboard as end users. This work is critical to connecting carceral settings to existing care coordination workflows and networks.
- **Reduced gaps in data access for behavioral health clinics** by promoting the use of Epic's EpicCare Link for behavioral health providers in Oregon. HIT Commons began this work with the Marion/Polk County region of the state and is now working on expanding this campaign statewide. Through use of EpicCare Link, virtually

[8] https://ohlc.org/wp-content/uploads/2024/12/Q1-2024-EDIE-Quarterly-Report.pdf

all medical records requests from behavioral health providers to hospitals across Oregon could be reduced and/or eliminated.

- **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.[9] Integration of PDMP access into the prescriber's EHR removes the need to remember passwords and log into the PDMP portal. More than 20,000 prescribers at more than 2,000 health care facilities in Oregon actively benefit from "one-click" access to controlled substance prescription data in Oregon's PDMP.

Health Related Social Needs (housing, nutrition, climate) and 1115 Medicaid Waiver (2022-2027) In 2023, OHITAI established the CIE and SHNAP teams to support the policy, programmatic, and analytics needs of the 1115 Medicaid waiver work. These teams participated in policy, contract, administrative rule, data, system, and implementation decisions to support the HRSN benefits. These teams also developed data and analytics structures to manage and report a variety of information about the state's landmark health-related services program.

- OHITAI's CIE team developed contract and OAR language to support the programmatic needs of the 1115 Medicaid Waiver in the areas of closed loop referrals and CIE. OHA expects to launch CIE services to support HRSN benefits for Medicaid Open Card (fee for service) members in Fall/Winter of 2025. OHA received CMS approval for the use of federal 90% Medicaid Enterprise Systems match to implement CIE. Also in 2025, OHA contractors will support CCO and CBO technical assistance, convening, and governance development related to CIE.
- Reporting on HRSN services will require knitting together a complex web of health and social services data sources, including building and maintaining strong cross-agency partnerships and data use agreements.

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

OHA's SHNAP team developed contract and reporting language and data collection tools to support program monitoring and produced analytics and reporting of early progress on waiver activities. The team expects to build both programmatic monitoring tools and public interactive reporting to equip partners with regular updates about waiver programs and activities. The team will also engage contractors to support a data equity and data justice project focused on creating accessible and community-centered data and analytics products for Oregon communities.

Medicaid Program Analytics: OHITAI teams supported improved and revamped interactive Medicaid membership dashboards, including the Medicaid enrollment dashboard[10] and Medicaid demographic dashboard[11] which now include granular REALD data on Medicaid members served by CCOs and Open Card (fee for service).

REALD/SOGI Implementation and Analytics: In 2021, the Oregon Legislature passed House Bill 3159 which requires all Oregon health providers and health plans to collect REALD and SOGI data annually for their patients or members and report those data to OHA. OHA is required to:

- Add SOGI questions to the current data collection standards in OHA Oregon Administrative Rules,
- Build a data collection system for both REALD and SOGI, and
- Develop and implement reporting requirements (including rulemaking) for provider and health plan reporting.

OHITAI's Data Equity team provided critical supports to HPA's health analytics staff to implement and support training and effective use of REALD data. The team participates in the broader HB 3159 implementation work led by the Equity & Inclusion Division and the Office of Information Services, in partnership with other OHA units.

With the support of OHITAI's Data Equity team, HPA REALD/SOGI 2023 accomplishments include:

[10] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/medicaid-enrollment.aspx
[1111] https://www.oregon.gov/oha/HPA/ANALYTICS/pages/medicaid-demographics.aspx

- Embedding REALD data in several HPA data collection efforts, including:
  - Oregon Health Insurance Survey (OHIS)[12]
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (adult and child)[13]
- Incorporating full REALD data from the Equity & Inclusion REALD repository in major dashboards, reports, and analyses, including:
  - Healthier Oregon Report[14]
  - 2022 CCO Metrics Performance Dashboard (Including repository data)[15]
  - 2022 Health Care Workforce Diversity Report[16]
- Incorporating Data Equity into CCO incentive metrics.
- Providing Data Equity training for HPA staff, including Equity & Inclusion Division's Data Analytics Institute for the use of REALD and SOGI data.

Revenue sources and changes

OHA's Office of Health Information Technology & Analytics Infrastructure leverages Medicaid administrative match for eligible programs and activities, including Medicaid-related health system transformation, technology, analytics, and staffing.

[12] https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Dataprofile_OHIS.pdf
[13] https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/Dataprofile_CAHPS.pdf
[14] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-110196.pdf
[15] https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome?%3Aembed=y&%3AisGuestRedirectFromVizportal=y
[16] https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/HWRP_Diversity_2022_final.pdf

Office of Health Information Technology and Analytics Infrastructure

Health IT and CIE policy and program work are expected to leverage a combination of federal Medicaid Enterprise Systems (MES) Medicaid match (90 percent Federal Funds, 10 percent state funds), Medicaid Designated State Health Program (DSHP), and Medicaid administrative match (50 percent Federal Funds/state funds). Applicable health IT-systems related work will transition in future years to ongoing 75 percent Federal Funds and 25 percent state funds MES match rate.

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 a blended statewide match rate.

Proposed new laws that apply to the program unit

None

Office of Health Analytics

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$16.65	$2.94	$11.00	$30.59	66	57.66
Gov. Budget 2025-27	$21.19	$2.55	$13.59	$37.34	63	63.00
Difference	$4.55	-$0.39	$2.59	$6.75	-3	5.34
Percent Change	27%	-13%	24%	22%	-5%	9%

The Governor's Budget continues funding the Office of Health Analytics at the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies.

Activities, programs and issues in the program unit base budget

OHA's Office of Health Analytics 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 community benefit data; licensed health care workforce data; data about health insurance coverage; administrative health insurance claims through the All Payer All Claims (APAC) database and the Medicaid Management Information System (MMIS); the Oregon Data Environment (formerly the Behavioral Health Data Warehouse); M110 Behavioral Health Resource Network (BHRN) data; Race, Ethnicity, Language and Disability (REALD) data; 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 interconnected work units – further described below – and is complemented by three analytics work units under the Office of Health Information Technology & Analytics Infrastructure (OHITAI). OHITAI analytics teams include the Medicaid Analytics and Data Integration unit, Social Health Needs and Analytics Projects unit, and Data Equity and Engagement unit. These OHITAI teams are matrixed with Health Analytics – the full group of eight analytics teams serve these overall functions:

Office of Health Analytics

- Ensure the availability of high-quality reliable data through data system integration and transparent reporting;
- Analyze data, and develop strategies and tools to assess the performance of OHA programs; and
- Support OHA policy development, implementation, and evaluation.

Staff in each unit collaborate closely with analytic, policy and program colleagues across the Office of Health Analytics and OHITAI, and within the Health Policy & Analytics Division. They also work closely with other OHA divisions such as Behavioral Health Division, the Medicaid Systems Division, the Equity & Inclusion Division, the Public Health Division, and the Oregon State Hospital, as well as other state agencies such as Oregon Department of Human Services (ODHS), and Department of Consumer and Business Services (DCBS).

The Behavioral Health Analytics Unit collects, analyzes and reports behavioral health data to other OHA programs, as well as state and national funders by:

- Developing, analyzing and reporting on data metrics for the BHRNs funded by Measure 110.
- Analyzing and reporting CCO behavioral health metrics to the Quality Metrics, Surveys and Reporting Unit.
- Analyzing and reporting annual state-led metrics for the Certified Community Behavioral Health Clinics (CCBHC) program.
- Operationalizing, calculating, and reporting quarterly and annual metrics for the Substance Use Disorder 1115 Demonstration Waiver.
- Analyzing, reporting, interpreting, and developing dashboards and other reports based on behavioral health program needs.
- Providing ongoing technical consultation to behavioral health programs around their data needs.
- Analyzing, reporting, and interpreting data from the Oregon Health Authority Data Environment (formerly known as the Behavioral Health Data Warehouse) for the Behavioral Health Division and the Medicaid Systems Division.

Office of Health Analytics

- Extracting and submitting client-level treatment episode data (TEDS) for the Substance Abuse and Mental Health Services Administrations' Behavioral Health Services Information System (BHSIS).
- Extracting data and conducting aggregate analyses for external research and evaluations.
- Supporting the analytic needs of Oregon's System of Care, which is a cross system collaboration supporting youth and families who have complex and significant behavioral and mental health needs.

The Behavioral Health Quality Metrics Unit supports the development of behavioral health quality metrics through:

- Planning and supporting calculation of behavioral health metrics.
- Conducting research into nationally recognized metrics for behavioral health outcomes.
- 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 Behavioral Health Committee to explore behavioral health metrics.

With newly expanded responsibilities in the 2023-2025 biennium, the Quality Metrics, Surveys and Reporting Unit facilitates using quality metrics in Oregon's health system through:

- Measuring CCOs' performance using the CCO incentive metrics, state quality metrics and CMS Adult and Child Core set metrics, including disaggregating by REALD to assess disparities and health inequities.
- Developing interactive data displays to showcase CCO performance on the metrics.
- Coordinating and facilitating the Metrics & Scoring Committee, which is a public committee charged with selecting the CCO incentive metrics and making design decisions about the program structure.
- Coordinating and facilitating a contractor to study the CCO quality incentive program to develop recommendations for programmatic changes and changes to the subcommittee structure so that the design of the CCO quality incentive program is primarily focused on addressing health inequities, including the structural drivers of health inequities.

Office of Health Analytics

- Assessing the feasibility of, and setting up, a quality incentive program for the Basic Health Program.
- Assessing member experience and conducting 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.
- Developing and collaborating with partners to develop upstream metrics to track the most innovative aspects of the health care transformation, including health equity[1], social determinants of health,[2] meaningful language access to culturally responsive care,[3] and health-aspect of kindergarten readiness social-emotional health[4]
- Collaborating with external data stewards to understand and apply changes to metrics specifications.

The Research and Data Unit produces data and analyses for state government and external partners by:

- Managing, analyzing and reporting on the Oregon's APAC database, which includes health insurance claims and member information for approximately 92 percent of Oregon residents; providing APAC data for analysis by state agency partners and external researchers.
- Collecting, analyzing, reporting, and interpreting data, and developing dashboards, presentations and reports featuring health care workforce data from licensees of 17 health care licensing boards.
- Analyzing, reporting and interpreting data, and developing dashboards, presentations and reports featuring hospital inpatient, outpatient and emergency department data, hospital financial data including community benefit reporting, and other critical hospital information.
- Maintaining the Hospital Community Benefit Minimum Spending Floor program.
- Implementing HB 3320 (2023), which makes hospital financial assistance more accessible to patients.

[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
[3] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Meaningful-Language-Access-FAQ-231114.pdf
[4] https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Social-Emotional-Health-Metric-FAQ.pdf

- Providing data expertise support to the Legislative Policy and Research Office for House Bill 3396 (2023), which creates a joint task force on challenges hospitals face when discharging patients to post-acute care settings such as nursing homes, residential care facilities, and in-home care.
- Providing data support for House Bill 2665 (2023), which requires OHA to adopt rules and set maximum rates for some types of providers (generally related to nursing) employed by temporary staffing agencies operating in Oregon hospitals, Long Term Care facilities, and other specific facilities.

Newly formed in the 2023-2025 biennium, the Monitoring and Evaluation Unit is responsible for:

- Overseeing and managing the independent contractor accountable for implementing the 2017-2022 1115 Oregon Health Plan (OHP) Demonstration Waiver evaluation.
- Overseeing and managing the independent contractor(s) responsible for the evaluation design and the implementation of the approved evaluation design for the 2022-2027 1115 OHP Demonstration Waiver.
- Coordinating quarterly and annual analysis and reporting of waiver measures outlined in the Waiver monitoring protocol.
- Managing evaluation services price agreement process as a resource to meet for HPA's evaluation needs.

Background information

In the 2023-25 Legislatively Adopted Budget, a new structure for the Office of Health Analytics was formalized, which reflects the modest structural changes between the Health Analytics and health IT offices to better align similar work and balance management resources. These changes moved the **Medicaid Analytics and Data Infrastructure Unit** out of the Office of Health Analytics, and formalized the reporting structure of the **Business Intelligence, Data Equity Unit** (which had been created earlier in 2022). Both units now reside in the Office of Health Information Technology & Analytics Infrastructure.

Office of Health Analytics

During the 2023-25 biennium, new Health Analytics high-priority work included:

Implementing Improvements to Hospital Financial Assistance. House Bill 3320 (2023) aims to make it easier for hospital patients to receive financial assistance through three main provisions: 1) screening patients for presumptive eligibility; 2) a robust, transparent appeals process; and 3) additional data reporting to OHA to monitor patient financial assistance approvals, denials, and debt collections. Oregon already had generous hospital financial assistance policy requirements, requiring a reduction of all hospital bill costs for patients with household incomes up to 200 percent of the Federal Poverty Level (FPL) and partial assistance for those with up to 400 percent of the FPL. HB 3320 aims to ensure that patients who already qualified for this financial assistance are more likely to receive it. Through extensive collaboration with partner organizations, hospitals, the Hospital Association of Oregon, and community members, Health Analytics drafted and implemented administrative rules for those three provisions and will begin collecting data from hospitals in January 2025.

Supporting the Legislative Joint Task Force on Hospital Discharge Challenges. House Bill 3396 (2023) created a joint taskforce on the challenges hospitals face when discharging patients to post-acute care settings such as nursing homes, residential care facilities, and in-home care. The task force includes 22 members spanning industry, community, and state agency domains. The Legislative Policy Research Office (LPRO) is taking the lead in supporting the taskforce through research and recommendations, including an interim report on December 15th, 2023 and a final report due November 15, 2024. Health Analytics has provided extensive support in identifying and procuring datasets, gathering information, and conducting analyses for LRPO research and taskforce presentations.

Focusing the CCO Quality Incentive Program on Health Equity. In Senate Bill 966 (2023), the Legislature tasked OHA with studying the Quality Incentive Program and providing recommendations for programmatic and governance structure changes. The intent of the study and recommendations is to align the design of the program to focus primarily on addressing health inequities. Health Analytics staff are overseeing two contracted studies of the

program and will take the lead in proposing Legislative action where needed to enact recommendations. This report is due to the Legislature on September 15, 2024.

Other Health Analytics reports reflecting work in the 2023-25 biennium include:

CCO Metrics Reports

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

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

- Tableau dashboard[10]
- Website with historical reports[11]

Health Care Payment Arrangement Dashboard

- Tableau dashboard[12]

[5] https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome
[6] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2021_CCO_metrics_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://visual-data.dhsoha.state.or.us/t/OHA/views/CommunityBenefitDashboard/Dash-Welcome
[11] https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
[12] https://visual-data.dhsoha.state.or.us/t/OHA/views/2022OregonHealthCareValue-BasedPaymentReport/welcome

Office of Health Analytics

Hospital financials (quarterly hospital financial and utilization data)

- Tableau dashboard[13]
- Tableau dashboard appendix with individual hospital data[14]
- Static report summaries of current trends and historical reports[15]

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

- Tableau dashboard[16]
- Website with data files and historical reports[17]

Health care workforce reports

Occupational profiles: Tableau dashboard[18]
Website with historical reports[19]

Measure 110

- Drug Addiction Treatment and Recovery Act (M110) Report[20]

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13 https://visual-data.dhsoha.state.or.us/t/OHA/views/Databankdashboard/MainPage
14 https://visual-data.dhsoha.state.or.us/t/OHA/views/databankdashboardappendix/Welcome
15 https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
16 https://visual-data.dhsoha.state.or.us/t/OHA/views/OregonHospitalPaymentReport2021/Home
17 https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
18 https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonslicensedhealthcareworkforce/Overview
19 https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx
20 https://app.powerbigov.us/view?r=eyJrIjoiODU1NDNlNzUtMDBkNy00NTM1LWE4NzgtNGEyNzQxYWY0NTU2IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9

Office of Health Analytics

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

- Overview of OHIS and links to resources and past static reports[21]

Revenue sources and changes

OHA's 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

None.

[21] https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Insurance-Data.aspx

Oregon Health Insurance Marketplace

Expenditures by fund type, positions, and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$28.85	$17.25	$0.00	$46.10	38	32.31
Gov. Budget 2025-27	$0.00	$41.89	$0.00	$41.89	28	26.00
Difference	-$28.85	$24.64	$0.00	-$4.21	-10	-6.31
Percent Change	-100%	143%	0%	-9%	-26%	-20%

The Governor's Budget continues funding the Oregon Health Insurance Marketplace for the 2025-27 biennium and invests $25.0 million Other Funds for policy package 424 for the second stage of implementation of a state-based marketplace enrollment platform and consumer assistance center.

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

OHA administers the Oregon Health Insurance Marketplace (Marketplace), which supports (1) achieving the triple aim of better health, better care, and lower costs; and (2) helping to ensure Oregonians who purchase commercial health insurance in the individual market have easy access to high quality, affordable health care by helping Oregonians leverage federal subsidies and enroll in private health insurance plans that best fit their health and financial goals and needs. Through targeted, equity-centered outreach (described below) to communities that have been disproportionately affected by health and social inequities, including the Nine Federally Recognized Tribes of Oregon, the Marketplace is supporting OHA's efforts to end health inequities by 2030 and to build healthy Tribal communities. Requested resources will be used to invest in and build on the below existing programs and ongoing activities to maintain current service levels for the 2025-27 biennium.

Policy package 424 will allow OHA to fund the second stage of Oregon's transition away from the federally facilitated marketplace (FFM) to a state-based eligibility and enrollment platform and consumer assistance center for operation and administration of Oregon's health insurance exchange. Moving away from the FFM will create new

opportunities for Oregon to pursue state priorities to advance health equity, enroll more people in affordable, high-quality health coverage, and improve the experience of current enrollees. Real-time access to race, ethnicity, language, and disability (REALD) and sexual orientation and gender identity (SOGI) data will help the Marketplace tailor outreach and be more intentional about efforts to enroll disproportionately uninsured people, including people of color and rural residents.

Programs

Program Administration:

- Works with federal partners to ensure eligibility and enrollment systems are available and accessible to Oregonians.
- Creates equity-centered outreach and education strategies to drive enrollment of individuals within communities of focus.
- Develops rules and policies to help eliminate health inequities and monitors the market for emerging trends.
- Engages partners from diverse communities to gather feedback when establishing and implementing policy.
- Approves carriers and certifies qualified health plans 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.

Outreach and Education:

- 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.

Oregon Health Insurance Marketplace

- 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 and insurance agents. Cultivates relationships with Oregon Tribal communities and provides outreach, education, Tribal health insurance policy, and operational direction services. Provides grants to support Tribal outreach events.
- Cultivates relationships and provides subject matter expertise support to Marketplace partners and community-based organizations.
- Provides English and Spanish training and certifies more than 1,600 community partners on Marketplace application assistance.
- Assists Oregonians with complex case resolution.
- Manages a call center dedicated to answering questions from individuals seeking enrollment in a qualified health plan.

Additional Responsibilities with State-based Marketplace Implementation:

- Assesses enrollment data to inform health coverage policy decisions, systemic improvements, and outreach strategy.
- Facilitates and manages applications submitted through the state-based marketplace platform.
- Trains and certifies insurance agents to guide Oregonians through the application and enrollment process.
- Manages a consumer assistance center to assist customers with questions, enrollments, and resolution of common Tier 1 and Tier 2 issues. Provides constituent services for escalated case issues, problem solving, and handling appeals.

Oregon Health Insurance Marketplace

Activities

During the 2023-25 biennium, the Oregon Health Insurance Marketplace had numerous accomplishments, including the following:

- Achieved enrollment of 141,963 and 145,509 individuals for the 2023 and 2024 plan years respectively.
- Facilitated a competitive marketplace in the 2023 and 2024 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 14 dental plans in 2023 and 2024. Most Oregonians had access to at least 36 medical plans and 20 dental plans in those same years.
- Deployed an effective statewide mass education campaign through radio, television, digital, and social media.
- Processed 6,663 calls through the Marketplace's outreach center in 2024.
- Responded to 784 emails in 2024 sent directly from consumers and 1,016 emails from community partners.
- Attended 948 outreach events and meetings in 2023 and nearly 1,003 in 2024. These were both in-person and virtual formats for a variety of audiences such as Tribes; LGBTQIA2S+; faith-based communities; Hispanic, Latina, Latino, or Latinx; and Rapid Response recipients.
- Provided grant and policy support to partner agents who, during the open enrollment period for the 2023 and 2024 plan years, enrolled 11,561 and 11,214 consumers respectively into Marketplace plans. For coverage year 2024, Oregonians made 52,300 total plan selections with an agent. With approximately 280 active agents, Marketplace partners accounted for 22% and 21% of total plan selections respectively in 2023 and 2024.
- Provided outreach, education, and private plan application assistance to the Nine Federally Recognized Tribes of Oregon.
- Provided comprehensive Marketplace certification training to more than 1,287 community partners and certified application assisters to ensure they are equipped with the necessary knowledge and skills to assist individuals in navigating the marketplace. Many of these community partners are experts in providing equity-centered outreach to communities that have been disproportionately affected by health and social inequities.

They are trained to assist individuals in special situations, such as survivors of domestic violence or spousal abandonment, refugees and immigrant communities, Tribal communities, veterans, and people with disabilities. These trainings were provided in English and Spanish, offered closed captioning and an accessibility menu to assist individuals with hearing and visual barriers, and were available via webinars, in-person classroom settings, and on-demand.

- Launched additional, optional courses to further enrich the learning experience for assisters. These courses focus on improving focus at work and providing strategies to effectively deal with stress, pressure, and burnout. Approximately 149 assisters have taken advantage of these additional courses, demonstrating their commitment to personal and professional growth.
- Resolved 34 complex cases between July 1, 2023, and December 15, 2024. The nationally declared public health emergency likely resulted in roughly a 27% 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.
- Developed and implemented outreach and education and operational strategies to transition individuals no longer eligible for OHP to coverage through the Marketplace. Metrics include the following:
    - Provided 90,655 customized plan option letters to individuals in 14 languages, sent 77,985 SMS messages, and 228,791 emails with a 53% open rate. In January and June 2024, as part of a survey, 102,603 SMS messages and 42,107 emails were distributed to individuals who had not yet signed up for coverage through HealthCare.gov. OHP members who were affected by procedural closures were also contacted. The Marketplace Transition Help Center made 367,202 outgoing calls to individuals who had either not enrolled in a private plan or had not provided requested information to OHP. Of the 6,425 inbound calls, 3,828, or 60%, requested assistance using the Window-Shopping tool, finding local help, or application assistance.

  - Collaborated with eight community-based organizations to expand the Marketplace's presence in communities where English is not the primary language, resulting in 238 enrollments.
- Provided subject matter expertise and coordination in the creation and implementation of the OHP Bridge program. Assisted in the creation of training for community partners and agents on the new program. Updated Marketplace Window Shopping site to include OHP Bridge eligibility, enabling Oregon to provide consumers with accurate information when HealthCare.gov cannot.
- Pursuant to SB 972 (2023), the State-based Marketplace Project:
  - Completed gates one and two of Enterprise Information Services Stage Gate review to verify the corresponding project planning artifacts and requirements for acquisition of a technology platform to transition away from the federally facilitated marketplace.
  - Scheduled and began quarterly external partner engagement sessions with insurance agents, insurance carriers, and community organization enrollment assisters to gather input on requirements, experiences, preferences, and potential health equity considerations related the planned technology platform and call center vendor procurement.
  - Released a request for proposal in November 2024 for a state enrollment and eligibility platform and a consumer assistance center. The Marketplace sought bids from qualified vendors with a proven track record in developing and managing health insurance marketplaces with a focus on user-friendly platforms, advanced technology solutions integration, and robust customer support services. Submitted a policy option package to fund Phase II of the transition to a state-based marketplace. Phase II will include obtaining the internal, external, and contracted sources for specialized expertise in the fields of project management, technology integration and implementation, procurement, quality assurance, data, legal, security, privacy, community outreach and education, training, and transition to ongoing operations.

Oregon Health Insurance Marketplace

Background information

The Oregon Health Insurance Marketplace is the state's health insurance exchange established in 2015 as part of Oregon Senate Bill 1 and under the Affordable Care Act (2010). The Marketplace contributes towards the state's goal of eliminating health inequities by 2030 by helping Oregonians understand their health coverage options, connecting people to free local assistance from trained health coverage experts who act as Marketplace subject matter experts for the community, and certifying the health plans sold to Oregonians through HealthCare.gov.

The Marketplace is a state-based marketplace which currently uses the federal platform (HealthCare. gov) for application and enrollment processing. Senate Bill 972 (2023) transitions the Marketplace away from the federally facilitated marketplace to a state-based enrollment and eligibility platform and call center for operation and administration of Oregon's health insurance exchange. The transition is required to be completed by November 1, 2026, in time for open enrollment for the 2027 plan year. Funding is being provided in two phases. Phase I funds are being used for research and planning purposes through the request for proposals 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 to a full state-based marketplace. Phase II funds will be used for the purchase and operation of the platform, call center implementation, and any additional staff necessary for operation of the new platform.

Enabling legislation/program authorization

The Oregon Health Insurance Marketplace is governed by Oregon Revised Statute Chapter 741.

Revenue sources and changes

The Oregon Health Insurance Marketplace is funded through a per-member-per-month (PMPM) fee charged to participating commercial health insurance companies that issue medical plans or 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 and is set in the spring of the year prior to its implementation.

The PMPM rate for 2025 has been established at $5.50 and $0.36 for the six participating medical plan and six participating dental plan issuers respectively. The PMPM for 2026 and 2027 is still to be determined. The 2027 assessment rate will be higher to cover the transition to state-based marketplace and will require authorization from the Legislature to be approved.

Proposed new laws that apply to the program unit

Legislative concept #44300-019 – Health Care Marketplace Affordability legislative concept to help lower costs for individuals who purchase health insurance through the Marketplace.

Public Employees' Benefit Board

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$0.00	$22.89	$0.00	$22.89	22	21.00
Gov. Budget 2025-27	$0.00	$26.87	$0.00	$26.87	22	20.58
Difference	$0.00	$3.99	$0.00	$3.99	0	-0.42
Percent Change	0%	17%	0%	17%	0%	-2%

The Governor's Budget continues funding for the Public Employees' Benefit Board's (PEBB) at the current service level for the 2025-27 biennium. It includes $3.2 million Other Funds for policy package 425 to support PEBB's portion of replacement costs for both the OEBB and PEBB benefits management systems and $2.9 million Other Funds for policy package 423 to support Program Integrity and Development.

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 PEBB eligibility to include local governments and special districts. As directed by the 1997 Legislature, 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 health plan and other state employee benefits at an affordable cost 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 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.

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

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.

Policy Package 425 OEBB-PEBB Benefit Management Replacement System
This POP will allow OEBB and PEBB to combine enrollment systems and enhance and modernize the member 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.
- Improved dependent eligibility verification among and between OEBB and PEBB member groups.

OEBB and PEBB are in the final stages of the replacement BMS implementation with their contracted vendor. 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. The implementation plan outlined by the selected vendor, TELUS Health with a go live date in the first quarter of 2026.

Policy package 423 Program Integrity and Development
This POP would allow PEBB to seek the services for RFP support, claims audits, clinical audits and support for the Joint Health Equity Workgroup (HEW), the Innovation Workgroup (IWG) and the Strategies on Evidence and Outcomes Workgroup (SEOW).

Currently PEBB does not have adequate budget limitation for these services. The commercial insurance market has evolved considerably over the past decade, to the extent that we must seek new means to ensure that PEBB and OEBB members are getting the best possible deals for high quality, equity-based healthcare.

An increased limitation for consultant services would immediately allow the boards to prioritize and schedule the clinical and claims audits. These are expensive and require significant resources. They are also critical to ensure benefit plans and services are being administered appropriately and according to the law. Further, it would enable both Boards to issue RFPs as necessary to bring the strongest vendors forward to focus on eliminating health

inequities for all PEBB and OEBB members RFP's cost money and take a significant amount of time, but the return-on-investment is undeniable.

Background information

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).
- Activities 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. Negotiations occur 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, pursuant to state procurement law.
- 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.

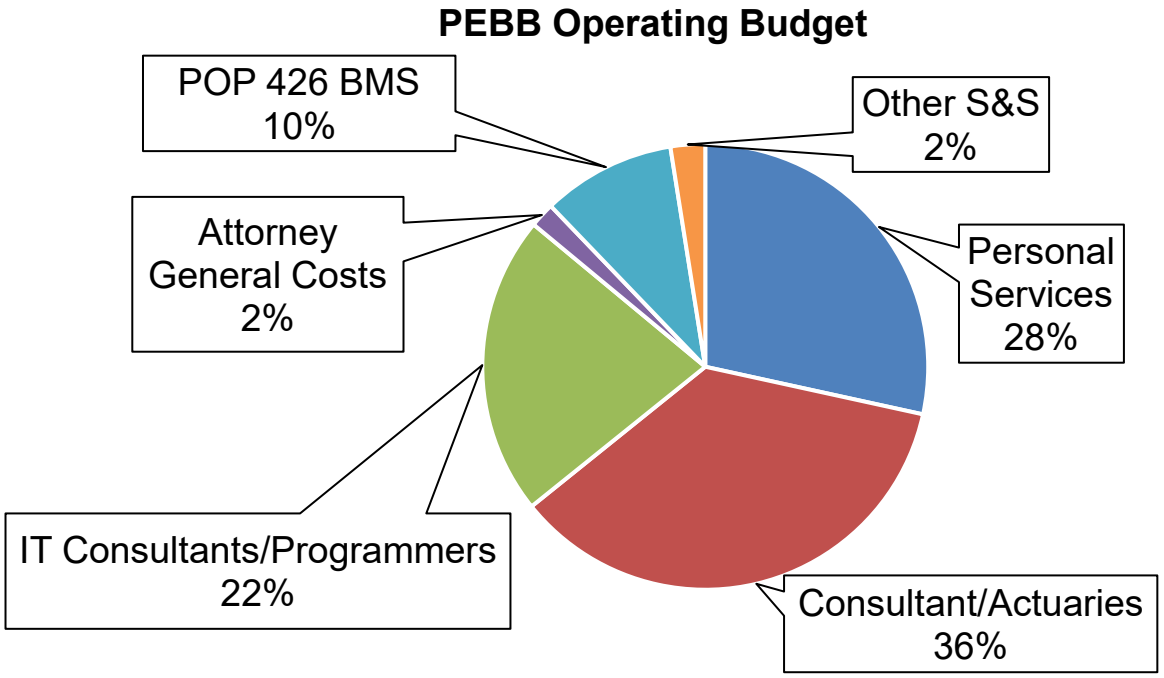
Public Employees' Benefit Board

Annual Renewal Process

Each year, the board begins an annual plan renewal process. During this process the board examines benefit offerings, renegotiates, premium rates with carriers, projects administrative fees, and makes final decisions 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, including undertaking the following activities:

- Updating contracts.
- Working with contractors to implement changes in the PEBB benefits system (PDB).
- Updating open enrollment communications materials with rates and benefit changes.
- Readying for Open Enrollment Oct. 1 – Oct. 30.

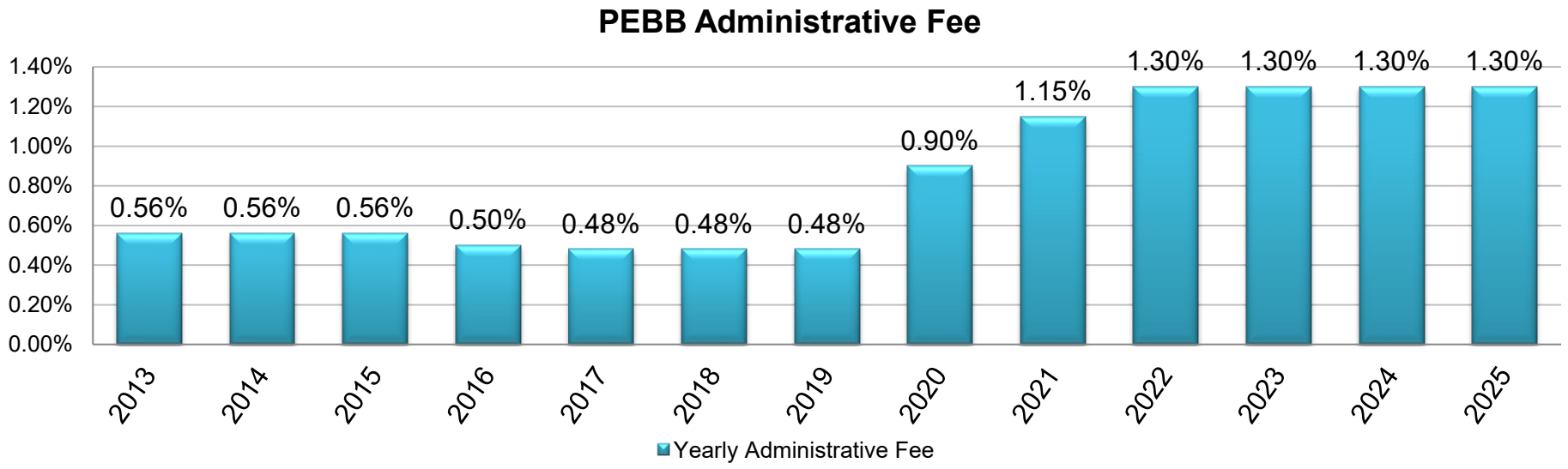
Operating expenditures are mainly driven by personal services, consultant actuary costs, IT consultant/programming costs, attorney general costs and open enrollment and wellness costs. The chart (right) demonstrates the percentages of budget line items in the PEBB operating budget.



Revenue sources and changes

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.

Operational costs are funded through an administrative charge (assessment) added to medical, vision 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. The Operations Budget is approximately one percent of the Total Funds budget for PEBB.



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The above chart demonstrates the evolution of the PEBB administrative fee and how it has both increased and decreased over time.

Public Employees' Benefit Board

Proposed new laws that apply to the program unit

None.

Oregon Educators Benefit Board

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$0.00	$20.99	$0.00	$20.99	21	20.75
Gov. Budget 2025-27	$0.00	$24.46	$0.00	$24.46	21	20.54
Difference	$0.00	$3.46	$0.00	$3.46	0	-0.21
Percent Change	0%	16%	0%	16%	0%	-1%

The Governor's Budget funds the Oregon Educators Benefits Board at the current service level for the 2025-27 biennium. It includes $ million Other Funds for policy package 425 to support OEBB's portion of replacement costs for both the OEBB and PEBB benefits management systems and funds for policy package 423 to support Program Integrity and Development.

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), and a health savings account (HSA). 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

Oregon Educators Benefit Board

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 recovering from 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
- Designing benefits that reduce barriers to care for members with chronic diseases

Policy Package 425 OEBB-PEBB Benefit Management Replacement System
This POP will allow OEBB and PEBB to combine enrollment systems, and enhance and modernize the member 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.
- Improved dependent eligibility verification among and between OEBB and PEBB member groups.

OEBB and PEBB are in the final stages of the replacement BMS implementation with their contracted vendor. 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. The implementation plan outlined by the selected vendor, TELUS with a go live date in the first quarter of 2026.

Policy package 423 Program Integrity and Development
This POP would allow OEBB to seek the services for RFP support, claims audits, clinical audits and support for the Joint Health Equity Workgroup (HEW), the Innovation Workgroup (IWG) and the Strategies on Evidence and Outcomes Workgroup (SEOW).

Currently OEBB does not have adequate budget limitation for these services. The commercial insurance market has evolved considerably over the past decade, to the extent that we must seek new means to ensure that PEBB and OEBB members are getting the best possible deals for high quality, equity-based healthcare.

An increased limitation for consultant services would immediately allow the boards to prioritize and schedule the clinical and claims audits. These are expensive and require significant resources. They are also critical to ensure benefit plans and services are being administered appropriately and according to the law. Further, it would enable both Boards to issue RFPs as necessary to bring the strongest vendors forward to focus on eliminating health inequities for all PEBB and OEBB members. RFP’s cost money and take a significant amount of time, but the return-on-investment is undeniable.

Oregon Educators Benefit Board

Background information

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).
- Activities 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. Negotiations occur 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, pursuant to state procurement law.
- 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.

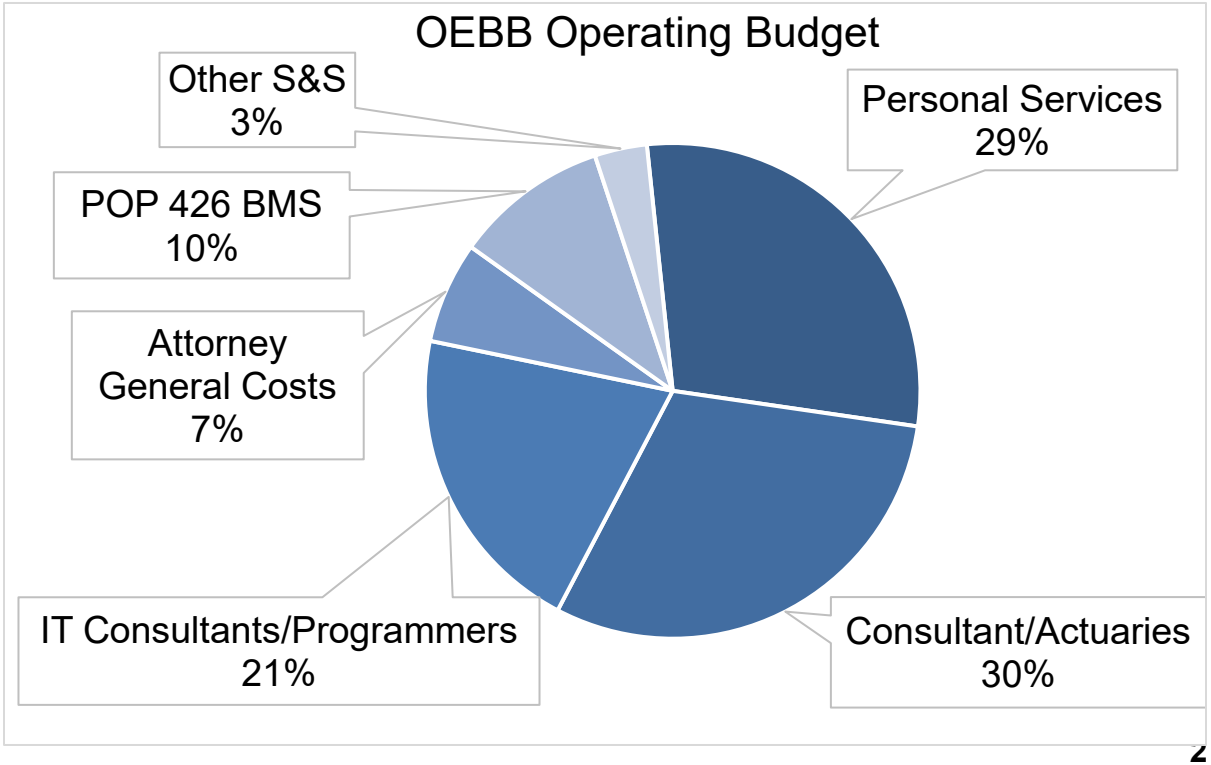
Oregon Educators Benefit Board

Annual Renewal Process

Each year, the board begins an annual plan renewal process. During this process the board examines benefit offerings, renegotiates premium rates with carriers, projects administrative fees, and makes final decisions 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, including undertaking the following activities:

- Updating contracts.
- Working with contractors to implement changes in the OEBB benefits system (MyOEBB).
- Updating open enrollment communications materials with rates and benefit changes.
- Readying for Open Enrollment, Aug. 15 - Sept. 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. The below chart demonstrates the percentages of budget line items in the operating budget.



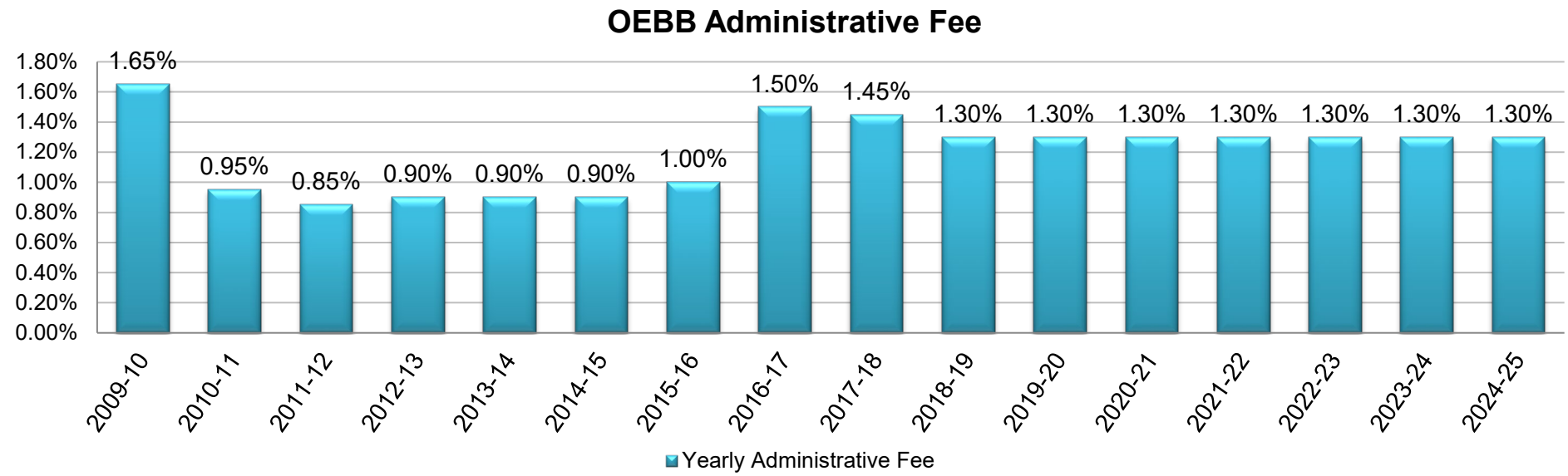
Oregon Educators Benefit Board

Revenue sources and changes

Oregon Revised Statute (ORS) 243.880 established the Oregon Educators Benefit Account to cover administration expenses. OEBB Operational costs are funded entirely with Other Funds revenue through an administrative charge (assessment) added to medical, vision and dental insurance premiums and premium equivalents. By statute, the assessment cannot exceed two percent of monthly contributions from employees and employers. ORS 243.882 prohibits the balance in the account from exceeding five percent of the monthly total of employer and employee contributions for more than 120 days.

OEBB Operations is funded entirely with Other Funds. OEBB collects premiums for all insured individuals and then purchases insurance with those revenues. The resources to pay for employee health insurance are 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.

Oregon Educators Benefit Board



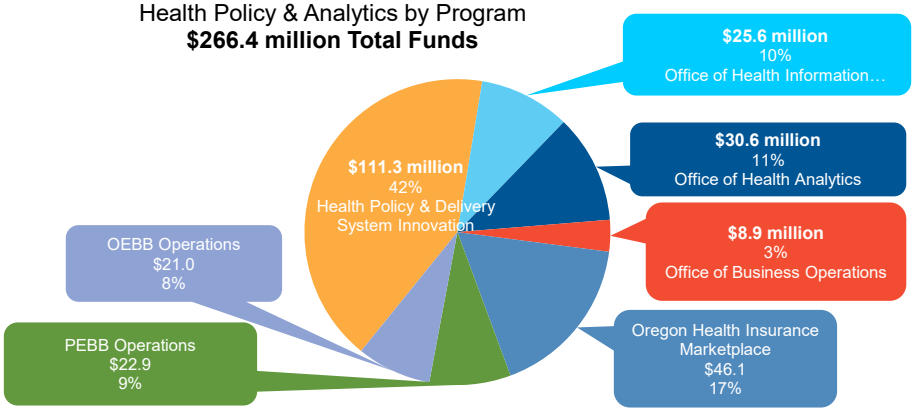
The above chart demonstrates the evolution of the OEBB administrative fee and how it has both increased and decreased over time.

Proposed new laws that apply to the program unit

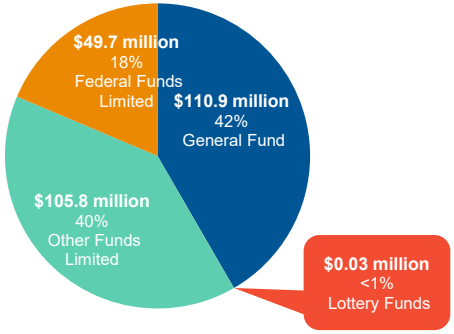
None.

Oregon Health Authority
2023-25 Legislatively Approved Budget

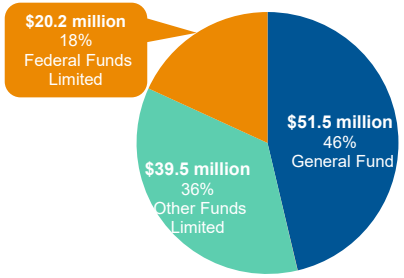
Health Policy & Analytics by Program
$266.4 million Total Funds



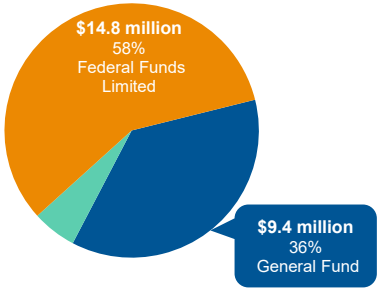
Health Policy & Analytics by Fund Type
$266.4 million Total Funds



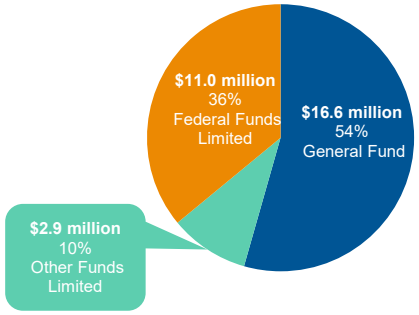
Health Policy & Delivery System Innovation by Fund Type
$111.3 million Total Funds



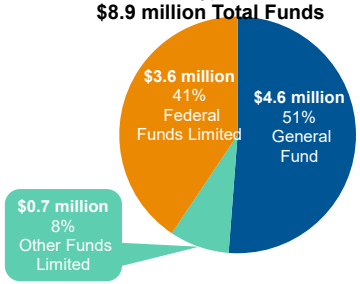
Office of Health Information Technology by Fund Type
$25.6 million Total Funds



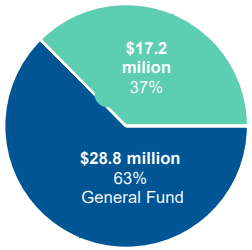
Office of Health Analytics by Fund Type
$30.6 million Total Funds



Office of Business Operations by Fund Type
$8.9 million Total Funds



Oregon Health Insurance Marketplace by Fund Type
$46.1 million Total Funds

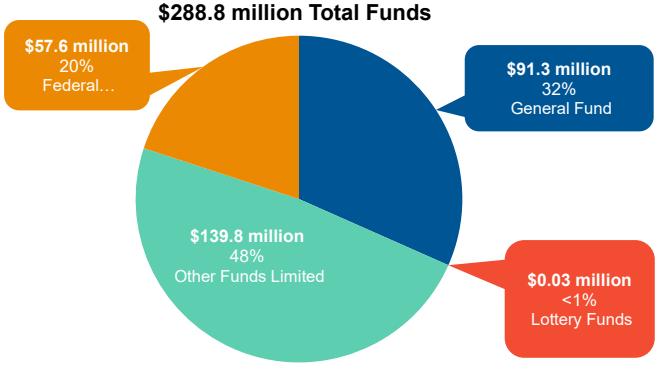


PEBB Operations by Fund Type
$22.9 million Total Funds

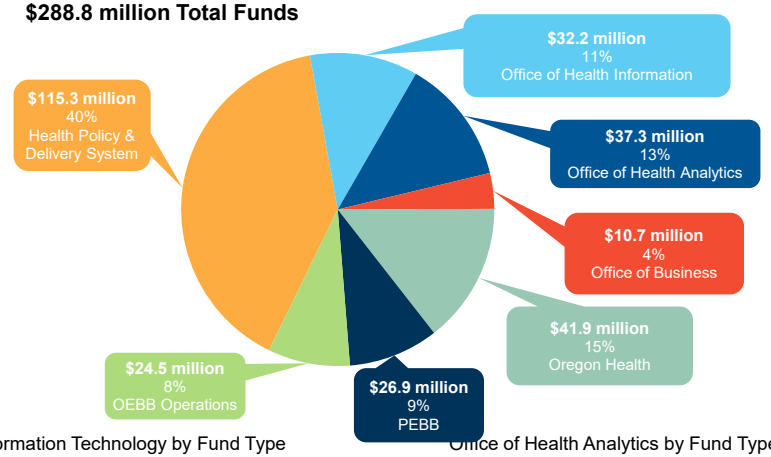
OEBB Operations by Fund Type
$21.0 million Total Funds

Oregon Health Authority
2025-27 Governor's Budget

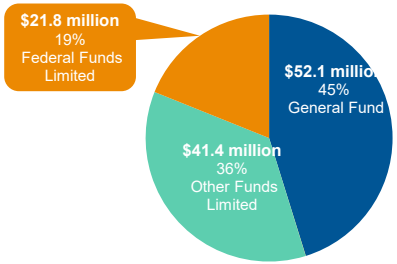
Health Policy & Analytics by Fund Type
$288.8 million Total Funds



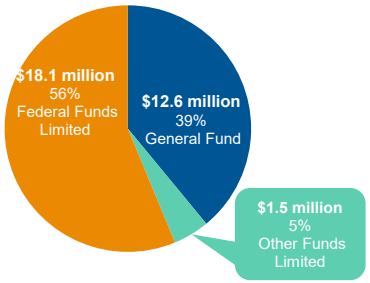
Health Policy & Analytics by Program
$288.8 million Total Funds



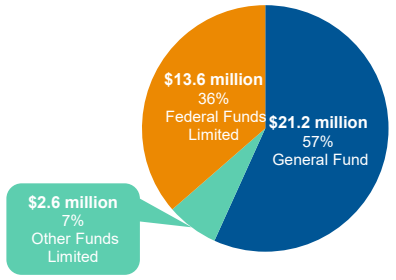
Health Policy & Delivery System Innovation by Fund Type
$115.3 million Total Funds



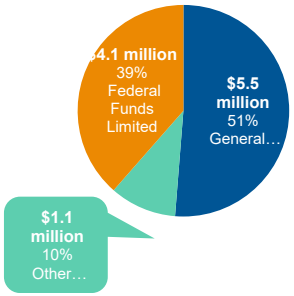
Office of Health Information Technology by Fund Type
$32.2 million Total Funds



Office of Health Analytics by Fund Type
$37.3 million Total Funds

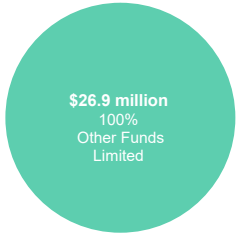


Office of Business Operations by Fund Type
$10.7 million Total Funds



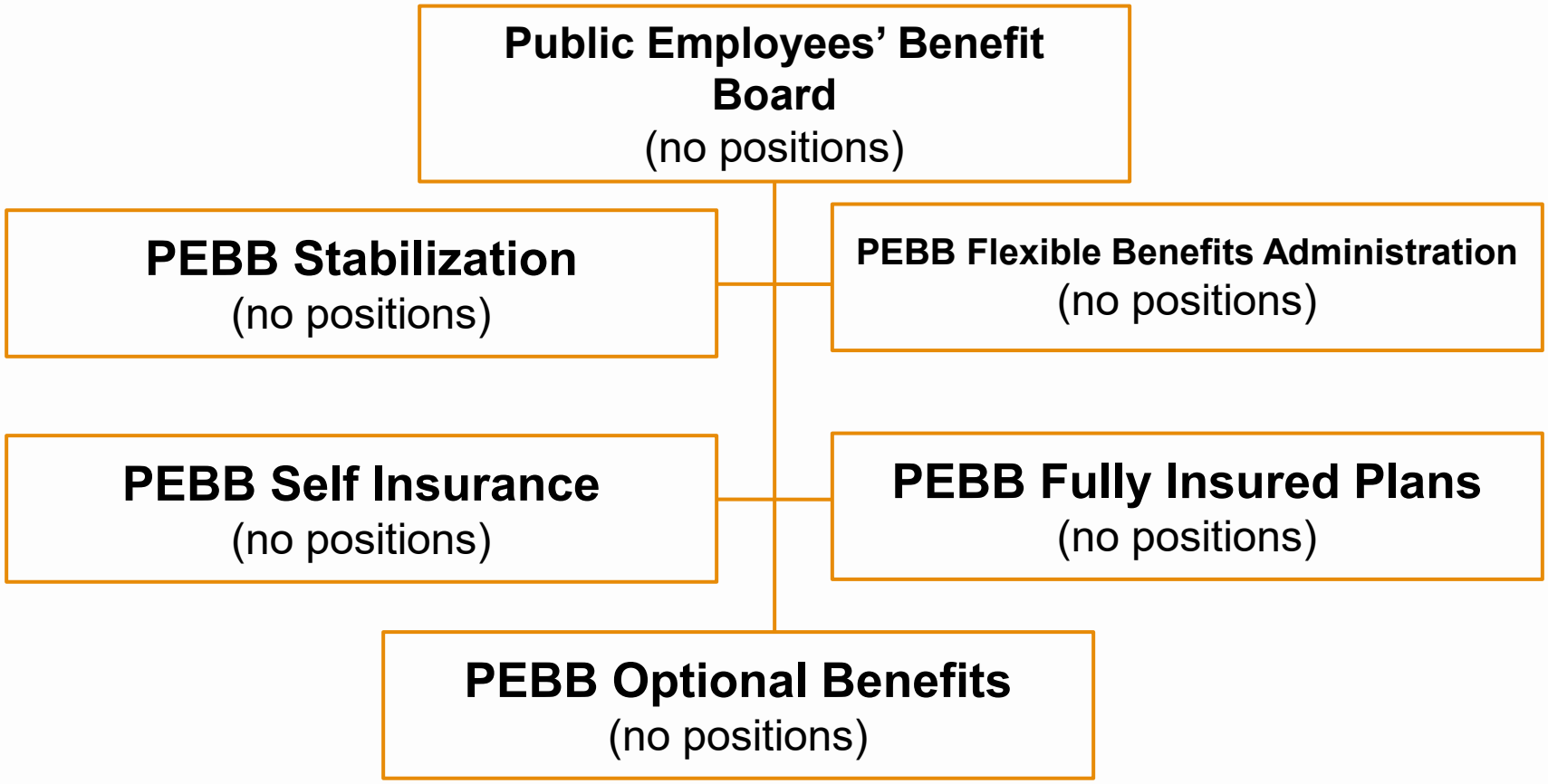
Oregon Health Insurance Marketplace by Fund Type
$41.9 million Total Funds

PEBB Operations by Fund Type
$26.9 million Total Funds



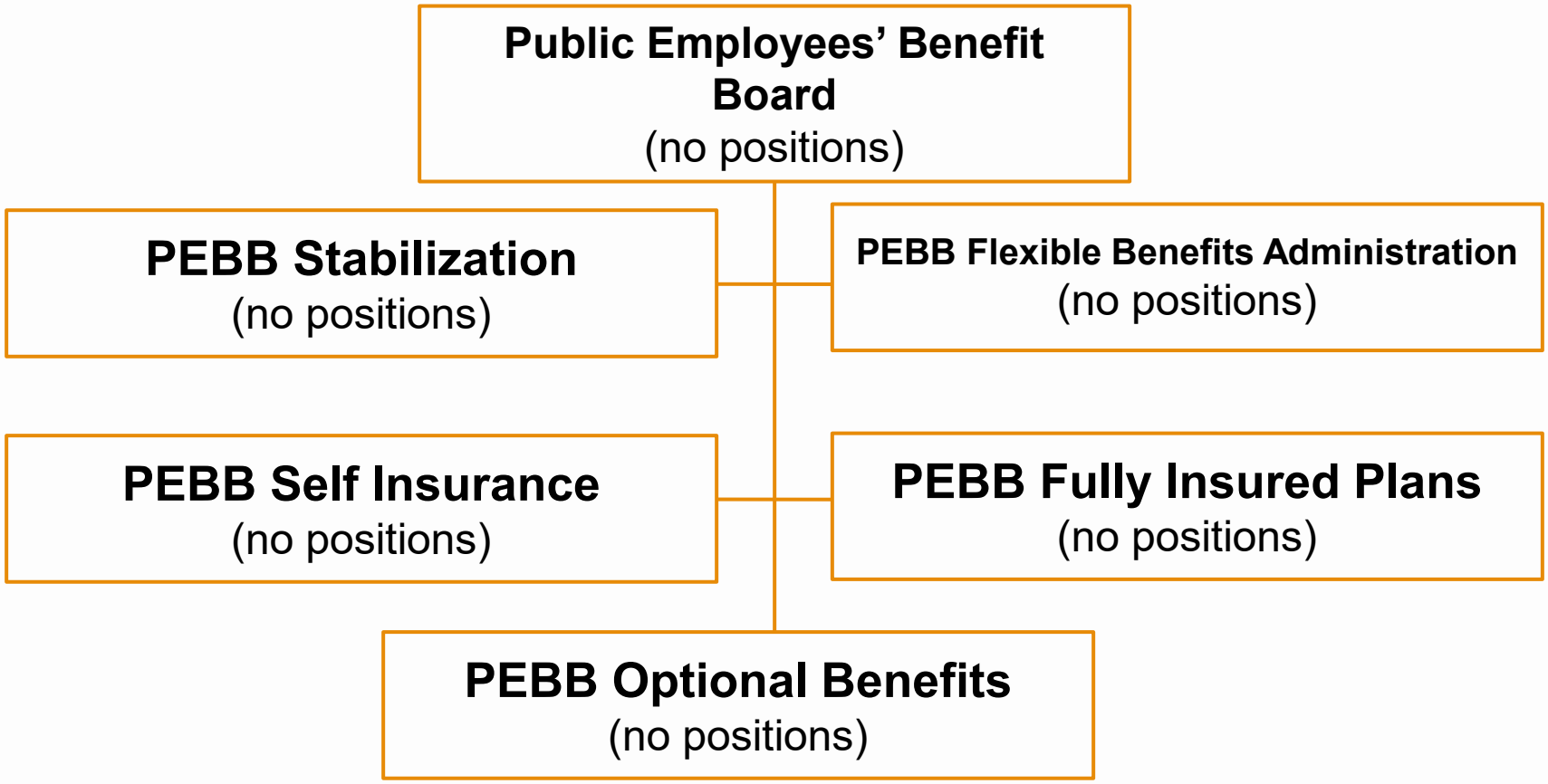
OEBB Operations by Fund Type
$24.5 million Total Funds

2023-25
Legislatively Approved Budget



Oregon Health Authority

2025-27
Governor's Budget

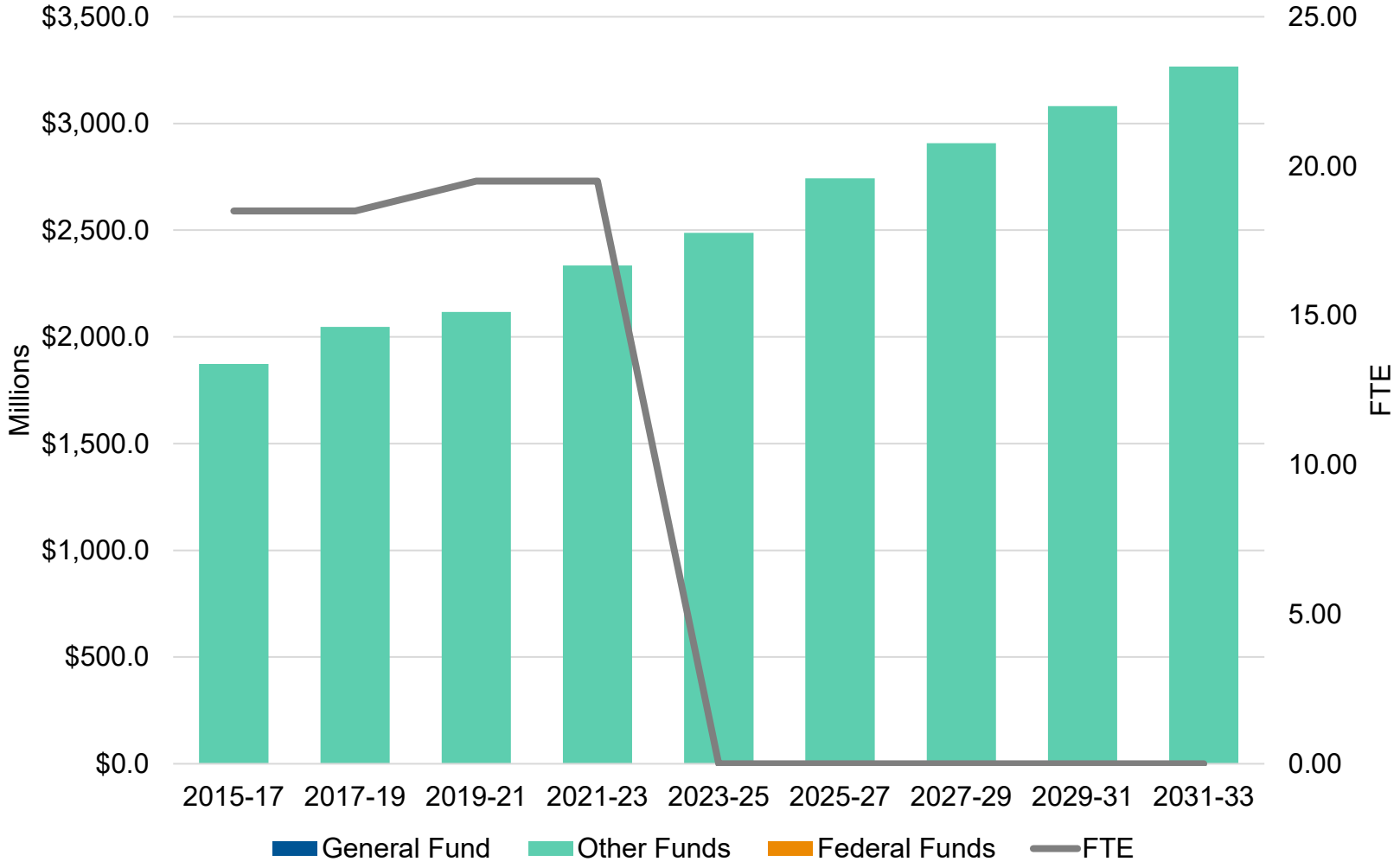


Oregon Health Authority

Oregon Health Authority: Public Employees' Benefit Board

Executive Summary

Program Contact: Clare Pierce-Wrobel Director of Health Policy and Analytics (503) 798-2714



Executive Summary

Expenditures by fund type, positions and full-time equivalents:

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$0.00	$2,488.16	$0.00	$22.89	22	21.00
Gov. Budget 2025-27	$0.00	$2,742.58	$0.00	$2,742.58	0	0.00
Difference	$0.00	$254.42	$0.00	$2,719.70	-22	-21
Percent Change	0%	10%	0%	11883%	-100%	-100%

Division overview

OHA's 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. PEBB'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. 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.

Recommended funding

OHA 2025-27 Governor's Budget includes $2.7 billion Total Funds for PEBB to continue current service levels, which includes cost growth for PEBB medical premiums, both self-insured and fully insured, at 3.4 percent. 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. This 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 (VBP) into plan design and aligned VBP targets with Coordinated Care Organization (CCO) goals to drive use of high-value services with aspirational goals.

Program justification and link to long-term outcomes

Transforming health care and advancing health equity

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. The Oregon commercial insurance market growth trend averages 6-7 percent per year. Staying at or under a 3.4 percent annual growth trend is without a doubt PEBB's biggest challenge and consumes most of the board's attention.

PEBB has prioritized transforming the health care delivery system 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 (CCM) 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.

Executive Summary

In 2021, PEBB and OEBB formed a joint subgroup, the Joint Subcommittee on Health Equity. This subgroup focuses on advancing and ensuring 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. Both programs 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. The workgroup is made up of PEBB and OEBB board members and legislators. The workgroup:

- Develops strategies on cost containment,
- Identifies ways to best leverage claims data stores for analysis of quality and cost performance, and
- Develops payment initiatives to ensure the programs meet 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. Providers are rewarded 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 VBP strategies to incentivize provider quality and efficiency. Many of the general strategies used align with VBP approaches also used by coordinated care organizations (CCOs) serving Oregon's Medicaid population.

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.

Executive Summary

	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. The Boards 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 2025. This matches the goals defined in CCO 2.0.

Wellness initiatives and promoting member health

In 2020, many PEBB members began working remotely due to the COVID-19 pandemic. Flexible work schedules continue to be the norm. PEBB's employee wellness efforts shifted away from a focus on environmental approaches. PEBB has increased direct member communications promoting PEBB wellness programs and benefits education.

Executive Summary

The Worksite Wellness Coordinating Council and the PEBB Member Advisory Committee (PMAC) developed and are implementing a Member Wellbeing Strategy aimed at addressing needs identified by both groups. Specifically, this strategy is focused on:

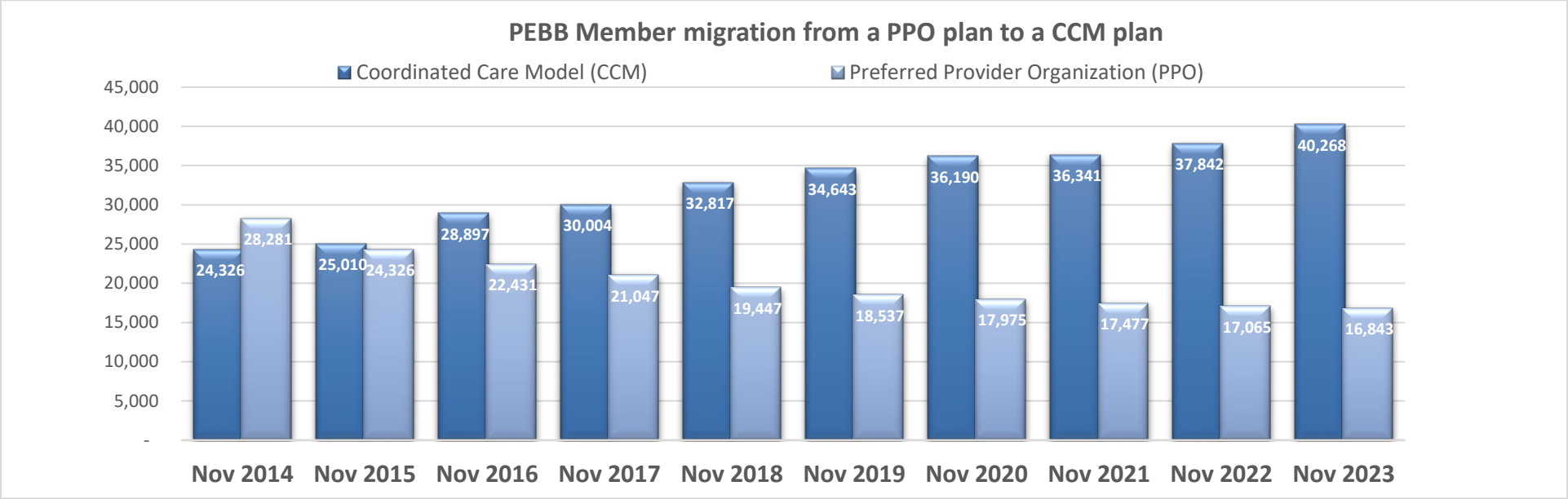
- Challenges with supporting employees in a remote and COVID-19 environment
- Defining "worksite" wellness in the future
- Supporting employees with current resources, while developing a long-term well-being strategy

The goals include:

- Improving awareness and promoting utilization of existing well-being resources
- Specifying Council and PMAC well-being roles
- Developing a multi-year well-being strategy
- Executing strategy in concert with the Health Engagement Model (HEM) program and appropriate partner groups (PMAC, Uplift Oregon, etc.)

PEBB supports prevention and member wellness by offering members no-cost to them programs through carrier contracts and direct vendor contracting. Wellness programs help members living with chronic conditions, behavioral health needs, weigh management and nutrition, and overcoming tobacco and other substance use.

Executive Summary



PEBB members also have the opportunity to improve their health and contain costs by participating in the Health Engagement Model (HEM) program. The HEM program allows members to learn more about their own personal health risks and take actions to reduce them. HEM members earn financial incentives by:

- Annually completing a private health assessment on their medical plan's secure website, and
- Completing two health-related activities during the year.

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

Executive Summary

PEBB quality measures and fees-at-risk

PEBB has made significant progress implementing 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. The menu was 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. They require health plans risk a portion of administrative fees or paid premiums. They retain at-risk dollars by achieving these targets. To achieve specific rates of improvement, each performance improvement target compares the health plan's current performance to:

- National benchmarks,
- Gold standard performance rates, and
- Organizational priorities.

Performance Guarantee categories include Administrative/Operational, Financial Trend, Clinical Quality, Clinical Management programs, Account Management, and Transparency.

Additional budget drivers

- Legislative cap on premium rate increases: The 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 passed at the federal level.

Joint PEBB and OEBB Innovation Workgroup

PEBB and OEBB formed the joint Innovation Workgroup (IWG) in 2018. The IWG includes PEBB and OEBB board members and legislators. The workgroup's mission is 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 aims to leverage its purchasing power and data to its maximum value. In the future, IWG plans to collaborate with other OHA programs like the Marketplace to further increase its buying power. Recent key IWG initiatives include:

Executive Summary

- Developing 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 assessment tool to all board policy decisions
- Develop a Diversity Equity and Inclusion assessment tool that audits PEBB and OEBB benefit vendors and ensures their business practices meet the standards the boards have set
- Amplify the boards' commitment to health equity and communicate it in all areas
- Incorporate health equity into governance, quality metrics and clinical protocols

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

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 cost containment strategies and promoting program efficiencies. PEBB face challenges in meeting the 3.4 percent tests as a payer in the commercial market, battling trend, provider market leveraging and the annual growth cap timing. From 2020-2022, the global pandemic heavily impacted utilization levels. We are learning more about the "bounce-back" of deferred care. Quantifying the impact on PEBB members' health is becoming better known as more data is collected.

Executive Summary

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 (CCM) plan. CCM plan choices are available at a lower cost to both members and the state.

PEBB benefit highlights include

- 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 in-network outpatient mental health services
- Alternative care including massage therapy

More recent PEBB changes include the following benefit additions:

- Infertility benefits in 2022, and
- Doula benefits effective for the 2025 plan year.

Executive Summary

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 (w/ Premium Tax and -0.855% funding assessment)	$1,607.63	0.8%	$1,597.78	0.2%
2022 (w/ Premium Tax – with Final Plan Changes)	$1,660.52	3.3%	$1,642.37	2.2%
2023 (w/ Premium Tax – with 0.9% PEBB admin + plan changes + 1.868% funding assessment)	$1,716.98	3.4%	$1,681.88	1.9%
2024 (w/ Moda buydown and 0.501% funding assessment)	$1,775.35	3.4%	$1,755.83	2.3%
2025 (w/ Premium Tax)	$1,868.69	5.3%		
2025 (w/ Premium Tax and Buydown of Choice and Moda and -0.001% funding assessment	$1,835.71	3.4%		

This chart outlines the percentage increase between plan years. Percentage changes are based on benefit changes, changes in premium taxes and if funding assessment funds were used to buy-down premiums to the legislatively mandated 3.4%.

Executive Summary

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.

Enabling legislation/program authorization

PEBB's authority lies in ORS 243.061 through ORS 243.302.

Funding streams

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 2023-25

The Board has stated that they wish to issue a Request for Proposal for medical and prescription services. The RFP is currently under development and is due to be issued in Q1 of 2025. The potential exists for any of the current three carriers to be displaced, or for other carriers to join. This could be potentially disruptive to a significant portion of PEBB membership or end up with the status quo by maintaining current carriers. The scheduled go-live for the selected carriers will be January 1, 2027.

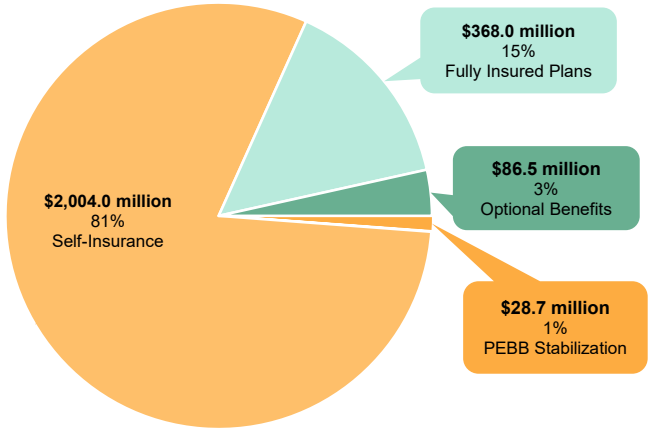
New Local Governments, of various size, are voluntarily joining PEBB. This increases the number of covered lives participating in PEBB plans. Local Governments have the option to participate in all PEBB plan offerings.

Oregon Health Authority

2023-25 Legislatively Approved Budget

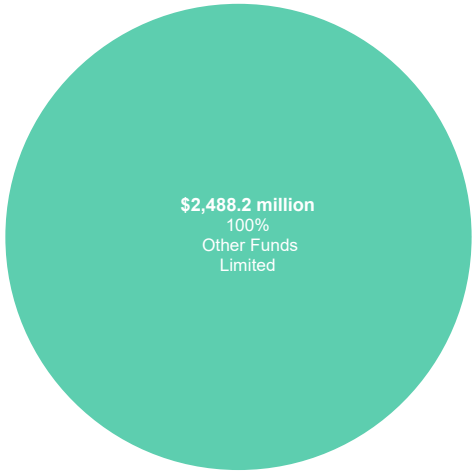
Public Employees Benefit Board by Program

$2,488.2 million Total Funds



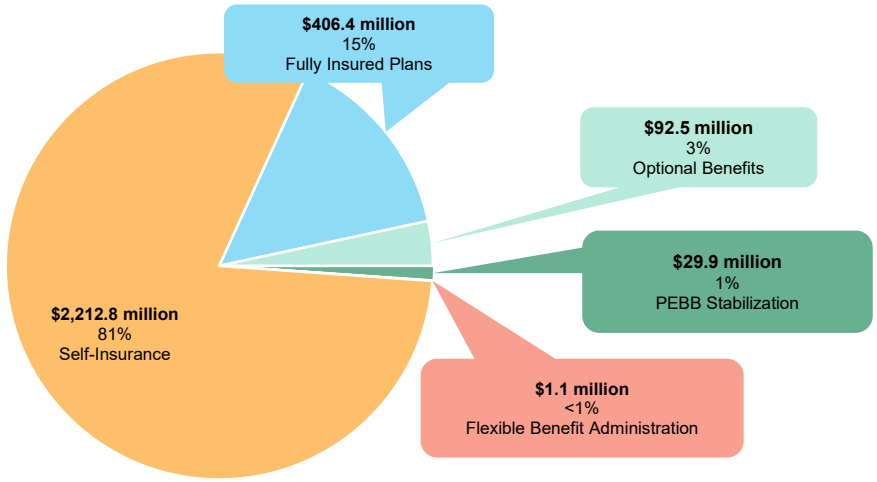
Public Employees Benefit Board by Program

$2,488.2 million Total Funds

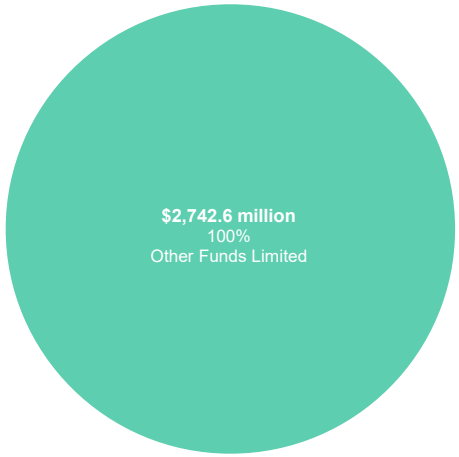


Oregon Health Authority
2025-27 Governor's Budget

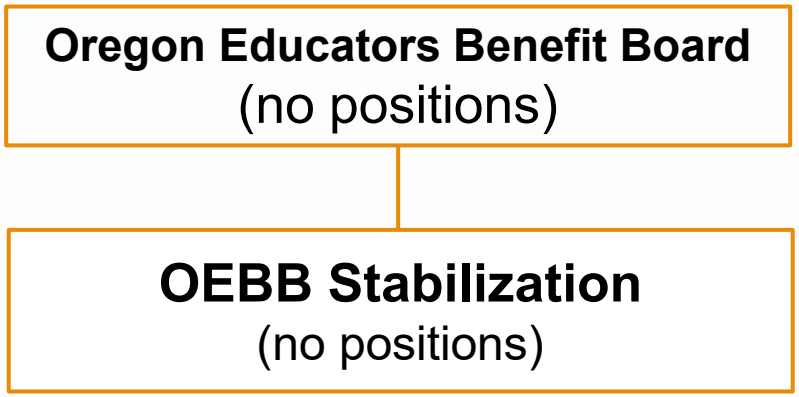
Public Employees' Benefit Board by Program
$2,742.6 million Total Funds



Public Employees' Benefit Board by Program
$2,742.6 million Total Funds

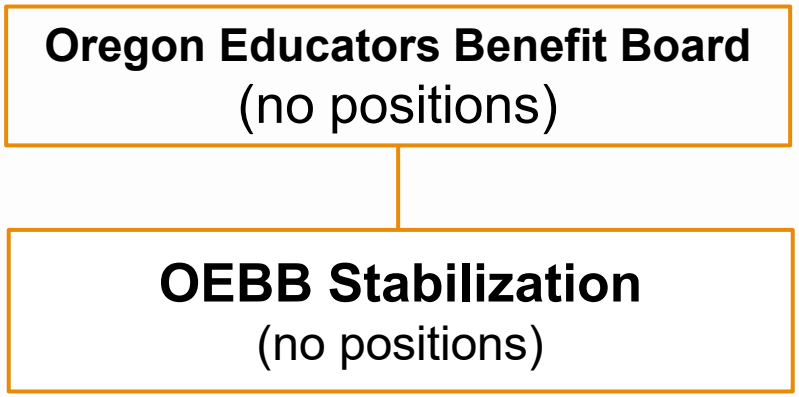


2023-25
Legislatively Approved Budget



Oregon Health Authority

2025-27
Governor's Budget

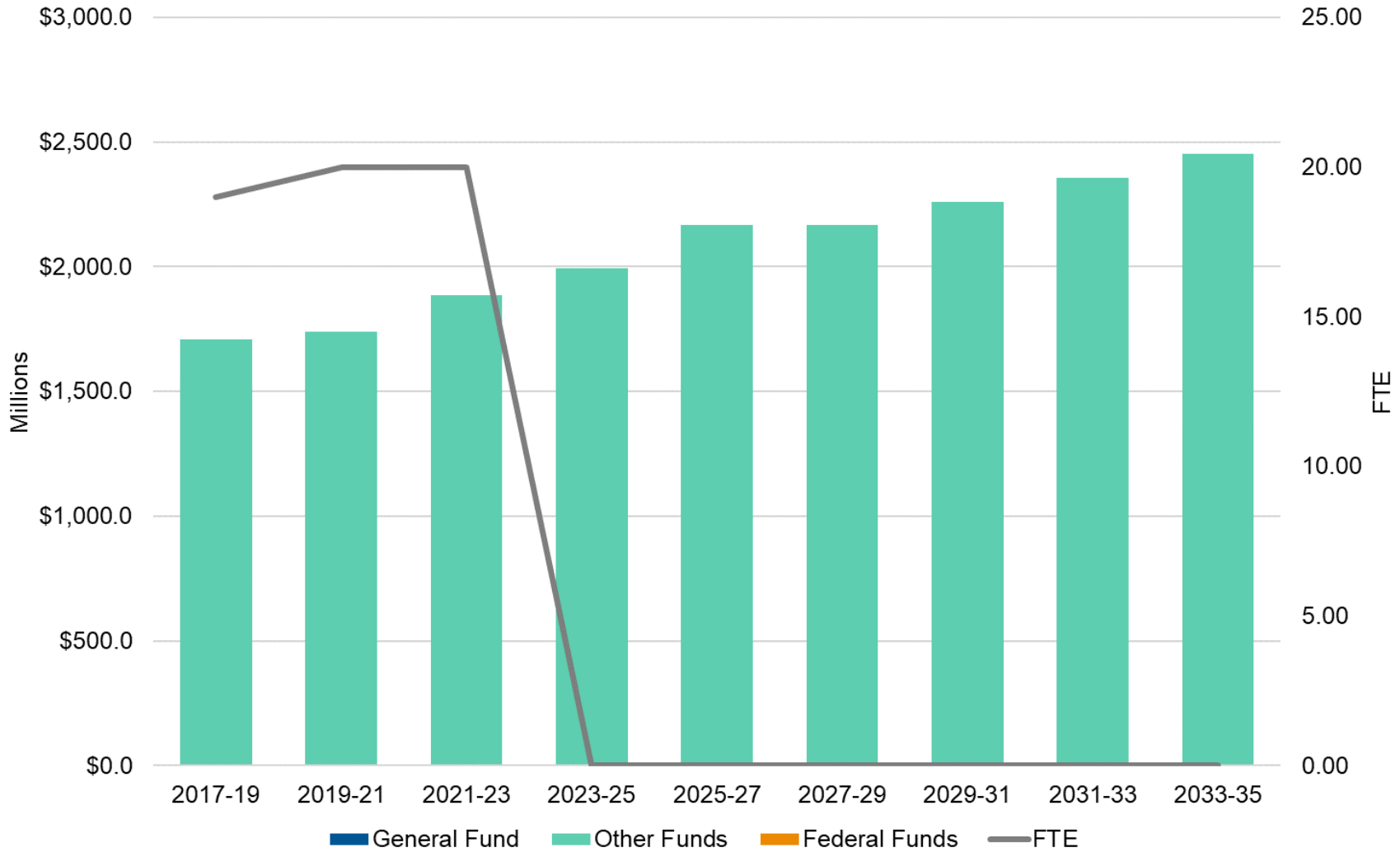


Oregon Health Authority

Oregon Health Authority: Oregon Educators Benefit Board

Executive Summary

Program Contact: Clare Pierce-Wrobel Director of Health Policy and Analytics (503) 798-2714



Oregon Health Authority: Oregon Educators Benefit Board

Executive Summary

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$0.00	$1,994.99	$0.00	$1,994.99	0	0.00
Gov. Budget 2025-27	$0.00	$2,168.95	$0.00	$2,168.95	0	0.00
Difference	$0.00	$173.96	$0.00	$173.96	0	0
Percent Change	0%	9%	0%	9%	0%	0%

Division overview

OHA's 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 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.

Recommended funding

OHA 2025-27 Governor's Budget includes $2.2 billion Total Funds to continue funding OEBB at current service levels, which includes cost growth for OEBB medical premiums, both self-insured and fully insured, at 3.4 percent. All OEBB expenditures are categorized as Other Funds.

Program description

OHA's 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.

Executive Summary

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 with two primary goals in mind:

- To eliminate the wide-ranging disparities among health plans offered by educational entities, and
- To respond to the rapidly rising costs of health care.

A statewide pool such as OEBB creates purchasing power and avoids unstable premium swings. OEBB offers streamlined administration and eliminates third-party fees and duplication of work. Educational entities benefit from cost predictability and controlling of expenditures year-over-year.

Transforming health care and advancing health equity

OEBB has prioritized transforming the health care delivery system 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 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.

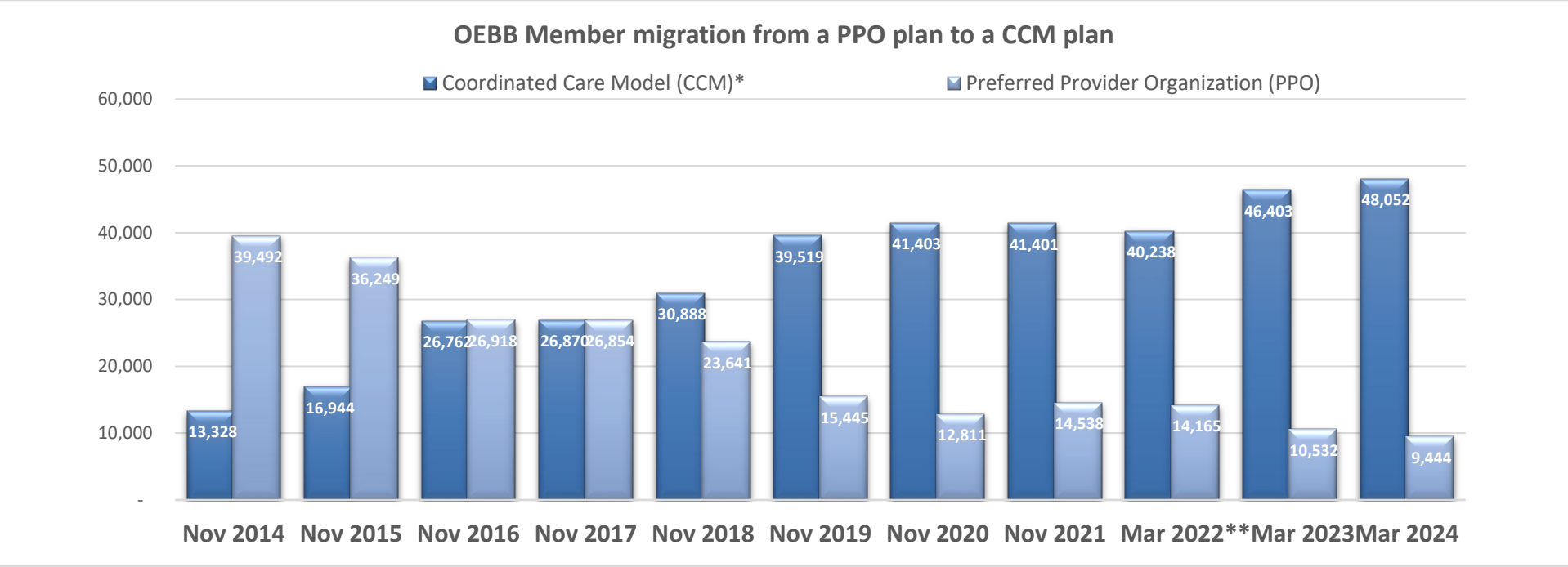
Executive Summary

In 2021, PEBB and OEBB formed a joint subgroup, the Joint Subcommittee on Health Equity. This subgroup focuses on advancing and ensuring health equity. The subcommittee 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. Both programs 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. The workgroup is made up of OEBB and PEBB board members and legislators. The workgroup:

- Develops cost containment strategies,
- Identifies ways to best leverage claims data stores for analysis of quality and cost performance and
- Develops payment initiatives to ensure meeting the 3.4 percent cap every year.

Executive Summary



**Moda CCM counts for 2023 are pending. March 2023 Moda CCM is estimated based on September 2023 CCM percentage reported in Board Meeting.

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 (VBP) 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	■	■	■

OEBB and PEBB continue to work toward increasing the percentage of total health care payments that use value-based approaches. The Boards 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 2025. This matches the goals defined in CCO 2.0.

OEBB quality measures and fees at risk

In the 2025-27 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. The menu was developed by the Health Plan Quality Metrics Committee for coordinated care organizations (CCOs), PEBB and OEBB plans, and the Oregon Health Insurance Marketplace.

Executive Summary

Wellness initiatives and promoting member health

OEBB supports prevention and member wellness by offering members access to no-cost to them wellness programs. Wellness programs help members:

- Living with chronic conditions live healthier lives,
- Prevent the onset of diabetes;
- Receive emotional, social and financial health services;
- Overcome tobacco use; and
- Receive weight management and nutrition services and support.

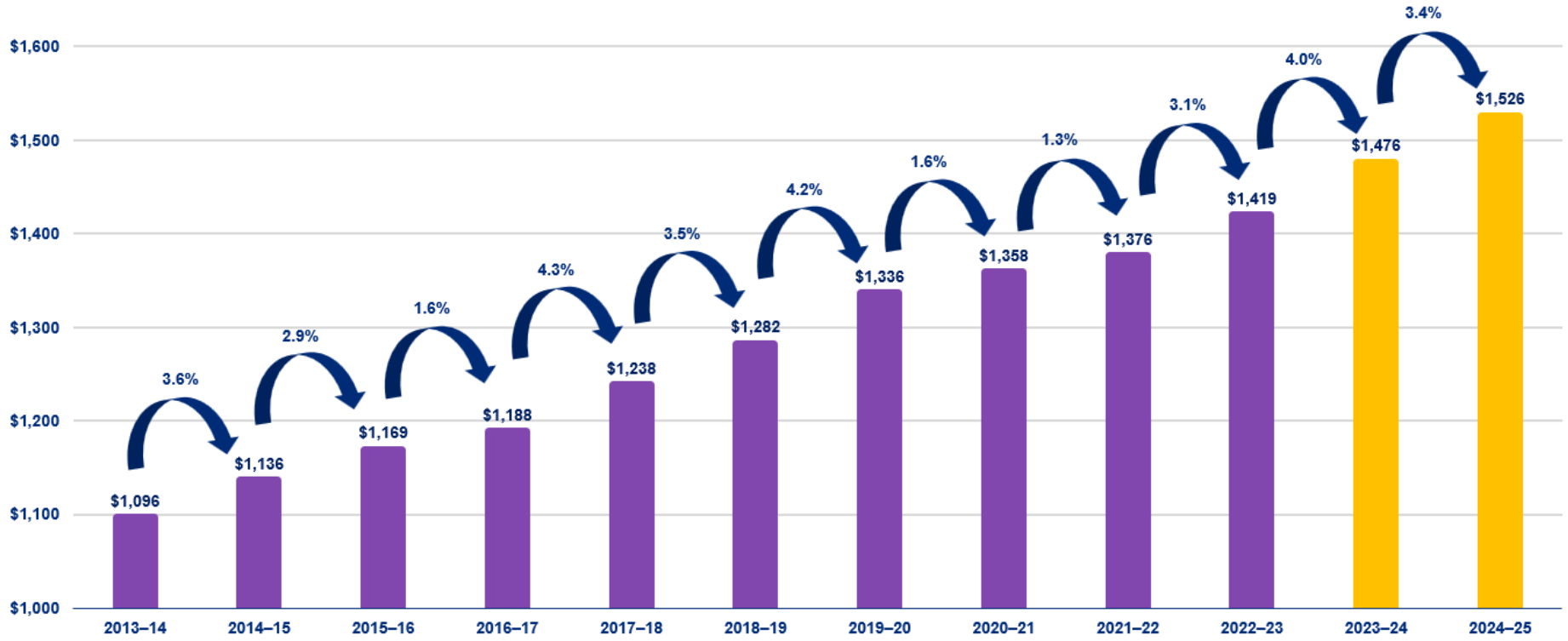
Program performance

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, battling provider shortages, high inflation, trend, provider market leveraging and the annual growth cap timing. From 2020-2022, the global pandemic heavily impacted utilization levels. OHA is learning more about the “bounce-back” of deferred care and provider revenue losses. Quantifying the impact on OEBB members’ health will be better understood in upcoming claims cycles.

Executive Summary

Actual and projected per employee per month (PEPM) premium increases

Annual increase in medical, dental, and vision premium PEPM, excluding the change in taxes/fees



Note that these increases do not reflect taxes / fees, but do reflect enrollment migration year over year so may not tie to the renewal increase in that year
The projected increases for 2023–24 and 2024–25 (yellow bars) are based on enrollment as of December 2023

Executive Summary

Strategies for success

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

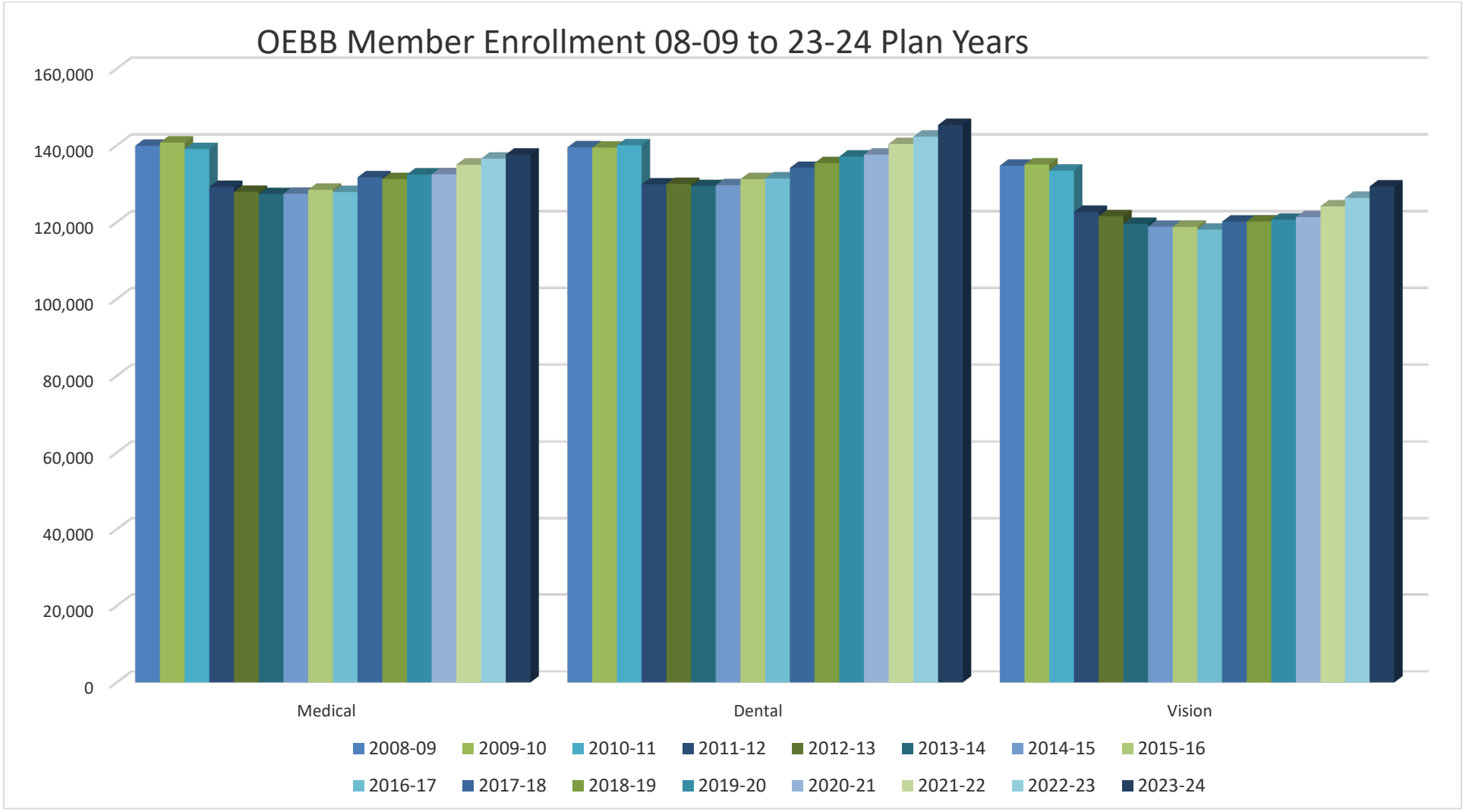
The OEBB board and staff are committed to its mission and guiding principles and have developed strategies to achieve the following long-term results:

- 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 2024-25 plan year

- OEBB will continue to offer the same medical, dental and vision plans through Moda, Kaiser, Willamette Dental and VSP for the 2024-25 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.

Executive Summary



*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

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 2023-25

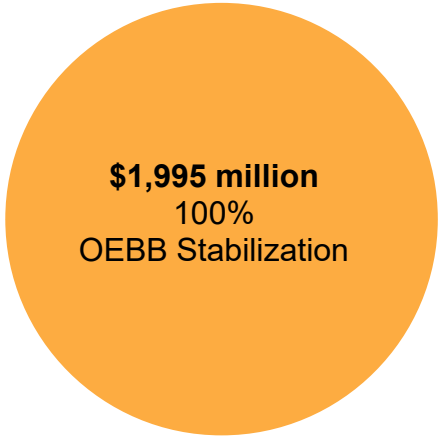
New Entities, of various size, are voluntarily joining OEBB. This increases the number of covered lives participating in OEBB plans. New Entities have the option to participate in all OEBB plan offerings.

Oregon Health Authority

2023-25 Legislatively Approved Budget

Oregon Educators Benefit Board by Program

$1,995 million Total Funds

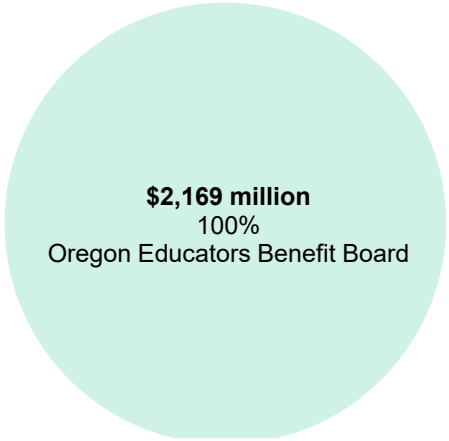


Oregon Educators Benefit Board by Program

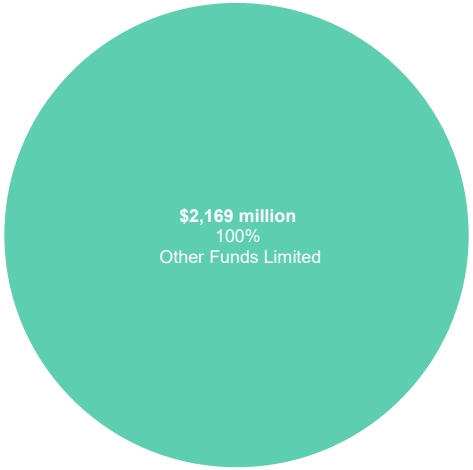
$1,995 million Total Funds

Oregon Health Authority
2025-27 Governor's Budget

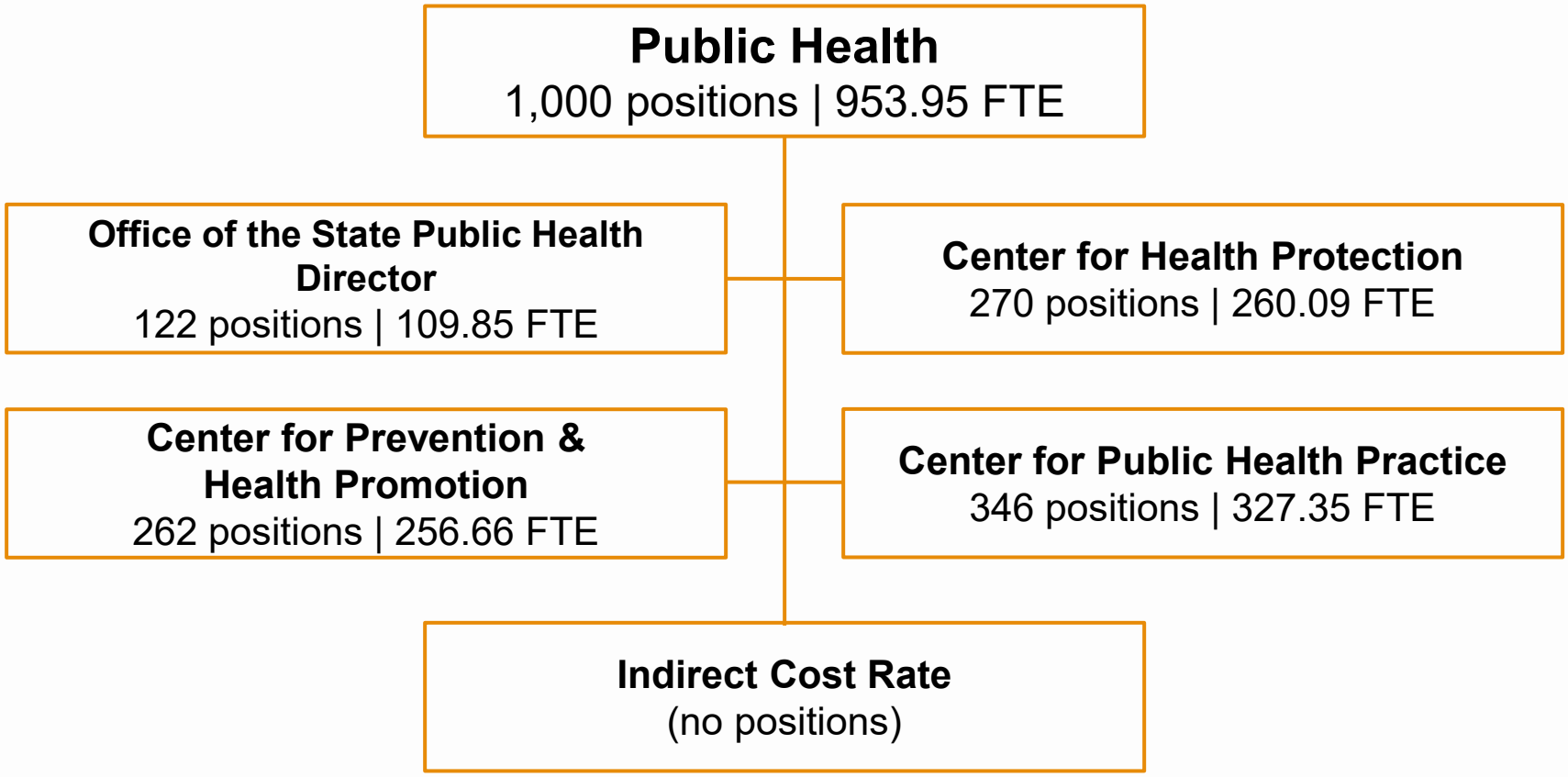
Oregon Educators Benefit Board by Program
$2,169 million Total Funds



Oregon Educators Benefit Board by Program
$2,169 million Total Funds

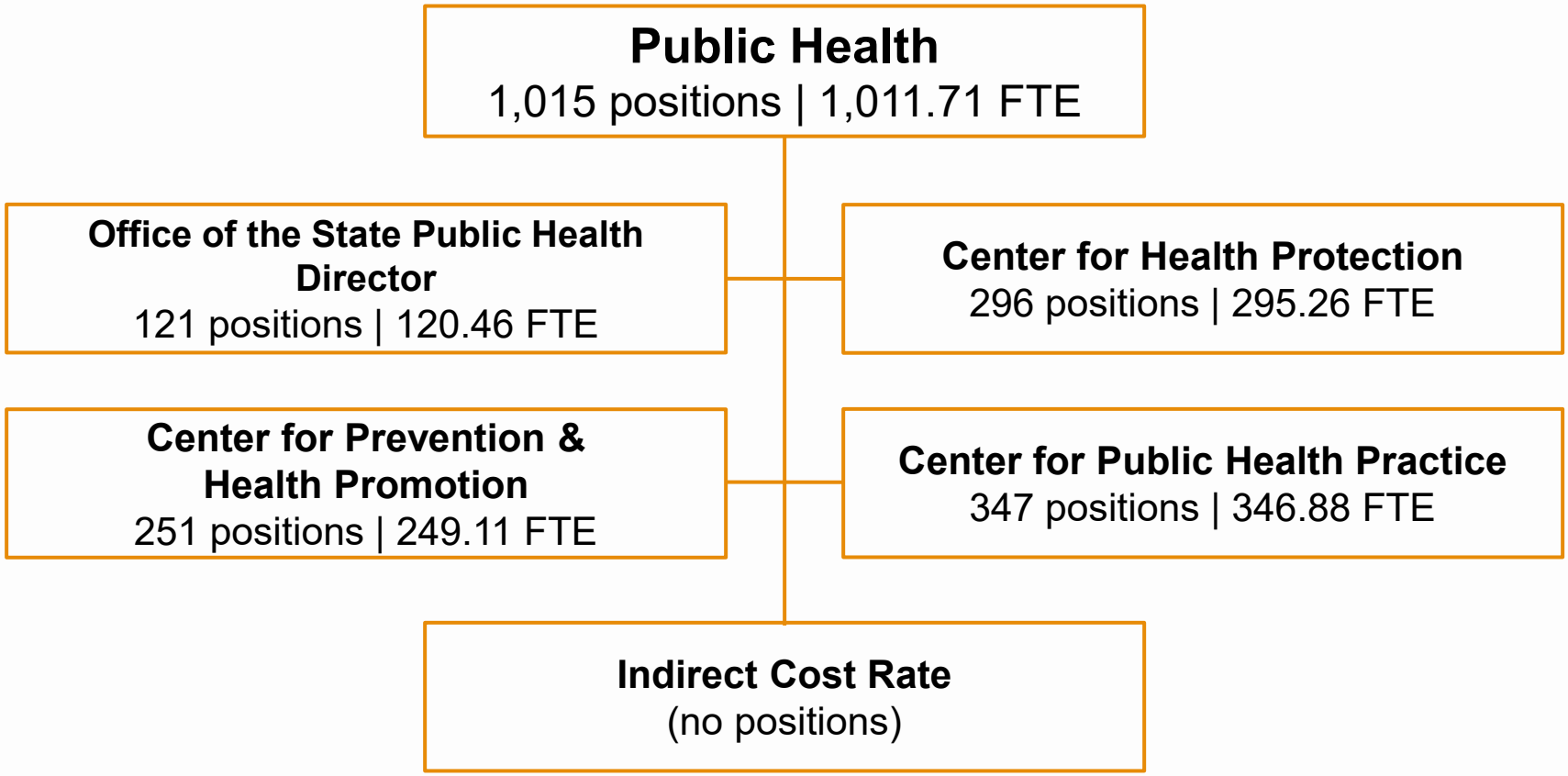


2023-25
Legislatively Approved Budget



Oregon Health Authority

2025-27
Governor's Budget

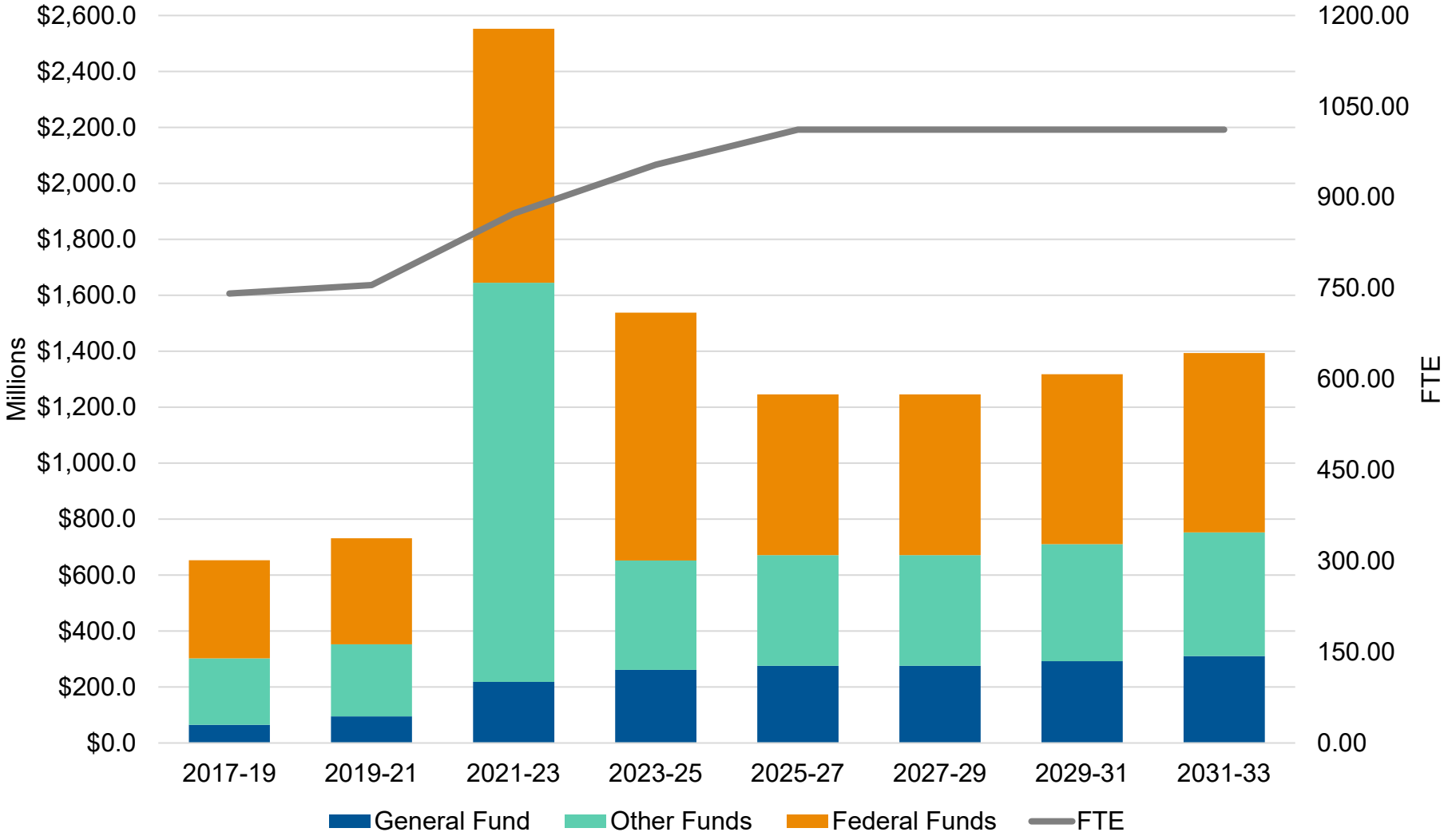


Oregon Health Authority

Oregon Health Authority: Public Health Division

Executive Summary

Program Contact: Naomi Adeline-Biggs, Public Health Director 971-673-2284



Executive Summary

Division overview

Public health uses equity practice, data, science and community wisdom to achieve better health outcomes by preventing the leading causes of death, disease, and injury in Oregon. The OHA Public Health Division (PHD) works in partnership with local public health authorities (LPHAs), Oregon's nine federally-recognized Tribes and NARA, community-based organizations (CBOs), health systems and other partners. PHD programs support implementation of the OHA Strategic Plan by: assuring access to clinical preventive services like immunizations and reproductive health services; preventing substance use; and ensuring healthy families and environments by modernizing Oregon's public health system and implementing home visiting programs.

Recommended funding

The OHA Governor's Budget for the Public Health Division includes $1.2 billion Total Funds for critical investments in public health infrastructure that are necessary to continue progress toward eliminating health inequities. The Governor's Budget includes a $1 million reduction in administrative services and supplies and significant reductions in Federal Funds due to the end of COVID-19 related investments in public health. In addition to the policy packages described below, the Governor's Budget proposes the following General Fund investments: $7 million investment for school based mental health centers and culturally specific suicide prevention, $2.5 million to Seeding Justice to support reproductive health, and $2.5 million in emergency funding should federal reproductive health program funding decline.

OHA has included four policy packages (POPs) that support PHD programs, representing incremental and meaningful increases in key public health initiatives:

- POP 410, Public Health Modernization, funds an additional $2 million in General Fund over current service level to continue critical investments in public health infrastructure for communicable disease prevention, including but not limited to promotion of and access to vaccines in long-term care facilities, and climate adaptation.

Executive Summary

- POP 415, Domestic Well Safety, continues OHA-PHD's commitments to well testing and safe drinking water in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA), and supports program capacity for domestic well safety across Oregon through an additional $3.2 million General Fund.
- POP 426 includes $1 million in Other Funds limitation to support staffing for the Health Care Facilities Licensing and Certification Program.
- POP 427 clarifies Oregon's existing tobacco products assessment, bringing synthetic tobacco products into the program, which adds new revenue to the Tobacco Use Reduction Account.

Program description

OHA's public health mission is to promote health and prevent the leading causes of death, disease, and injury in Oregon. To advance this mission, OHA implements the 2020-24 State Health Improvement Plan (SHIP), Healthier Together Oregon through 62 strategies across 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 services; Behavioral health (including mental health and substance use). OHA is in the process of updating its 2018 State Health Assessment (SHA), which will yield an updated SHIP in 2025.

The public health infrastructure developed as a result of public health modernization has been essential to Oregon's response to emerging public health threats, including opioids, domestic well contamination, and disease outbreaks.

Program justification and link to long-term outcomes

Public health programs and interventions contribute to reductions in health care costs and improved health outcomes, such as:

- A 40 percent decline in the percentage of Oregon adults who smoke cigarettes and an 80 percent decline in youth tobacco use since 2001.

Executive Summary

- Decline in youth alcohol use by nearly 50 percent since 2009.
- Up-to-date immunizations for 91 percent of children served by the Nurse Family Partnership Program at 6 months of age in 2023.
- Decreased prescription opioid dispensing from retail pharmacies from a high of 3.6 million prescriptions in 2013 to a low of 2.2 million in 2021.
- A total of 129,181 visits at 85 school-based health centers during the 2022-2023 school year for 38,188 clients.

Program performance

OHA has a system of performance management and quality improvement to inform public health program implementation. Specifically, OHA collects and reports annually on SHIP health outcome measures and public health accountability metrics, with an updated reporting structure in Fall 2024 that includes statewide, local public health and OHA progress toward metrics. OHA has included several public health accountability metrics in the OHA Performance System and the OHA Strategic Plan, establishing agency-wide commitment to monitoring and improving urgent population health issues through system and policy approaches. OHA has completed all steps to apply for reaccreditation with the national Public Health Accreditation Board and will receive final determination by September 2024.

Enabling legislation/program authorization

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.

Executive Summary

Funding streams

For the 2025-27 biennium, the OHA Governor's Budget for PHD is comprised of General Fund, Federal Funds and Other Funds. Federal revenue includes entitlement grants and more than 150 categorical grants. As a part of COVID-19 response, OHA 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. Remaining funds awarded through these Acts expire in 2026. Other Funds for revenue sources for PHD 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 2023-25

In the 2025-27 biennium, OHA will continue advancements in public health modernization by continuing a focus on health equity, communicable disease control, emergency preparedness and climate adaptation.

To sustain the costs of service delivery in fee-based programs, the 2025-27 OHA Governor's Budget for PHD programs includes fee increases for the Health Care Facilities Licensing and Certification program. Additionally, OHA will implement the Nurse Staffing Law among other legislation impacting public health in Oregon.

Office of the State Public Health Director

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$125.43	$8.03	$153.33	$286.80	122	109.85
Gov. Budget 2025-27	$135.48	$9.30	$35.50	$180.28	121	120.46
Difference	$10.05	$1.27	-$117.83	-$106.52	-1	10.61
Percent Change	8%	16%	-77%	-37%	-1%	10%

The Governor's Budget continues funding the Office of the State Public Health Director at the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies. It invests $2 million General Fund in policy package 410 to modernize public health.

Activities, programs and issues in the program unit base budget

OHA's Office of the State Public Health Director (OSPHD) guides the strategy, operations, science, communication, and policy of 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. The office sets public health priorities in collaboration with state and local government agencies, the Nine Federally Recognized Tribes of Oregon, and community-based organizations. With support from OSPHD, the Public Health Division (PHD) is organized into three centers: Center for Public Health Practice, Center for Prevention and Health Promotion, and Center for Health Protection. OSPHD provides equity, science and epidemiology, 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 Evaluation.

The OSPHD Equity Unit provides overall coordination and leadership for public health division-wide strategic initiatives and systems change, including capacity building related to antiracism and decolonization within public

health practice. The Equity Unit mobilizes partners to advance health equity and address social determinants of health among underserved populations through statewide community- and culturally-specific strategies including outreach, engagement and equitable service delivery. The unit manages cross-division funding programs for 199 community-based organizations.

The Equity Unit works with the OHA Equity and Inclusion Division, Community Partner Outreach Program, regional health equity coalitions, and affected communities in health equity strategy. The Equity Unit partners with communities to determine culturally-specific priorities and invest public health resources in them.

The Finance Unit manages OHA's PHD budget process, provides fiscal management, and manages contracts with local public health authorities, federally recognized Tribes and community-based organizations. It monitors and tracks all funding sources moving into or out of the Division to ensure appropriate resource allocation and responsible fiscal stewardship.

The Science and Evaluation Unit leads 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 Institutional Review Board. The Science and Evaluation 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 Operations Unit manages OHA's PHD human resources, position management, building operations, risk, employee safety and wellness, internal communications, business continuity, quality improvement activities and workforce development. The Operations Unit facilitates optimal public health employee engagement to inform the OHA strategic plan and performance system, leads the implementation of the PHD Strategic Plan, workforce

recruitment, retention and professional development, and quality improvement initiatives. The Operations Unit also provides oversight and coordination across PHD's Health Information Technology projects; and directs and implements PHD's Continuity of Operations Plan, safety procedures and practices.

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's nationally-accredited status, including Oregon's State Health Improvement Plan (SHIP). The unit manages cross-division funding programs for 33 local public health authorities, the Nine Federally Recognized Tribes of Oregon and one Urban Indian Health Program. The unit cultivates strategic partnerships for a cohesive public health system across OHA divisions and through multiple external steering committees and advisory groups. The unit staffs the Public Health Advisory Board, which directs the public health system to lead with racial equity and supports the public health system's commitment to health equity through implementation of public health modernization. The unit provides guidance, technical assistance and project management support for key initiatives related to quality improvement, performance management, accreditation, system integration and innovation for staff. The unit leads collaboration, innovation and consultation for business operations to ensure public health programs and services continue to advance health equity and public health modernization.

OSPHD works across its five units with partners to implement Oregon's SHIP, Healthier Together Oregon, which focuses 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 guided by an external advisory committee and supported by staff throughout OHA. OSPHD is currently conducting a State Health Assessment, which is further described below.

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In addition to the five units described above, OSPHD supports the Oversight of the Interview Process Committee and the Search Advocate program, which leads organizational change for hiring processes to ensure recruitments for public health program positions are equitable, inclusive, anti-racist and culturally responsive.

Background information

As part of national accreditation, OHA's OSPHD is responsible for maintaining five prerequisites on five-year cycles: a state health assessment, a state health improvement plan, an organizational strategic plan, a quality improvement plan and a workforce development plan. OHA anticipates confirmation of reaccreditation in September 2024.

State Health Assessment: In 2018, OHA conducted a State Health Assessment, which informed the five priorities in Oregon's current State Health Improvement Plan, Healthier Together Oregon. State population health indicators from the State Health Assessment are updated annually and serve as the backbone for OHA's reporting of key public health metrics, including key performance measures, Oregon's State Health Improvement Plan (SHIP) measures, and public health accountability measures.

OHA is conducting a new State Health Assessment in 2024. This assessment considers health status, community assets and priorities, and the readiness of the public health system. Information from this assessment will be used to develop an updated State Health Improvement Plan, beginning in 2025. OHA has convened a Steering Committee of community partners and organizations responsible for community health planning to guide the 2024 State Health Assessment and develop the 2025-29 State Health Improvement Plan.

State Health Improvement Plan: The current priorities in Healthier Together Oregon were selected by an external steering committee, based on 2018 State Health Assessment data and feedback provided through extensive community engagement. Priorities include: 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; and behavioral health (including mental health and substance use).

Healthier Together Oregon launched in September 2020. An external steering committee has continued to provide leadership and guidance for advancing the priorities in Healthier Together Oregon. OSPHD partners across OHA and with local public health authorities, coordinated care organizations and nonprofit hospitals for collective impact to achieve statewide health outcomes.

OHA Public Health Division Strategic Plan:
The Oregon Public Health Division Strategic Plan identifies and describes the Division's role in advancing the vision of Public Health Modernization, the commitments of the State Health Improvement Plan and OHA's Strategic Plan. This plan focuses on the PHD workforce and strategic impacts that address internal inequities and builds organizational infrastructure through four strategic priorities: recruitment; retention; promotion and development; and organizational culture.

PHD will use data from the Performance System, the Public Health Workforce Interests and Needs Survey (PH WINS) and measures written into the plan to assess progress toward the plan's short, medium and long-term goals. This plan closely aligns with the PHD Workforce Development Plan and the PHD Quality Improvement Plan.

Public Health Division's Quality Improvement Plan:
The Quality Improvement (QI) Plan for OHA's Public Health Division provides a framework for staff to align quality improvement efforts with the division's mission, vision and strategic priorities. The QI Plan defines the roles and responsibilities of PHD employees related to QI, describes the learning opportunities offered to PHD staff and describes the process for identifying, prioritizing and initiating QI projects. This plan outlines QI goals and objectives for PHD, provides communication strategies and ongoing evaluation processes to support the progression and maintenance of a culture of quality improvement in the division. The QI plan outlines a systematic approach that

allows staff to reflect on how work is completed and how PHD can continue to assess and improve processes to work towards eliminating health inequities by 2030.

Public Health Division's Workforce Development Plan:
OHA's PHD Workforce Development Plan was developed as a guiding force to hold PHD accountable for maintaining a prepared and capable workforce to support the achievement of optimal health for all people in Oregon. The plan was informed by data from the Public Health Workforce Interests and Needs Survey (PH WINS) and includes four goals: increase employee retention; robust professional development; increase workforce diversity; and prioritize workforce well-being.

The objectives listed within this plan will be measured annually to assess progress. This plan will be updated to include needs and gaps identified through a project OHA is collaborating on with the Public Health Advisory Board, the Oregon Coalition of Local Health Officials, several Community Based Organizations, Tribal partners and academic partners to develop a workforce plan that looks at the needs of the workforce across Oregon's entire public health system.

Public Health Modernization
OHA Governor's Budget includes $2 million from POP 410 to further support immunization rates in the state by increasing vaccine clinics at long-term care facilities for older adults and culturally specific outreach in communities to increase 2-year-old vaccinations. 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, OHA's 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.

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- Changed the composition and role of the Oregon Public Health Advisory Board (PHAB) and gave PHAB statutory authority to provide guidance and recommendations for Oregon's population health priorities.
- Required an assessment of capacity to provide foundational capabilities and programs and the resources needed to achieve full implementation.
- Requires PHAB to make recommendations for priorities for state General Fund dollars allocated for public health modernization each biennium and for OSPHD to implement those recommendations with legislative funding allocated.
- 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), including adding a Tribal representative position to PHAB and requiring accountability metrics to be used to monitor progress toward statewide population health goals.

The Legislature has increased funding for public health modernization since an initial investment of $5 million was made in 2017. This critical funding has begun to close gaps in capacity and resources that were identified in the initial assessment of foundational capabilities and programs in 2016. Additional funding provided by the Legislature is as follows:

- 2017-19: $5 million (Initial funding)
- 2019-21: $10 million
- 2021-23: $45 million
- 2023-25: $50 million

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In the current 2023-25 biennium, State General Funds support significant investments in communities through payments to Local Public Health Authorities, the Nine Federally Recognized Tribes of Oregon, community-based organizations and reproductive health providers. Funding is used to:

- Enhance regional infrastructure created during the 2021-23 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.
- Ensure the needs of communities are prioritized in emergency 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.
- Deliver a statewide health equity framework and a statewide workforce plan for Oregon's public health system.

OSPHD and all local public health authorities are currently completing an updated assessment of foundational capabilities and programs and the resources needed to fully achieve a modern public health system that is equity-focused and accountable for improving health outcomes. This updated assessment will provide information on progress made since the initial requirements for public health modernization were enacted in 2015, including continued gaps, and will inform future prioritization of public health system investments. A report of high-level assessment findings will be published online in January 2025.

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Per ORS 431.123, the Public Health Advisory Board, a 21-member committee of the Oregon Health Policy Board, supports implementation of public health modernization through two 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.

Public Health Advisory Board
The Public Health Advisory Board also provides oversight for Oregon's State Health Assessment, State Health Improvement Plan and the Preventive Health and Health Services Block Grant.

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 and improved health outcomes. The local public health authority funding formula includes several variables related to health equity so that future General Fund resources are focused on communities experiencing the greatest burden of poor health outcomes.

Revenue sources and changes

OHA's 2025-27 Governor's Budget for OSPHD programs and services is composed of 76 percent General Fund, 19 percent Federal Funds (primarily through the agency's federally approved cost allocation plan) and 5 percent 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 $112.5 million General Fund to support the ongoing implementation of public health modernization in the 2023-25 biennium. Of this investment, $90 million has been allocated to local public health authorities, community-based organizations, reproductive health providers, 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 and to ensure accountability for these funds.

Finally, the office also receives federal funding from the Centers for Disease Control for the Public Health Infrastructure Grant (PHIG), to implement core public health practices such as communication, community outreach, surveillance and data analysis. Over 60 percent of the grant goes to local public health authorities, Tribes, and community-based organizations; 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

None.

Oregon Health Authority: Public Health Division

Center for Health Protection

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$43.82	$83.45	$56.67	$183.94	270	260.09
Gov. Budget 2025-27	$32.76	$95.92	$57.24	$185.92	296	295.26
Difference	-$11.05	$12.47	$0.57	$1.98	26	35.17
Percent Change	-25%	15%	1%	1%	10%	14%

The Governor's Budget continues funding the Center for Health Protection at the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies. It invests $3.2 million General Fund from policy package 415 supporting domestic well safety in the Lower Umatilla Basin Groundwater Management Area and $1 million Other Funds in policy package 426 to ensure high-quality care in Oregon hospitals.

Activities, programs and issues in the program unit base budget

OHA's Center for Health Protection (CHP) protects the health of individuals and communities by establishing, implementing, and ensuring compliance with regulatory and health-based standards, and identifying risks from environmental exposures. CHP programs and services protect 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. Through CHP programs, OHA 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.

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 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. 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. 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 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.

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 qualifications, 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. OHA's 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. This section also promulgates and oversees cannabis testing rules.

Oregon Psilocybin Services (OPS) administers the Oregon Psilocybin Services Act, the first regulatory framework for psilocybin services in the nation. OPS licenses and regulates the production of psilocybin products and the provision of psilocybin services. In addition to licensing and regulation, OPS partners with state agencies, organizations, and communities across the state to share information about the regulated model.

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. OHA's RPS provides Oregon's sole public resource for radiation-related incidents.

Background information

OHA's 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 approximately 2,400 public water system operators and 1,800 backflow device testers and specialists. Contracts

with county health departments and the Oregon Department of Agriculture provide oversight of smaller public water systems served by groundwater sources. DWS provides technical expertise and best management practices related to emerging contaminants that may affect drinking water quality.

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 including 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.

- The Healthy Homes and Schools Unit includes the Healthy Homes Grant Program, enforcement of lead-based paint safety practices, detection and prevention of childhood lead poisoning, radon awareness and outreach, and regulating hazardous chemicals in children's products under the Toxic Free Kids Act Program.
- The 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 this work by providing technical assistance to local public health authorities, Tribal health departments and community-based organizations to conduct climate and health work.
- The Data and Epidemiology Unit houses Oregon Tracking, part of the CDC's national Environmental Public Health Tracking Network, providing accessible data and analysis on environmental hazards and health outcomes to public health partners and the public. The unit monitors data on adult lead poisoning, pesticide exposures and occupational health with a focus on populations at disproportionate risk from environmental health hazards.
- The Healthy Waters Unit carries out programs related to domestic well safety, fish consumption advisories, harmful algae blooms advisories, beach water quality monitoring and assesses water insecurity and related health issues. A major focus of domestic well safety is to implement OHA's project in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA) to provide outreach and education and water testing and

treatment to residents exposed to elevated levels of nitrates. The Governor's Budget funds a policy package 415 to continue support for the agency's response to nitrate-contaminated domestic wells in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA) and to increase capacity to respond to emerging statewide domestic well contaminants and impacted communities.

- The 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. It also has direct local responsibility to license, inspect and carry out enforcement responsibilities for facilities in Curry and Wallowa Counties.

Health Care Regulatory and Quality Improvement (HCRQI*)* oversees several health care facility types and providers. The Health Facility Licensing and Certification program oversees approximately 97 ambulatory surgical centers, 12 birthing centers, 70 dialysis facilities, 736 hemodialysis technicians, 72 home health agencies, 77 hospice agencies, 64 hospitals and hospital nurse staffing programs, 201 in-home care agencies, 107 rural health clinics, and 10 other provider types.

- The Health Facilities Planning and Safety unit ensures 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. The Certificate of Need program evaluates whether a proposed service or facility is needed.
- Emergency Medical Services (EMS) Program works with partners and 12 advisory boards to monitor and improve the emergency systems of care. The program licenses 137 ambulance service agencies, 794 ambulances, and 12,816 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. The new time-sensitive emergency Specialty Care Centers in hospitals will include stroke, cardiac, pediatric and behavioral health starting in 2026. The Trauma program triennially reviews 45 trauma centers.

Health Licensing Office (HLO) administers 19 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; Sexual Offense Treatment, Genetic Counseling, Temporary Staffing Registration and Sign Language Interpreters. OHA's HLO regulates 6,077 facilities and 79,563 licensees. In 2023, it administered 19,998 examinations, issued 9,918 licenses and registrations, renewed 34,960 licenses and registrations, conducted 8,468 inspections, and investigated 272 complaints.

Oregon Medical Marijuana Program (OMMP) registers 14,585 medical marijuana patients, over 5,000 caregivers, and regulates over 3,711 medical growers at 3,286 grow sites. OHA's 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 administers 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) administers the Oregon Psilocybin Services Act which directs OHA to license and regulate the production of psilocybin products and the provision of psilocybin services. After a two-year development process, from January 1, 2021, to December 31, 2022, OPS adopted rules and began accepting applications for licensure on January 2, 2023. OPS provides technical assistance to licensees and has established the OPS Data Dashboard in order to share data on psilocybin services in Oregon.

Radiation Protection Services (RPS) licenses or registers more than 14,000 sources of radiation statewide. It routinely inspects radiation sources in more than 4,200 facilities including hospitals, dental and medical clinics,

radiation oncology clinics, tanning salons, and academic and research facilities. OHA's RPS investigates and mitigates registrant, licensee, and public domain incidents involving potential/actual radiation over-exposure. RPS staff also conduct environmental radiation surveillance and test food products for radiation contamination prior to import/export.

Revenue sources and changes

OHA's 2025-27 Governor's Budget for the Center for Health Protection comprises of 51 percent Other Funds, primarily in the form of fees for services, 31 percent Federal Funds, and 18 percent General Fund. Funding for each program is described below.

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). The Drinking Water Primacy grant and the Drinking Water State Revolving Fund (DWSRF) capitalization grant. The DWSRF base funding includes support for infrastructure project financing and set asides for specific program functions. From 2022 to 2026, DWS's annual allocation from the Bipartisan Infrastructure Law (BIL), is about $38 million for infrastructure projects, $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.

Environmental Public Health (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. EPH also receives federal funding from the EPA for radon monitoring and public outreach and to enforce

lead-based paint best practices. EPH receives Other Funds revenues through delegated authority and agreements with local public health authorities that assess license fees to support foodborne illness, public pools, 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 work supporting the Department of Environmental Quality's Cleaner Air Oregon program is funded through an interagency agreement. The Pesticide Exposure Safety and Tracking Program is funded through an interagency agreement with Oregon Department of Agriculture. EPH received General Funds for the Healthy Homes Grant Program through HB 2842 (2021), SB 1536 (2022) and SB 1530 (2024); and to support toxicology, epidemiology, climate, built environment and emerging environmental threats staff. HB 4077 (2022) appropriated General Fund for EPH to staff development of an Environmental Justice Mapping Tool. In 2023, EPH received $3 million in General Funds to test and treat domestic well water of people exposed to nitrate-contaminated groundwater in the Lower Umatilla Basin Groundwater Management Area (LUBGWMA) and to support local partners to conduct outreach. The Governor's Budget funds policy package 415 with $3.22 million to continue support for the agency's work in the LUBGWMA and to increase capacity to respond to emerging statewide domestic well contaminants and impacted communities.
EPH also receives General Fund to help support the Toxic Free Kids program. General Fund also supports fish consumption advisories related to the risks of exposure to PCBs and other toxic substances in Oregon's rivers; and to license, inspect and enforce food, pool and lodging health and safety rules in Curry County. HB 3409 (2023) established General Fund resources for OHA to implement a statewide strategy to identify and alert the public to risks of harmful algal blooms in freshwater bodies.

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 staffing and in-home care agencies 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

Center for Health Protection

Medical Services (EMS) program 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 also receives about $3.5 million General Fund per biennium and roughly $331,000 per biennium from the Criminal Fines and Assessment Account. The Hospital Staffing Program receives $2.78 million General Fund per biennium. Policy package 426 includes $1 million in additional funds limitation through licensing fees to improve regulation and ensure high quality care in Oregon hospitals and ensure support during an emergency.

The Health Licensing Office (HLO) collects over $7 million in fees for applications, examinations, licenses and renewals, registrations, disciplinary actions, and other administrative fees. Each board, council and program assess fees, which are used to cover their administrative costs. House Bill 2696 (2023) directed HLO to license and regulate Sign Language Interpreters. Senate Bill 217 (2023) directed the Board of Cosmetology to establish the cosmetology curriculum taught by schools. SB 1552 (2024) directed HLO and licensing boards commissions to provide predeterminations to persons as to whether a criminal conviction will prevent the person from receiving an occupational or professional license.

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. Fee revenue continues to decline since the legalization of recreational marijuana in 2015. The program's budget balance is projected to be in the negative by the end of the current 23-25 biennium. The section also receives some General Fund to support the Oregon Cannabis Commission.

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Oregon Psilocybin Services (OPS) received both General Funds and Other Fund limitation to support one year of the 2023-25 biennium. On January 2, 2023, OPS began accepting applications for licensure of psilocybin services. OPS continues to see an increase in licenses and renewals. OPS expects to continue to transition to Other Funds by the 2027-29 biennium.

Radiation Protection Services (RPS) receives funding from three fee-based regulatory programs, 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 a fee-for-service contract with the Food and Drug Administration to inspect all Oregon facilities performing mammography examinations. Gross RPS program fees total approximately $6.2 million per biennium.

Proposed new laws that apply to the program unit

Legislative concept #44300-013 & Policy package #426: Ensuring High Quality Care in Oregon Hospitals – Hospital Fee Increase

This LC & POP seeks to ensure that OHA has sufficient resources for hospital oversight. Funding for hospital licensing program has remained unchanged for 15 years and no longer covers costs of the program and the full scope of regulatory work required to regulate and support the hospital licensees. There is also a need for more detailed and accessible licensing information about hospitals and other health care facilities during an emergency or natural disaster not supported by existing fees.

Prevention & Health Promotion

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$71.92	$137.12	$273.36	$482.40	262	256.66
Gov. Budget 2025-27	$86.23	$138.66	$282.17	$507.07	251	249.11
Difference	$14.32	$1.55	$8.81	$24.67	-11	-7.55
Percent Change	20%	1%	3%	5%	-4%	-3%

The 2025-27 Governor's Budget continues funding for the Center for Prevention and Health Promotion programs at the current service level and includes the following General Fund investments:

- $2.5 million to Seeding Justice to expand reproductive health equity, including patient navigation services, and support for providers to upgrade facilities due to an increase in patient needs post-Dobbs.
- $2.5 million to hold in reserve to protect Oregon from an immediate disruption in care, should federal reproductive health program funding decline.
- $6 million for school-based health centers to allow for expansion of mental health services, SUD screenings, and prevention services.
- $1 million to expand culturally-responsive youth suicide prevention work.

The Governor's Budget also includes $900,000 of additional Other Funds revenue for tobacco-use reduction and prevention work by modernizing Oregon's existing tobacco products assessment, bringing synthetic tobacco products into the program.

Activities, programs and issues in the program unit base budget

OHA's Center for Prevention and Public 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 2030 goal of eliminating health inequities. Through center programs, OHA promotes population and community-based strategies to increase capacity for K-12 schools to provide school health services, health education, and to be a safe and supportive environment; increases stability and safety in families; increases equitable access to preventive health services; decreases the burden of health inequities borne by communities of color and Tribal communities; increases access to healthy food and increases opportunities for healthy eating and physical activity for all people in Oregon; reduces harms related to opioids and other drugs while promoting protective factors to prevent substance use disorders and reduce drug use; reduces suicide and other intentional and unintentional injuries and deaths; prevents and reduces secondary impacts of COVID-19 and supports recovery. The 2025-27 Governor's Budget includes a $7 million investment for school based mental health centers and culturally-specific suicide prevention. Of this investment, $6 million will be dedicated to school-based health centers to expand capacity for comprehensive behavioral health services, and to support youth-led substance use and suicide prevention projects in partnership with schools across Oregon. $1 million will increase and sustain culturally-responsive youth suicide prevention efforts, including a tribal set-aside and dedicated funds to support Black, African and African American youth prevention programs.

Background information

OHA's Center for Prevention and Health Promotion has the following five sections that work to achieve its mission:

Adolescent, ScreenWise and Reproductive Health (ASRH). OHA's ASRH programs 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 to practice eliminate health inequities in all its programming and services. ASRH:

Prevention & Health Promotion

- 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.
- 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.
- Develops comprehensive programmatic and policy responses to emergent needs related to the changing national landscape of reproductive health access and services. The governor's budget sets-aside an additional $2.5 million to ensure services remain available in response to any federal actions regarding reproductive health.
- Funds community-specific organizations that serve communities of color and Tribal nations 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 the Nine Federally Recognized Tribes of Oregon 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 by analyzing and monitoring the occurrence of chronic diseases and their risk factors by demographic characteristics, including but not limited to gender, race, ethnicity, geography, income, disability, education, age. HPCDP strategies to prevent and manage chronic disease include:

- Equipping the Nine Federally Recognized Tribes of Oregon, local public health authorities, and other diverse communities with the strategies, data, training, technical assistance, 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 in their environments.

- Maintaining mass-reach communications brands to communicate about chronic disease risk factors and to encourage Oregonians to take action in their communities, including Smokefree Oregon and Rethink the Drink, as well as two culturally specific sub-brands, Vive sin fumar and the Native Quit Line.
- Partnering with Oregon's Behavioral Health Division to understand barriers to treating nicotine addiction and increase access to tailored cessation supports.
- Developing data and metrics goals and strategies to improve the section's surveillance and evaluation systems to better reflect the experiences of Oregonians facing health inequities.
- Regulating more than 2,600 tobacco retailers, inspecting more than 99 percent of tobacco retailers licensed by the state since 2023 and decreasing sales to people under the age of 21 from 26 percent in 2022 to 21 percent in 2023, and the Governor's Budget includes policy option package 427 to ensure new nicotine products are appropriately regulated.

Injury and Violence Prevention (IVP) works to prevent intentional and unintentional injuries and deaths due to violence, suicide, substance use, motor vehicle and other transportation crashes, child maltreatment, firearms, traumatic brain injury among youth, and other health risks. Some strategies include:

- Preventing harms related to opioids and other drugs through grants, training and technical support to local public health authorities, the Nine Federally Recognized Tribes of Oregon and community-based organizations serving disproportionately affected populations.
- Working with pharmacies, employers and community human services organizations to make naloxone rescue universally available to prevent deaths due to opioid overdose, including 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.

- Supporting local jurisdictions with overdose emergency response protocols, development of overdose fatality review processes and pain management clinic closures.
- Monitoring intentional (e.g., suicide and homicide) and unintentional (e.g., falls and poisonings/overdoses) injuries and deaths among Oregonians.
- Providing timely, high quality, public data on injury and violence via interactive web-based data dashboards.
- 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 focusing support on high-risk populations and implementing the Zero Suicide health system quality improvement model.
- Providing enhanced Prescription Drug Monitoring Program access to authorized users from within electronic patient care workflows for streamlined access to crucial data at the point of need.
- Managing the Oregon Violent Death Reporting System that tracks deaths by suicide, homicide, and unintentional firearm injury, as well as deaths of undetermined intent.
- Managing the State Unintentional Drug Overdose Reporting System, which tracks trends and circumstances surrounding unintentional overdose deaths.

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, monitors the health of Oregon's pregnant individuals and families with three-year-old children through the Pregnancy Risk Assessment and Monitoring System and Early Childhood Health in Oregon surveys; and monitors the prevalence of birth anomalies through the Birth Anomalies Surveillance System and oral health through the Oregon Oral Health Surveillance System. MCH leads with social justice and anti-racism to identify and focus on historical and current inequities that lead to poor health outcomes.

OHA's 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 pregnant people, postpartum people, 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 is the home of 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 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 one to three 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.

Nutrition and Health Screening (NHS) The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) safeguards the health of about 115,000low to moderate-income pregnant, postpartum, and breastfeeding individuals, 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. In addition, the Oregon Farm Direct Nutrition Program), which encompasses both the WIC FDNP and the Senior FDNP (SFDNP), provides around 60,000 WIC participants and 65,000 income eligible seniors with FDNP checks once a year to purchase fresh, locally grown fruits, vegetables, and cut herbs directly from local farmers. FDNP and SFDNP serve a racially and ethnically diverse population. FDNP and SFDNP connect with participants speaking 82 languages and offer print and translation services through program partner 211 info.

WIC services are delivered through local public health, Tribal health clinics, and non-profit programs. The WIC Program focuses on the pre and perinatal period 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.

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 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

OHA's Governor's Budget for the Center for Prevention and Health Promotion revenues comprises of 17 percent General Fund, 32 percent Federal Funds Limited, 23 percent Federal Funds Non-Limited, 20 percent Other Funds Limited, and 8 percent 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 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, the WIC Farm Direct Nutrition Program food vouchers, and establishment of hospital-based violence intervention programs.

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 reduction, cancer registry and early hearing detection and intervention.
- Core State Injury Prevention Program, National Violent Death Reporting System, Addressing Violence Epidemiology in Real Time, Comprehensive Suicide Prevention, and Overdose Data to Action in States.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) grants for the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program, Strategic Prevention Framework – Partnerships for Success, and Grants to Implement Zero Suicide in Health Systems.
- 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, Early Hearing Detection and Intervention, 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.

- Funding to support opioid overdose prevention by means of grants awarded to other programs within the Oregon Health Authority via the SAMHSA State Opioid Response grant (OHA Behavioral Health Division).

The center's Other Funds revenues include statutorily dedicated funds under the Tobacco Use Reduction Account (TURA), Ballot Measure 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

- Legislative concept 44300-014: School-Based Health Centers Technical Fix. Several technical fixes relating to School-Based Health Centers (SBHCs) will encourage youth participation in decision making, remove out-of-date grant references, and improve technical assistance for SBHCs, without making substantive policy changes.
- Legislative concept 44300-012. Policy package #427: Equitable Enforcement of Commercial Tobacco. The proposed bill will amend the definition of tobacco products to include synthetic oral nicotine products, protects Oregon youth, and provides clear enforcement pathways for tobacco sales violations, by addressing gaps in Oregon tobacco laws.

Oregon Health Authority: Public Health Division

Center for Public Health Practice

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$20.20	$142.47	$384.09	$546.76	346	327.35
Gov. Budget 2025-27	$21.72	$150.86	$200.10	$372.68	347	346.88
Difference	$1.52	$8.39	-$183.99	-$174.07	1	19.53
Percent Change	8%	6%	-48%	-32%	0%	6%

The Governor's Budget continues funding the Center for Public Health Practice at the current service level for the 2025-27 biennium, except for a portion of the administrative reduction to services and supplies. It includes $0.3 million Federal Funds and position authority for one position in the HIV, Sexually Transmitted Diseases and Tuberculosis Prevention section.

Activities, programs and issues in the program unit base budget

OHA's Center for Public Health Practice programs and services protect 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 played a key role in Oregon's response to the COVID-19 pandemic. OHA is committed to bringing community into the design and implementation of interventions to reduce health inequities and burden of disease, along with the impacts of all hazard response and recovery on communities facing systemic, contemporary and historic racism, bias and oppressions. Work within the Center for Public Health Practice is central to Oregon's achievement of the triple aim, health system transformation and the OHA's strategic goal to end health inequities by 2030.

Center for Public Health Practice

The Center for Public Health Practice has six sections:

- Center for Health Statistics, also called 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 (IMM)
- Health Security, Preparedness and Response (HSPR)

In collaboration with partners, OHA invests resources to reduce the burden of disease and health inequities across the state. OHA works with local and Tribal governments, a wide range of community partners, health care providers, and affected communities to prevent, investigate and control infectious diseases. OHA 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, OHA conducts testing for biological agents of mass destruction, such as anthrax and plague, along with emerging public health events and diseases such as the COVID-19 pandemic.

OHA delivers core public health services necessary to maintain a healthy population and respond to and recover from disasters. Vaccine-preventable disease programs ensure that children are healthy enough to attend school regularly and learn successfully. OHA's communicable disease interventions for healthcare associated, respiratory, water-borne, vector-borne, food-borne, zoonotic, and other disease outbreaks prevent disease spread and allow parents to remain at work and sustain a healthy economy. OHA's HIV/STD and tuberculosis programs work with local partners and the community to prevent and eliminate disease transmission. OHA's Oregon State Public Health Lab (OSPHL) screens all newborns in Oregon and provides surveillance testing and whole genome sequencing to support public health programs performing infectious disease control and outbreak investigations. OSPHL is responsible for coordinating emergency laboratory response to emerging pathogens and biological or chemical

threats throughout Oregon. OHA's HSPR programs track the surge capacity of hospitals and public health agencies to respond to public health emergencies, such as respiratory illness, heat events, 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, epidemiology guidance, and coordination for initial stages of emerging public health incidents.

Through programs in the Center for Public Health Practice, OHA is engaged or working toward the following health equity and inclusion strategies by:

- Increasing staff cultural competency.
- Increasing workforce diversity, equity and inclusion.
- Conducting health equity impact analyses on new and existing efforts.

Background information

OHA's 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 and fetal death.
- Registering 126,000 vital events that occur in Oregon annually.
- Issuing 150,000 certified copies of records and 35,000 amendments annually.

Information from vital records is used to assess overall health and identify health inequities needed to develop programs and implement actions to help all people in Oregon stay healthy. For example, race, ethnicity, language and disability information now gathered on birth records will provide a better understanding of inequities related to

health and birth outcomes for different populations. The vital statistics system is modernizing by implementing interoperability standards so that timely death and birth 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 food- and water-borne diseases, meningococcal disease, viral respiratory infections, including influenza and COVID-19, hepatitis, antibiotic-resistant bacterial infections, 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 ACDP implements genomic surveillance; wastewater surveillance; data systems; clinical expertise; infection control capacity; and regional epidemiology support.

The Oregon State Public Health Laboratory (OSPHL) performs 10.7 million tests on approximately 400,000 human specimens biennially. This includes clinical testing for communicable diseases and newborn bloodspot screening. OSPHL coordinates laboratory response to emerging pathogens and biological or chemical threats. OSPHL's Laboratory Compliance section oversees certification of clinical laboratories and accredits environmental laboratories.

The HIV, Sexually Transmitted Diseases and Tuberculosis section (HST) works collaboratively to prevent the transmission of HIV, STD and TB, improve health outcomes, and eliminate health inequities. The primary program functions include prevention, communicable disease control, and monitoring. Services funded promote the elimination of HIV/STD/TB transmission and improved health outcomes. These services include local outreach and education, testing, prevention supplies, lab costs, medications, case management and adherence support.

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. 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 small stockpile of personal protective equipment and medical supplies.

The Oregon Immunization Section (IMM) section ensures access to vaccine and immunization services for all. IMM supports local public health authorities, public and private immunization providers, Tribes, schools, childcare facilities, higher education, community-based organizations, and coalitions to meet Oregon's vaccination needs and to reduce the incidence of vaccine-preventable disease in Oregon. These efforts include maintaining the ALERT Immunization Information System and distribution of approximately $100 million worth of vaccine to immunization providers.

Revenue sources and changes

OHA's 2025-27 Governor's Budget for the Center for Public Health Practice is comprised of 54 percent Federal Funds, 40 percent Other Funds, and 6 percent General Fund.

In response to the COVID-19 pandemic, during the last biennium OHA 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 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. OHA 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.

Center for Public Health Practice

General Fund is used to pay for staff, supplies and equipment necessary to coordinate and deliver the center's services to people in Oregon. OHA 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, 56 percent of General Fund is allocated for distribution to local public health for HIV prevention, STD and TB testing, contact tracing and treatment. 43 percent of General Fund supports lab assistance, medications, medical services, outbreak response and other patient services. The increased need for services necessary to control and ensure treatment for sexually transmitted infections and tuberculosis has grown at a faster rate than the funding received from external partners, such as the CDC.

Health Resources and Services Administration (HRSA) funds are used to support medication access and adherence services through Oregon's AIDS Drug Assistance Program (aka CAREAssist). CAREAssist also generates program income through its 340B Drug Pricing Program model, which accounts for over 80% of the program budget. This Other Fund net balance promotes a continuing annual carryover of restricted funds for maintenance of program operations. OHA 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, as allowed by HRSA.

HST directly administers the Oregon Housing Opportunities in Partnership (OHOP) program funded by three Housing and Urban Development funded, Housing Opportunities for Persons With AIDS (HOPWA) grants. OHA currently receives a total of approximately $1.6 million annually to provide rental assistance and utility support to persons living with HIV/AIDS via OHOP. OHA received a new HUD award effective October 2024. This project was awarded $2.5 million over three years to improve transitions into housing and care for people living with HIV who are exiting Oregon's carceral systems.

Center for Public Health Practice

The Acute and Communicable Disease Prevention (ACDP) section historically receives about $20 million Federal Funds per biennium from the CDC through the Emerging Infections Program (EIP) and the Epidemiology and Laboratory Capacity (ELC) grants. These grants, along with roughly $1 million General Fund, 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.

ACDP received approximately $526 million from the CDC dedicated to COVID-19. Of the $526 million, approximately $98 million remains available for completion of requirements for federally funded projects in the 2023-25 biennium. ACDP received general fund support for four regional epidemiologists and 24 grant funded positions.

In the Immunization section (IMM), state funding supports pass-through dollars to the local public health authorities; a contract for ALERT IIS; and staff and infrastructure support. IMM received $86 million additional Federal Funds to support pandemic activities over the course of 2020-2025, with the majority of those funds passed to local public health authorities, Tribes and community-based organizations. Those funds end on 6/30/2025.

The Oregon State Public Health Laboratory (OSPHL) funding for the 2023-25 biennium totaled approximately $52.7million. In recent biennia, increasing operating costs have outpaced revenues. 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. New laboratory technology is changing the number and types of specimens sent to OSPHL and shifting the workload to OSPHL without corresponding funding to support the testing.

The Center for Health Statistics (CHS) revenues include 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. OHA 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.

The Health Security, Preparedness and Response (HSPR) section is primarily funded through two federal grants, the 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 July 2023, OHA is receiving approximately $22 million from CDC and ASPR to support HSPR program activities.

OHA has received short-term grants for HSPR, including: $2.5 million from the Administration for Strategic Preparedness and Response (ASPR) to advance MRC Coordinator readiness; $6 million from the CDC Epidemiology and Laboratory Capacity grant to support the Oregon Medical Coordination Center at OHSU, as well as $6.2 million to fund national connectivity and expansion for Oregon's hospital capacity system tracking platform. The Corporation for National and Community Service provides $200,000 over the biennium to support OHA's AmeriCorps VISTA Partnership Project. HSPR also receives General Fund to support one position related to Senate Bill 762 and one position related to House Bill 3409.

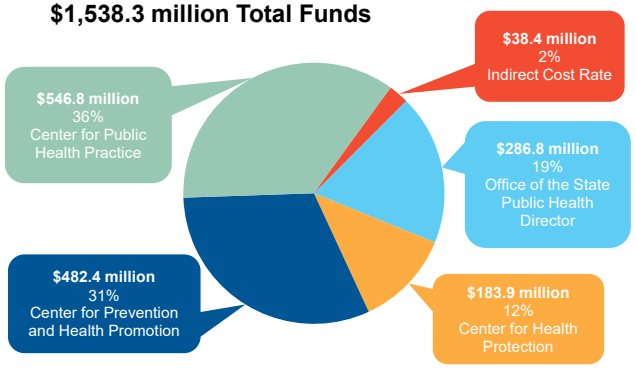
Proposed new laws that apply to the program unit

None.

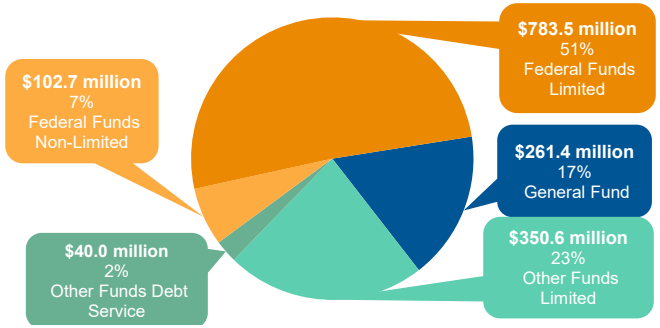
Oregon Health Authority

2023-25 Legislatively Approved Budget

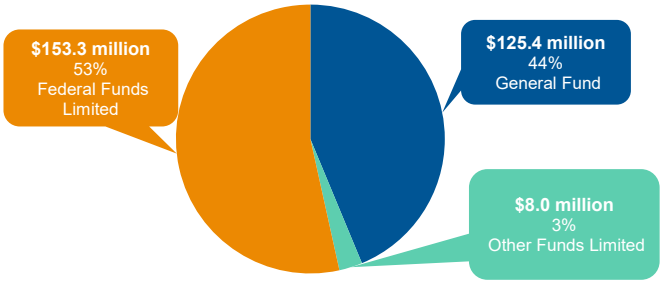
Public Health by Program
$1,538.3 million Total Funds



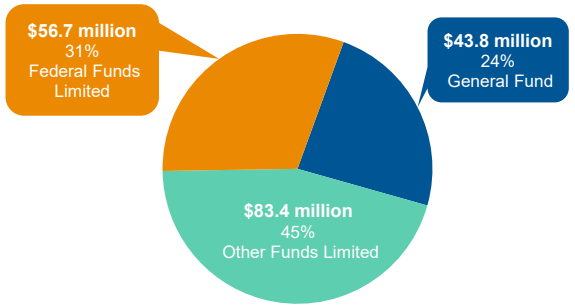
Public Health by Fund Type
$1,538.3 million Total Funds



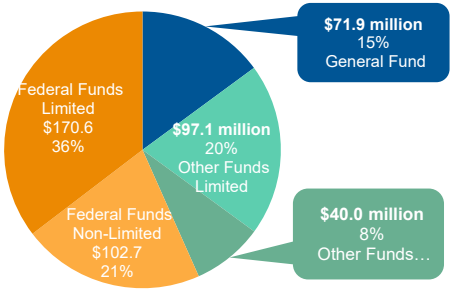
Office of the State Public Health Director by Fund Type
$1,315.9 million Total Funds



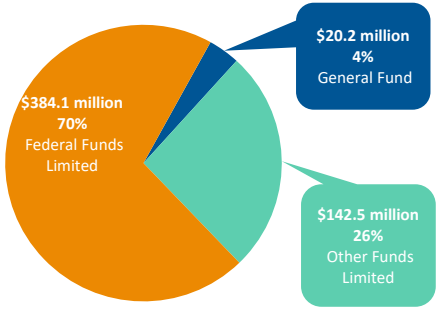
Center for Health Protection by Fund Type
$118.3 million Total Funds



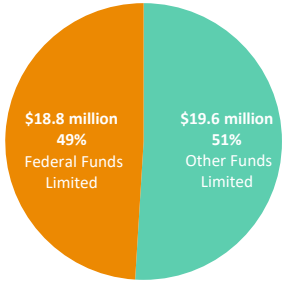
Center for Prevention and Health Promotion by Fund Type
$482.4 million Total Funds



Center for Public Health Practice by Fund Type
$546.8 million Total Funds

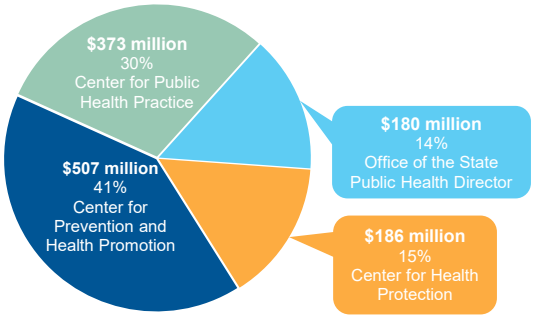


Indirect Cost Rate by Fund Type
$38.4 million Total Funds

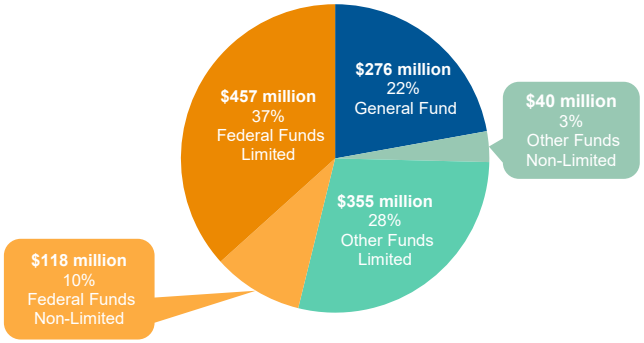


Oregon Health Authority
2025-27 Governor's Budget

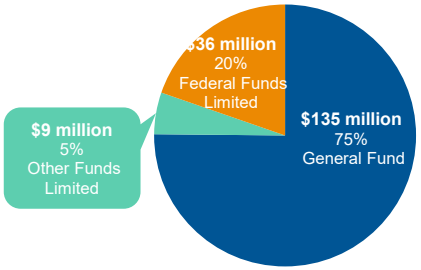
Public Health by Program
$1,343 million Total Funds



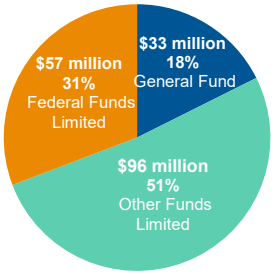
Public Health by Fund Type
$1,343 million Total Funds



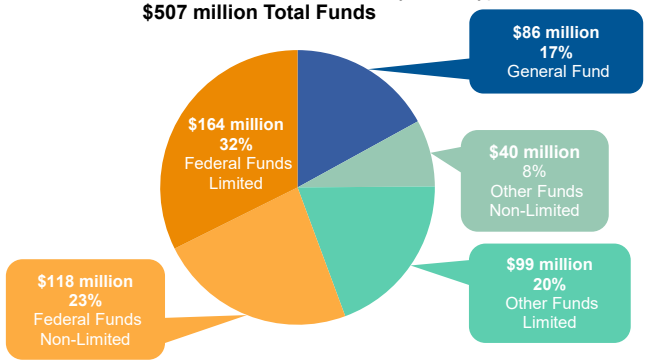
Office of the State Public Health Director by Fund Type
$180 million Total Funds



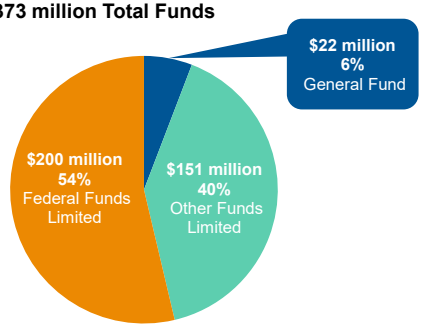
Center for Health Protection by Fund Type
$186 million Total Funds



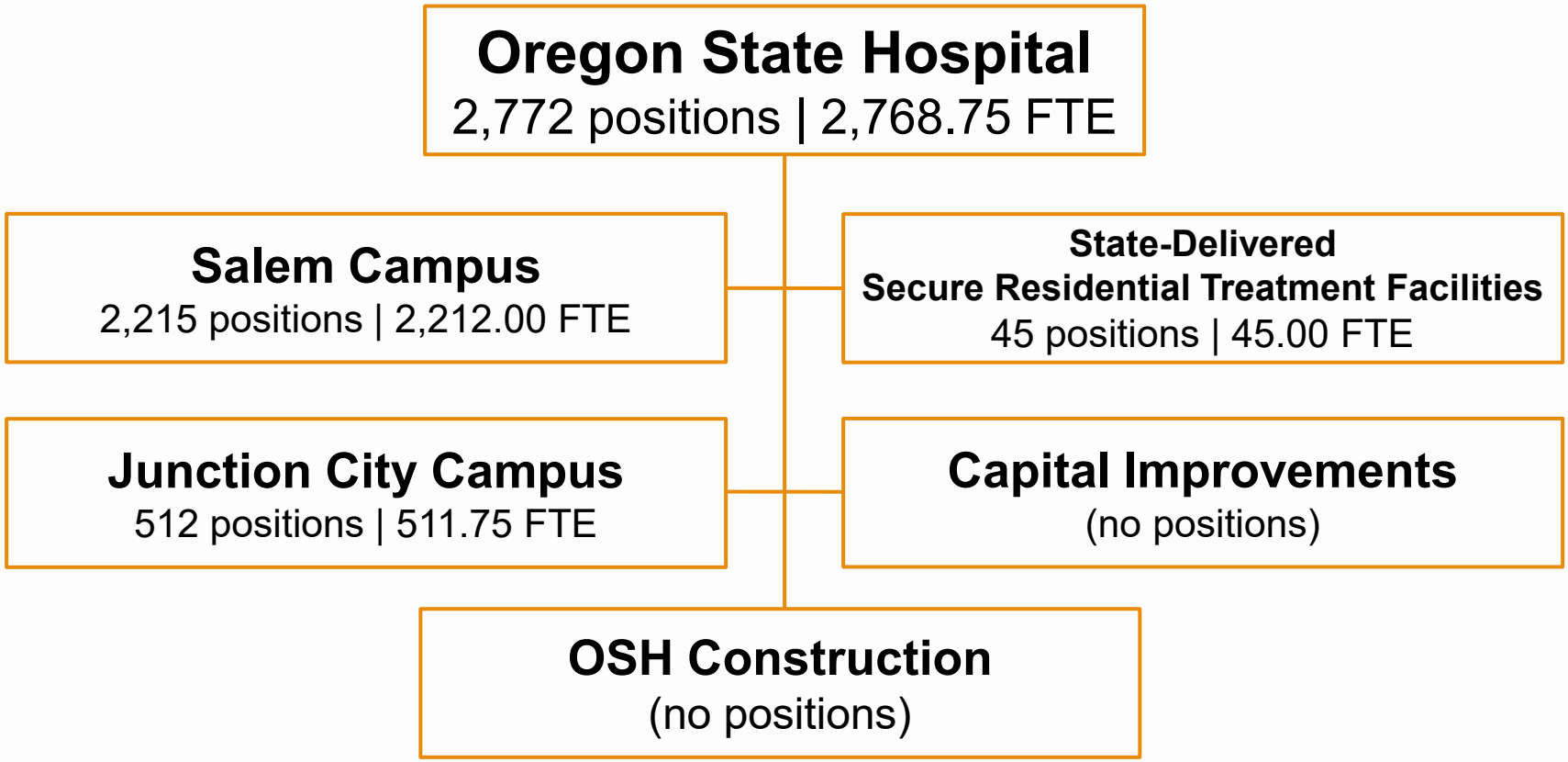
Center for Prevention & Health Promotion by Fund Type
$507 million Total Funds



Center for Public Health Practice by Fund Type
$373 million Total Funds

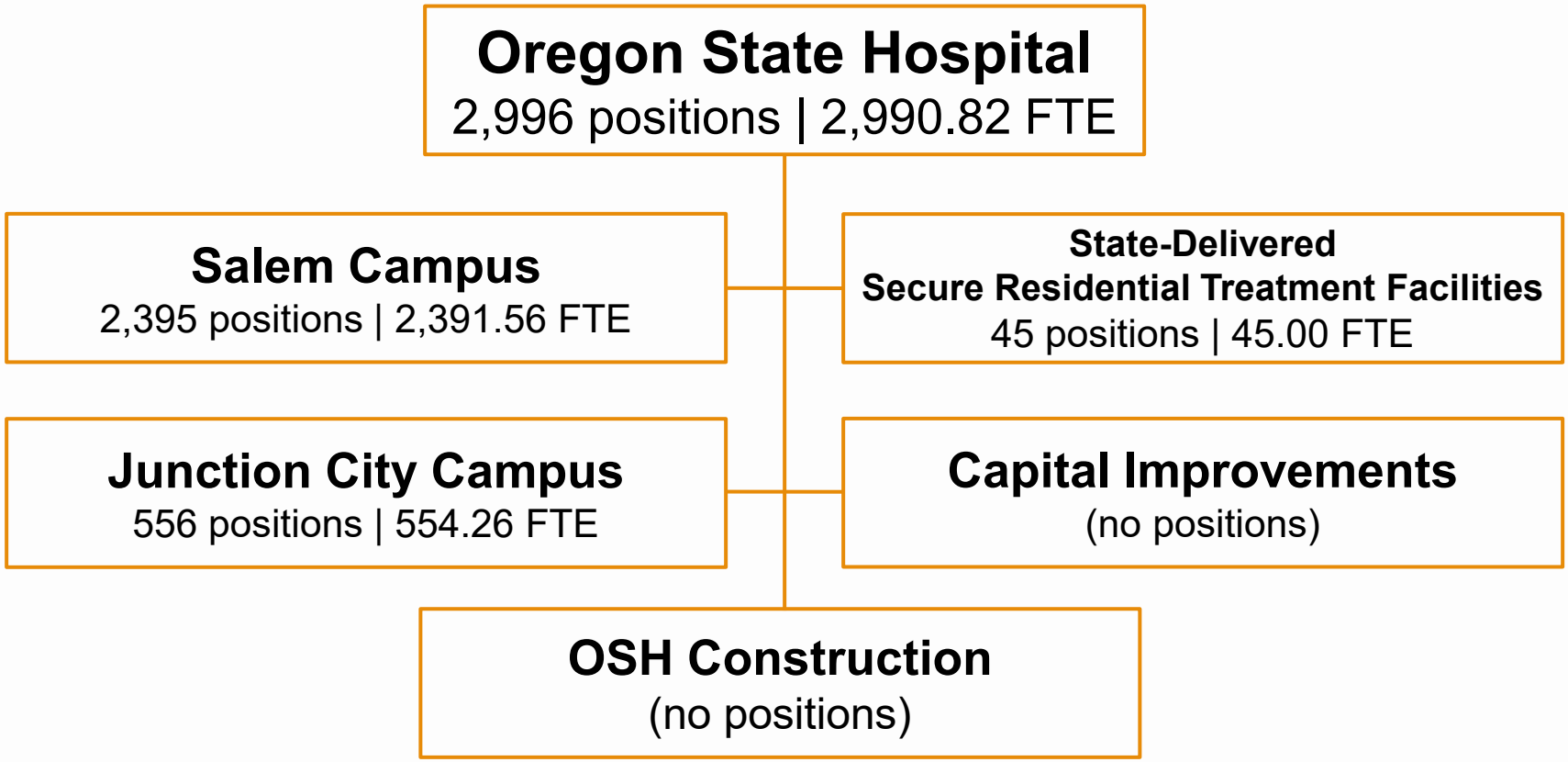


2023-25
Legislatively Approved Budget



Oregon Health Authority

2025-27
Governor's Budget

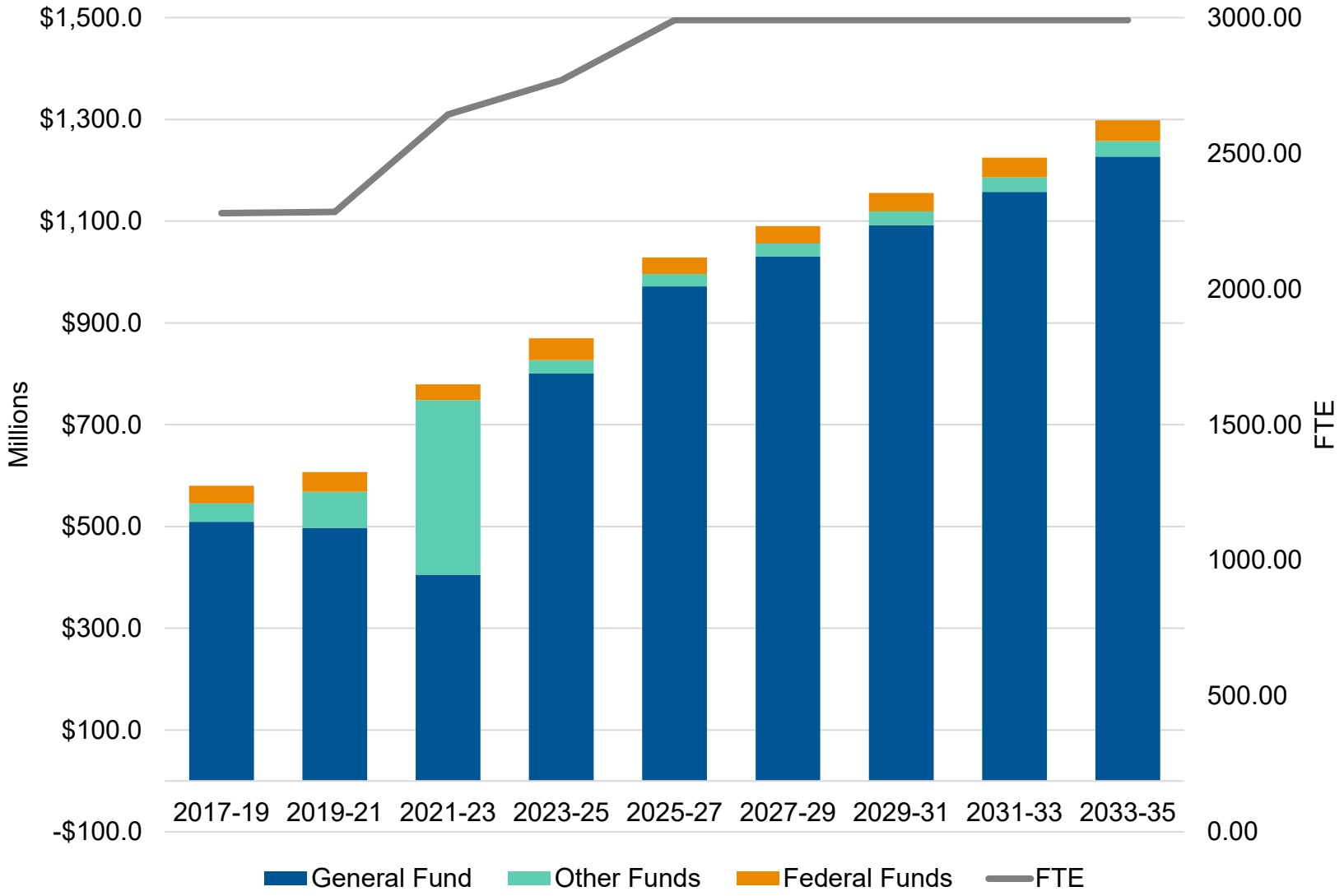


Oregon Health Authority

Oregon Health Authority: Oregon State Hospital

Executive Summary

Program Contact: Karen Jamieson, Chief Financial Officer / Chief Operating Officer 503-572-7663



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 various programs within the Oregon Health Authority, 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 742 licensed beds, with 592 beds in Salem and 150 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.

Recommended funding

2025-27 Governor's Budget for the Oregon State Hospital includes $1.0 billion Total Funds to support continuing operations and policy package requests, including capital improvement and bond financed proposals, and other investments. It also includes position authority for 2,996 positions (2,990.82 FTE). New investments of $11.7 million for 136 nursing positions, $530,000 for behavioral health community navigators, $530,000 to reclassify positions to registered nurses, $690,000 for forensic evaluation services, $3 million for patient vitals monitoring and $5.8 million for enhanced security contracts. Additionally, the 2025-27 Governor's Budget includes funding for the following policy packages in support of OSH:

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- **POP 409 EHR and Information Technology –** Governor's Budget funds $3.1 million for OHA to make enhancements to OSH's electronic health record system (EHR). These information technology investments will promote the safety and wellbeing of patients by ensuring data integrity of patient health records, efficient management of hospital staffing and scheduling, and identification and analysis of risk factors affecting patients and staff safety.

- **POP 414 Native Services** – OHA is funded $212,000 to expand the Native Services program within OSH to ensure adequate provision of culturally responsive care. Enhancements to the Native Services will increase the quantities of native and spiritual services such as sweat lodges, smudge ceremonies, and talking circles. These rituals and ceremonies offer patients a way of remaining connected to their cultural heritage as well as practices that are essential in their recovery.

- **POP 419 Facility Conservation and Development** – This package is funded $4.8 million to provide OSH funding for bond-financed capital improvements and deferred maintenance necessary to keep hospital grounds functional and operational. Repair and replacement of worn facilities components, machinery, and equipment is critical to provide a safe and secure environment for patients and staff, as well as maintaining business continuity.

Program description

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 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

Executive Summary

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 89 percent of OSH's 2025-27 Governor's Budget. Of the 2,996 positions currently budgeted for the Oregon State Hospital, approximately 74 percent are non-managerial, patient care staff such as nurses, psychiatrists, psychologists, therapists, 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 (aid and assist, guilty except for insanity, civil). 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 requirements. The Mink Order of 2003 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 two reports to

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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 public 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.
- Employing resources 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

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organizational goals and desired outcomes. OSH also tracks performance metrics throughout each level of the hospital using the OSH Performance System. This framework provides a clear line of sight to ensure the work is achieving the desired outcomes.

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:

- Incidents of aggression
- 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

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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, ORS 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 2025-27 Governor's Budget for OSH, excluding capital improvement, totals $1.0 billion and is made up of 95 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 2023-25

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.

The 2025-27 Governor's Budget includes policy packages to enhance the Native Services being provided at the hospital (POP 414), critical investments to technology resources (POP 409), and physical plant projects related to deferred maintenance and the replacement of aging equipment (POP 419).

Peter Courtney Salem Campus of the Oregon State Hospital

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$643.46	$15.27	$37.35	$696.08	2,215	2,212.00
Gov. Budget 2025-27	$779.37	$19.82	$26.19	$825.39	2,395	2,391.56
Difference	$135.91	$4.56	-$11.16	$129.30	180	179.56
Percent Change	21%	30%	-30%	19%	8%	8%

The Governor's Budget of $825.4 million Total Funds continues funding for the Peter Courtney Salem Campus of the Oregon State Hospital at the current service level for the 2025-27 biennium. It invests $147,000 General Fund in policy package 414 for the expansion of Native Services and $3.1 million General Fund in policy package 409 to support technology needs.

The analyst adjustments (Package 090) include investments in several OSH programs and services at the Peter Courtney Salem Campus. The Governor's budget provides $9.9 million and 115 MHT positions on the Peter Courtney Salem to allow for an ongoing posting factor for non-licensed Nursing staff. Two (2) Social Work program analysts are funded at $531,300 for the biennium to support the expansion of the OHA Community Navigator program. The reclassification of four (4) Licensed Practical Nurses into four (4) Mental Health Registered Nurses is supported at the $531,500 expenditure difference between those classifications. Funding for forensic evaluation services is provided at $685,900 to support reducing the current caseload awaiting evaluation by OSH. Support for the purchase and continuing use of a biometric solution of monitoring patient vitals was approved at $2.4 million. Security investments of

Peter Courtney Salem Campus of the Oregon State Hospital

$3.6 million were approved to assist with contraband mitigation and increased safety for all employees or visitors to the hospital.

Activities, programs and issues in the program unit base budget

Peter Courtney Salem Campus of the Oregon State Hospital detail

- Capacity: 24 units (592 beds)
- Operating: 24 units (558 beds)
- Population served: aid and assist, guilty except for insanity (GEI), neuropsychiatric (high medical need), and civil commitment (includes voluntary commitments by guardian).
- Census: 543.7 (Daily average population for 2023)
- 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 Peter Courtney Salem Campus of the Oregon State Hospital 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.

Peter Courtney Salem Campus of the Oregon State Hospital

- **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.

- **Archways** – The Archways program serves patients from all three commitment types. This program focuses on stabilization to help patients transition to the next step in their process – which could be a correctional facility, their community, or a Secure Residential Treatment Facility within OSH. Patients each have individual treatment care plans and attend treatment mall groups every weekday. Patients who are at OSH for aid and assist services, receive psychoeducational groups focused on competency restoration. Other treatment groups and resources include a law library, legal assistance, symptom management, anger management, physical fitness, medication management and drug and alcohol education. For those that are at OSH for aid and assist services, 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.

- **Springs/Crossroads** – The Springs and Crossroads program serves patients from all three commitment types. Two of the units serve patients experience co-occurring mental and physical illnesses that often require hospital-

level care for dementia or organic brain injuries. The other four units have the same population and services as Archways and Pathways. For the two specialized units, treatment groups feature sensory and behavioral therapy, focusing on daily living skills, coping and problem-solving skills, and medication management. Patients who are at OSH for aid and assist services, also receive psychoeducational groups focused on competency restoration. Other treatment groups and resources on all units include a law library, legal assistance, symptom management, anger management, physical fitness, and drug and alcohol education. For those that are at OSH for "aid and assist" services, 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 high-acuity 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 symptom management, medication management, legal skills acquisition, and practicing coping skills. In addition to treatment groups, patients may also have individual plans designed to help them improve their ability to maintain safe behavior toward themselves and/or others. For those that are at OSH for aid and assist services, 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.

- **Pathways/Bridges** – Pathways/Bridges are two programs that are supervised by one leadership team. Pathways serves all three commitment types in Hospital Level of Care and has the same population and services as Archways. Bridges is a Secure Residential Treatment Facility (SRTF) that serves all three commitment types. For Bridges, the goal is to help patients achieve their highest level of health, safety, and independence as they

prepare for discharge to a less-restrictive community setting. Individuals work on living skills through daily treatment mall activities, classes, and approved outings (for GEI and Civil only). They also participate in discharge planning with their treatment team members. For those that are in Pathways for aid and assist services, 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.

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 started to increase dramatically in October 2018 and has continued to increase through 2024. The Average Daily Population (ADP) of patients under an Aid & Assist court order has increased by 67% from 221 in 2018 to 370 in 2024 (Jan-Jun). Court orders for competency restoration have increased by 53%, from an average of 61 per month in 2018 to an average of 93 per month in 2024 (Jan-Jun). 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.

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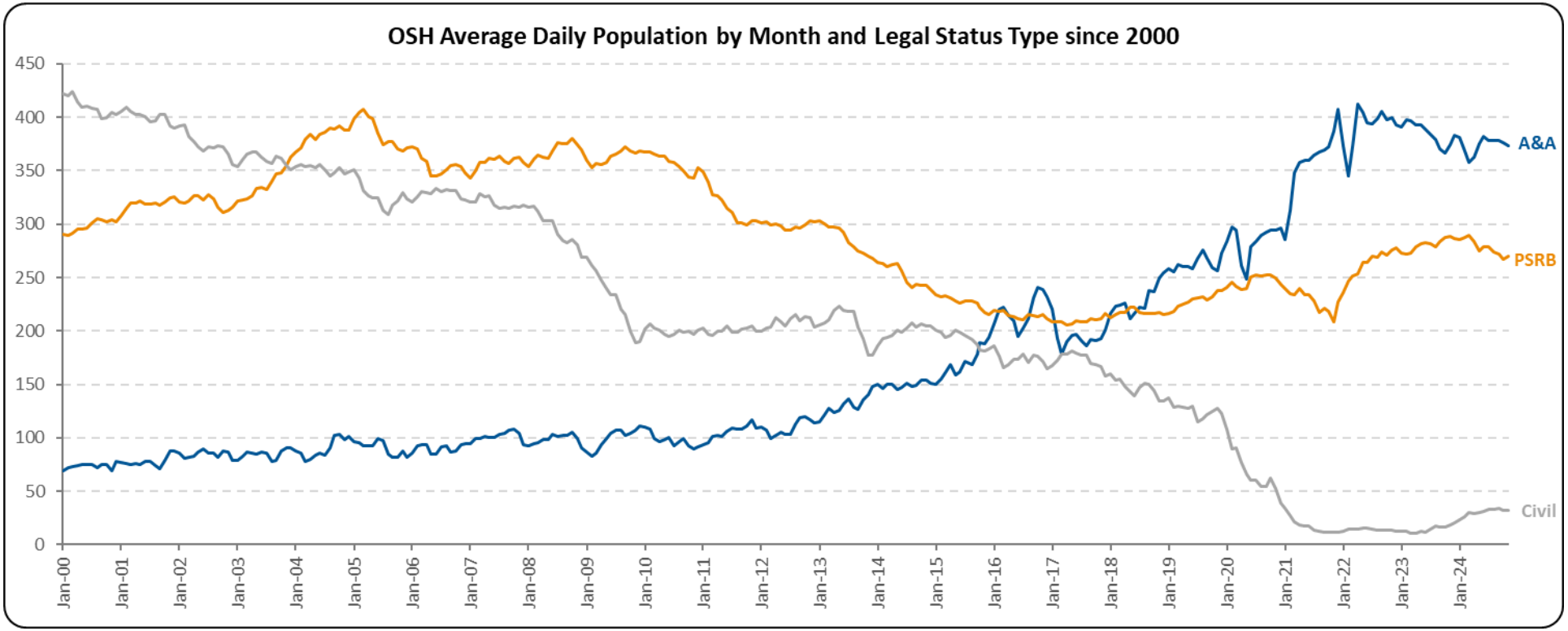

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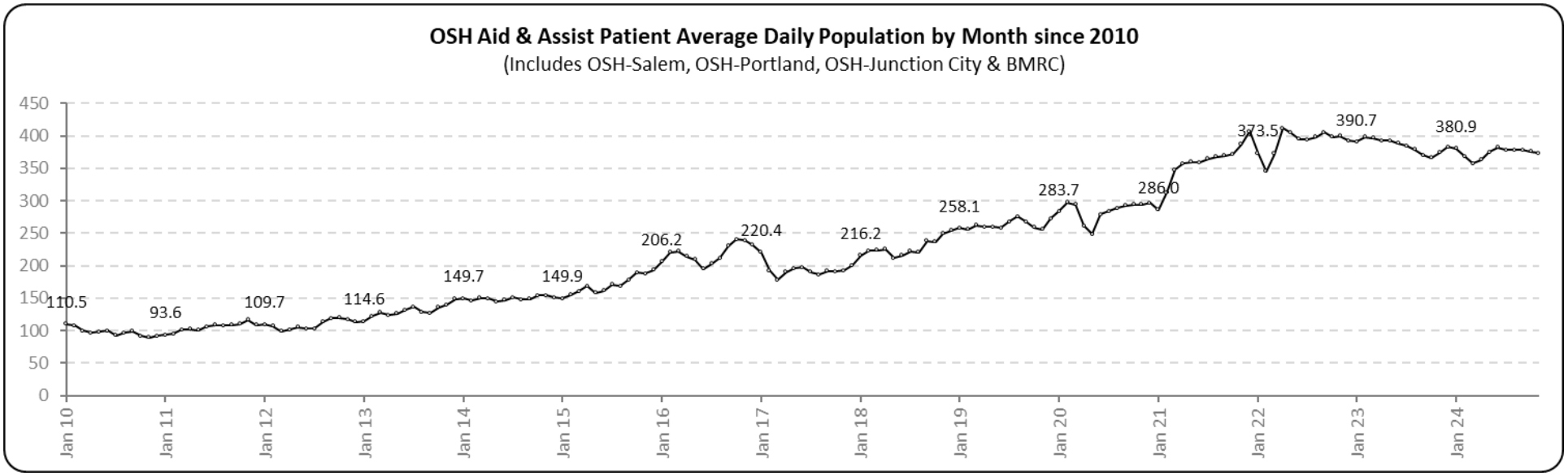


Key to addressing this issue is developing a robust array of community services, including crisis interventions – such as mobile crisis teams and assertive community teams – that enable law enforcement and other community partners to connect people with mental health services, rather than arrest them. 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) is working with community partners to strengthen and expand these services.

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 over the last year, from December 2023 to November 2024, about 22.5 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 would like to secure 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 number of staff on the unit to maintain a safe environment for a patient-centric and effective treatment to occur due to the severity of illness in the patient population.
- Enhanced supervision – The hospital needs additional staff to carry out physician-ordered patient enhanced supervision, 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 behavioral risk (risk of harming themselves or others.)

The OSH Nurse Staffing Committee established its most recent staffing plan in June 2024, to maintain compliance with HB 2697 (2023). 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.

The prevalence of staff callouts (unplanned absences) and physician-ordered patient enhanced supervisions has driven staffing needs well beyond the Nurse Staffing Committee's staffing plan a. 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 12 months, Nursing at OSH has averaged 19,646 hours and

Peter Courtney Salem Campus of the Oregon State Hospital

$1,111,424 in monthly overtime to fill planned and planned and unplanned direct-care staff vacancies, in addition to an increased reliance on contract agency staffing. With a new investment in Nursing Department positions, 115 Mental Health Therapy Technicians, OSH expects a decrease in overtime dependency to cover these absences.

The reliance on overtime to meet staffing needs is not sustainable in the long run. OSH has been cited twice for concern over this practice. First in 2015, via a 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."*

The second citing was by The Joint Commission (TJC) in 2016. TJC 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 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. OSH has put forward proposals for consideration of “phase two” implementation of a sustainable staffing plan.

Revenue sources and changes

The Oregon State Hospital receives 95 percent 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 2 percent of the budget. Finally, Federal Funds from Medicaid and Disproportionate Share Hospital (DSH) payments make up the remaining 3 percent.

One of the financial impacts of a shifting population at Oregon State Hospital is lower numbers of billable days for patients with Medicare coverage due to shorter length of stays. This has reduced the collection of Medicare revenue necessitating fund shift adjustments that occurred most notably in 2021-23. DSH payments have also declined due to adjustments in the FMAP rate.

Proposed new laws that apply to the program unit

OSH has introduced two Legislative Concepts.

In 2002, the federal court issued an injunction requiring OSH to admit specified patients to the hospital within a seven-day period. However, there is no such time limit or requirement for restoration services within community settings. The first legislative concept is a placeholder put forward by a legislative workgroup, but then intends to create restoration time limits and standards for community restoration, or the process by which an individual receives care to reach the mental capacity to stand trial. This bill also intends to change certain admissions requirements for criminal defendants to be admitted to the Oregon State Hospital when they lack the mental capacity to stand trial.

Peter Courtney Salem Campus of the Oregon State Hospital

The second legislative concept is a “housekeeping” bill that adjusts existing statutory language to clarify the intent and amends language with ORS 426 and ORS 161. ORS 426 is revised in multiple sections to clarify that OSH is an inpatient facility for persons 18 years of age or older. Language is added to include care provided by psychiatric nurse practitioners to the treatment received when considering if a patient qualifies as extremely dangerous under ORS 426.701 and allows OSH to hire a Chief Medical Officer whether the Superintendent is also a physician or not under ORS 426.020. The concept clarifies that evaluations performed under ORS 161.371 should be by certified evaluators. And the proposal makes a technical change to ORS 161.362, replacing the term “symptomology” with the “symptomatology” term in use by care providers to prevent any confusion.

Pendleton Cottage

Expenditures by fund type, positions and full-time equivalents

	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
Leg. Approved 2023-25	$6.72	$0.56	$5.63	$12.92	45	45.00
Gov Budget 2025-27	$7.91	$0.23	$6.25	$14.38	45	45.00
Difference	$1.19	-$0.34	$0.62	$1.47	0	0.00
Percent Change	18%	-60%	11%	11%	0%	0%

The Governor's Budget of $1.47 million Total Funds 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 2025-27 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 2023-25 biennium, the facility averaged a 96.6 percent occupancy rate, with an average daily population of 15.5. In accordance with the OHA strategic plan to build a behavioral health system that works for every person, 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. As the transformation of behavioral health strategic actions progress, the Pendleton facility will remain a necessary steppingstone on the overall path of recovery for some individuals who would otherwise not have any options.

Pendleton Cottage

Background information

People served
Pendleton Cottage serves people 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.

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

Pendleton Cottage

- 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.

Staffing

The Agency Request Budget would increase Pendleton Cottage to 46 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 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

Pendleton Cottage

Revenue sources and changes

Revenue sources for Pendleton Cottage in the 2025-27 Agency Request Budget include 56 percent General Fund. Other Funds revenues consisting primarily of private payment Room and Board, with additional revenues for service reimbursement and meal tickets, account for 2 percent of the budget. Federal Funds revenue make up the remaining 42 percent and 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 a 2023-25 fund shift adjustment.

Proposed new laws that apply to the program unit

None.

Junction City Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Funds	Positions	FTE
Leg. Approved 2023-25	$149.41	$0.65	$0.00	$150.06	512	511.75
Gov. Budget 2025-27	$183.81	$0.65	$0.00	$184.46	556	554.26
Difference	$34.40	$0.00	$0.00	$34.40	44	42.51
Percent Change	23%	0%	0%	23%	9%	8%

OHA's Governor's Budget of $184.46 million Total Funds continues funding for the Oregon State Hospital – Junction City Campus services for the 2025-27 biennium and includes $65,250 for policy package 414 for native services.

Analyst adjustments increased the OSH budget in Junction City by adding four new investments. The budget contains funding for 21 MHT positions at $1.8 million to allow for an ongoing posting factor for non-licensed Nursing staff. Approval and support for the $617,000 purchase and continuing use of a biometric solution of monitoring patient vitals. Approval for Security investments of $2.1 million to assist with contraband mitigation and increased safety for all employees or visitors to the hospital.

Activities, programs and issues in the program unit base budget

Junction City Campus Detail

- Capacity – 7 units, (151 beds)
- Operating – 7 units, (144 beds)
- Populations served – civil commitment (includes voluntary commitments by guardian), guilty except for insanity (GEI)
- Census – 139.8 (Daily average population for 2023)

Junction City Campus

- 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.

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.

Nurse Staffing
The Junction City campus staffing continues to present complexities. In 2021-23, OSH opened the final two units at the Junction City campus making a total of six units. Without a posting factor, Junction City experiences difficulty in reaching staffing levels approved by their Nurse Staffing Committee. Junction City Nursing experiences average monthly overtime utilization of approximately 1,954 hours and $195,931 per month. The average percentage of staff absent each day (non-delivered rate) for the last 12 months, December 2023 through November 2024, is 23.9 percent.

Revenue sources and changes

The Agency Request Budget for Junction City campus of the Oregon State Hospital is almost exclusively funded by General Fund. Other Funds revenues from 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 contribute slightly (less than 1%) to the budget profile. The Junction City campus receives no Federal Funds revenue.

Proposed new laws that apply to the program unit

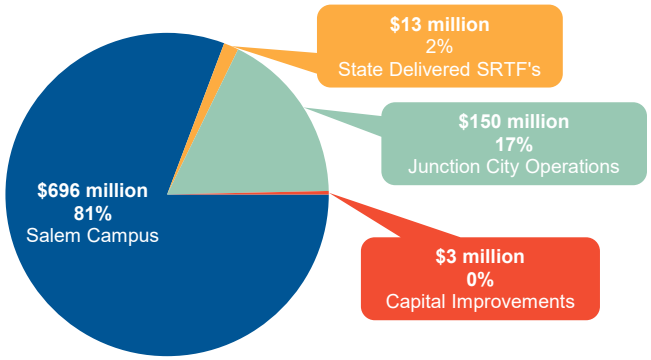
OSH has introduced one Legislative Concept, which applies to the Junction City program.

OSH introduced a “housekeeping” bill that adjusts existing statutory language to clarify the intent and amends language with ORS 426 and ORS 161. ORS 426 is revised in multiple sections to clarify that OSH is an inpatient facility for persons 18 years of age or older. Language is added to include care provided by psychiatric nurse practitioners to

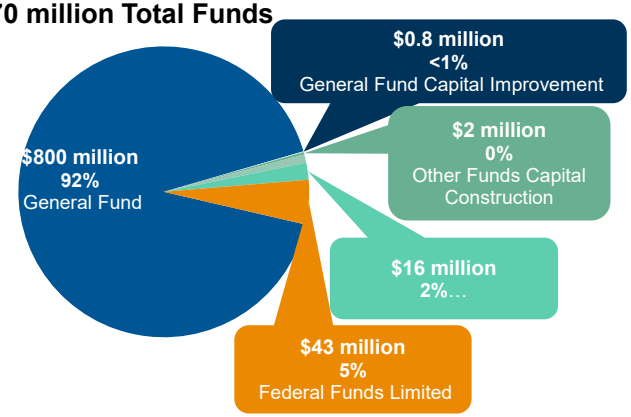
the treatment received when considering if a patient qualifies as extremely dangerous under ORS 426.701 and allows OSH to hire a Chief Medical Officer whether the Superintendent is also a physician or not under ORS 426.020. The concept clarifies that evaluations performed under ORS 161.371 should be by certified evaluators. And the proposal makes a technical change to ORS 161.362, replacing the term “symptomology” with the “symptomatology” term in use by care providers to prevent any confusion.

Oregon Health Authority
2023-25 Legislatively Approved Budget

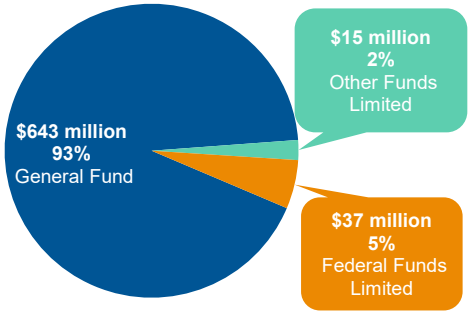
Oregon State Hospital by Program
$870 million Total Funds



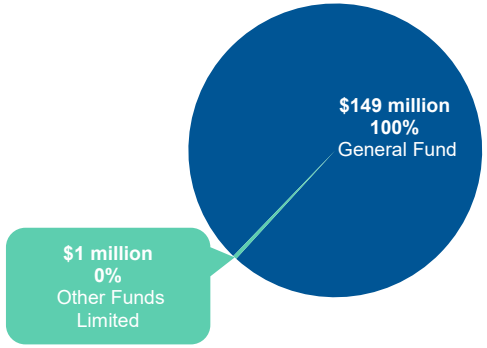
Oregon State Hospital by Fund Type
$870 million Total Funds



Salem Campus by Fund Type
$696 million Total Funds

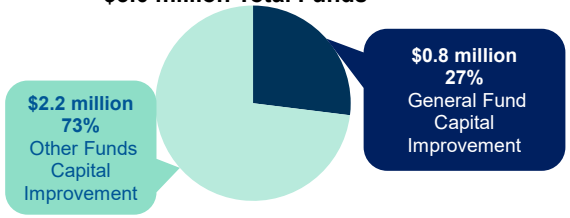


Junction City Operations by Fund Type
$150 million Total Funds



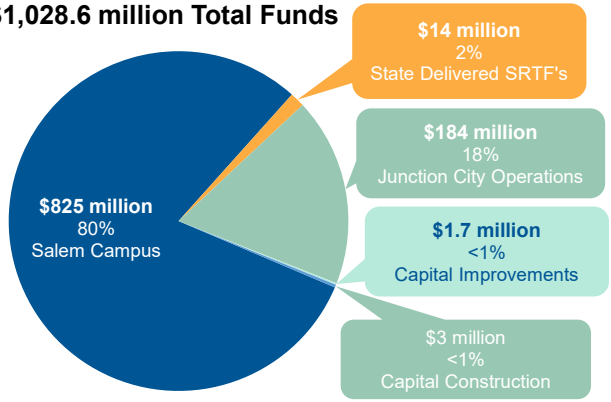
State Delivered SRTFs by Fund Type
$13 million Total Funds

Capital Improvements by Fund Type
$3.0 million Total Funds

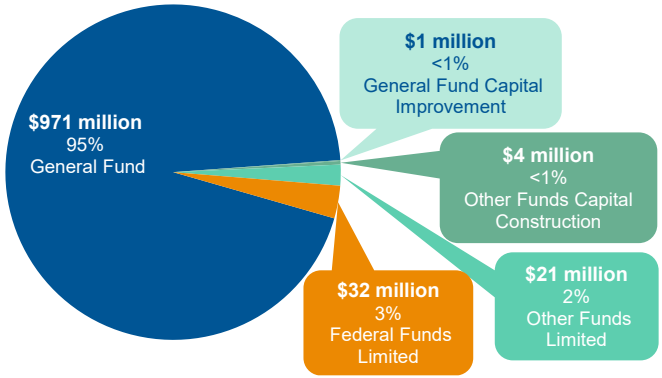


Oregon Health Authority
2025-27 Governor's Budget

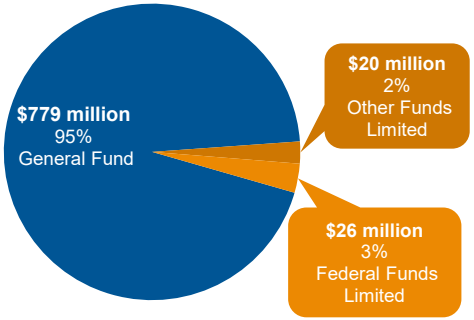
Oregon State Hospital by Program
$1,028.6 million Total Funds



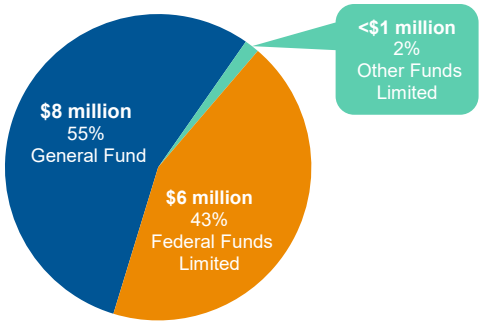
Oregon State Hospital by Fund Type
$1,028.6 million Total Funds



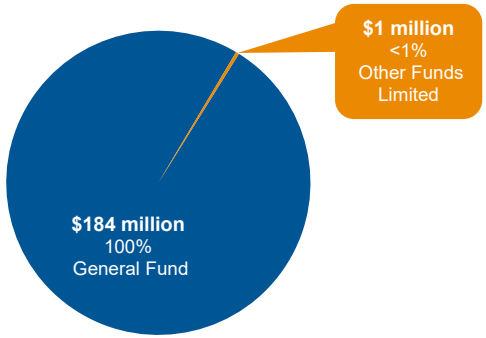
Salem Campus by Fund Type
$825.4 million Total Funds



State Delivered SRTFs by Fund Type
$14.4 million Total Funds



Junction City Operations by Fund Type
$184.5 million Total Funds



Capital Improvements by Fund Type
$1.7 million Total Funds

Capital Construction by Fund Type
$2.7 million Total Funds

Oregon Health Authority Policy Package for the 2025-27 Governor's Budget

POP #	Title	Description	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
201	**Mainframe Modernization**	Over a million people in Oregon depend on an aging mainframe platform supported by a dwindling number of technical specialists. POP 203 was approved in 2023-25 to start moving from the mainframe to a more modern, flexible, and supportable technology that can meet the needs of constituents who expect and rely on ODHS to provide services reliably and securely. Moving off a 50-year-old platform requires a multi-biennium effort and this POP continues work that has already begun.	$734,146	$5,951,252	$223,773	**$6,909,171**	-	-
202	**Improve IT Security and Privacy Posture**	The Information Security and Privacy Office (ISPO) supports both OHA and ODHS programs by providing assurances in the protection of agency regulated data, (Health Insurance Portability and Accountability Act, Personally Identifiable Information, Federal Tax Information, etc.) risk identification and mitigation, and the confidentiality, integrity, and availability of information for the communities whom OIS serves. ODHS|OHA remain responsible for the protection of their regulated data including the breadth, volume, scope, and associated governance, risk, and compliance of that data. Information, security, and privacy standards are much greater than most other state agencies; as the human impact of information security and privacy risks in government health and human services data is substantial, encompassing compromised privacy, financial harm, emotional distress, potential medical mismanagement, and erosion of public trust. ODHS|OHA must proactively invest in resources and tools to strengthen these essential areas, address Secretary of State audit gaps and mitigate privacy risks and vulnerabilities impacting both agencies.	$869,154	$3,869,840	$361,033	**$5,100,027**	4	2.00
406	**Required Inclusive & Supportive Access**	This policy package outlines long needed strategic investments that are necessary to achieve 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 OHA's health equity definition. This package outlines necessary investments to bolster current service levels as well as resources to meet upcoming regulatory requirements including the U.S. Department Of Justice's requirement for comprehensive digital accessibility; the ongoing requirement to provide facilities and services that are meaningfully accessible to our employees and the public alike regardless of their language abilities and disability status; and to establish and steward a work environment that is respectful, professional and in alignment with people's wellbeing.	$1,894,022	$165,727	$307,778	**$2,367,527**	5	5.00
407	**Health Care Market Oversight Program Funding Support**	Requests General Fund to support the Oregon Health Authority's (OHA) administration of the Health Care Market Oversight (HCMO) program in the 2025-27 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 POP requests funds for program staff and operating	$2,648,565	$466,688	$-	**$3,115,253**	2	4.54
408	**Medical Benefits for Incarcerated Individuals**	Transforms health care access and support within Oregon's carceral system by funding the service delivery of the 1115 Reentry Demonstration Waiver. Ensures adequate OHA staffing, technical assistance, and best practices for implementation, enhancing service delivery and equity. Without funding, these efforts stall, risking no availability of state budget for service costs, causing delays in CMS compliance, hindering technology integration, and preventing the development of essential health care benefits for populations experiencing incarceration. This shortfall would exacerbate health disparities, impeding progress towards health equity in Oregon's prisons and reintegration into community-based services thereafter. Funding also includes building a similar benefit package for Tribal members who may not opt into CCO enrollment for 1115 coverage to	$14,290,185	$0	$49,725,345	**$64,015,530**	7	5.75
409	**EHR and Information Technology (AVATAR)**	The components within this POP are essential to delivering clinical care and meeting Centers for Medicare and Medicaid Services (CMS) requirements at the Oregon State Hospital (OSH). This POP contains enhancements that promote the safety and wellbeing of patients, ensure data integrity of patient health records, efficient management of hospital staffing and scheduling and identification and analysis of risk factors affecting patients and staff. This request will replace an outdated version of OSH's EHR that will no longer be supported in 2025.	$3,100,000	$-	$-	**$3,100,000**	4	1.89
410	**Public Health Modernization**	Since 2013, Oregon has been on a path to fundamentally transform the public health system to ensure essential protections for every person in Oregon. A modern public health system is equity-focused and accountable for improved health outcomes. The groundwork laid with early investments in public health modernization have better prepared Oregon to respond to public health threats, including the COVID-19 pandemic and cyclical events due to Oregon's changing climate. However, each new public health threat and event highlights gaps in the public health system's capacity to adequately serve communities at greatest risk of harm. This policy package provides an incremental increase in funding to implement the key priorities selected by the Oregon Public Health Advisory Board (PHAB). This critical funding will be used to address system-wide gaps that prevent Oregon from making progress toward eliminating health inequities, specifically within immunization rates for children and older adults. Not funding this policy package challenges OHA in continuing to meet the deliverables and timelines prescribed in House Bill 3100 (2015).	$2,000,000	$-	$-	**$2,000,000**	-	-
411	**Regional Health Equity Coalition Expansion**	Sustaining and growing the RHEC program provides expertise and assistance to the state to demonstrate and carry out regionally appropriate, concerted efforts to address issues of inequity across Oregon. This program is one of OHA's key mechanisms for meaningful community engagement and creates a direct link between the agency and those the agency serves. This policy package increases funding for existing RHECs, expands the total number of RHECs to work toward greater statewide representation, and increases OHA staffing to ensure sufficient grantee	$3,640,000	$39,316	$73,018	**$3,752,334**	2	1.38
412	**Operationalizing Equity in Health System**	This POP is focused on building organizational equity infrastructure through strategic investments needed to create and operationalize equitable health services delivery system across the full health spectrum: physical, behavioral, and oral health. Each of the component of this POP offers opportunities for strategies, functions, and meaningful deliverables that will drive OHA's work towards eliminating health inequities by 2030.	$588,118	$0	$0	**$588,118**	3	2.38
414	**Native Services**	The purpose of this request is to establish a permanent Native Services program by establishing six positions that would provide native services spiritual and recovery practices at OSH on both the Salem and Junction City campuses. Providing equitable native services is federally required as stated in the Indian Religious Freedom Act (IRFA) of 1978 and the Indian Health Care Improvement Act (IHCIA)-Public Law 94-437.	$211,729	$-	$-	**$211,729**	6	2.93
415	**Domestic Well Safety Program**	This policy package will support ongoing OHA obligations to protect residents of the Lower Umatilla Basin Groundwater Management Area (LUBGWMA) from high levels of nitrate in their domestic well water and increasing demands statewide from rural residents experiencing water insecurity due to contaminated drinking water from their domestic wells. The package includes an increase of $3.2 million above the 2023-25 General Fund service levels of $3 million for education, outreach and community engagement, including for health consultations, statewide; and in the LUBGWMA pay for testing and kitchen-tap treatment systems; cover Oregon Department of Human Services field operations to collect and transport water samples for laboratory testing, cover paid media expenses, develop and maintain case management data systems, and contract with Morrow and Umatilla local public health authorities and local community based organizations to support residents in accessing safe water	$3,225,146	$-	$-	**$3,225,146**	8	8.00

Oregon Health Authority Policy Package for the 2025-27 Governor's Budget

POP #	Title	Description	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
417	**Healthier Oregon: Reinvesting OHP Bridge Savings**	Transitions qualifying individuals from Healthier Oregon to OHP Bridge.Seeks to secure $75 million per year in federal funds. Reinvests $60.3 million in savings after offsetting the $2 million cost of for IT system updates to facilitate the transition. The timing of this transition remains unknown, but the target effective date is July 1, 2026. In the absence of this policy package, the state would forgo $130-160 million in federal funds per biennium. This package recommends reinvesting $54 million General Fund into Healthier Oregon and offers $6 million General Fund savings to be available to fund other investments in the Oregon Health Plan (OHP). This package continues benefit coverage for these members as they are currently covered with OHP.	($18,131,796)	$-	$42,863,403	**$24,731,607**	-	-
418	**Child Medicaid Behavioral Health: Home and Community-Care Based Services**	Provides initial resources to develop and implement CMS requirements to deliver Home and Community-Based Services (HCBS) for children and youth with behavioral health needs. Provides resources and addresses CMS compliance by implementing key steps: selecting assessment tools, developing case management systems, establishing provider networks, and refining eligibility processes. Builds upon, and is contingent on, resources and structures outlined in the Adult Medicaid BH POP for HCBS. Provides access to HCBS for children and youth with behavioral health needs, ensuring equitable service delivery and compliance with federal requirements while enhancing health outcomes and reducing disparities. If not funded, Oregon risks continued non-compliance with CMS mandates, potentially losing federal funding crucial for HCBS programs, exacerbating disparities in health care access, and hindering efforts to improve health outcomes for children and youth with behavioral health	$395,977	$-	$523,731	**$919,708**	3	2.25
419	**OSH Facility Conservation and Development**	The Salem campus of the Oregon State Hospital (OSH) consists of 1.2 million sq. ft. of buildings and interior secure perimeter court yards, and 23 cottages with a current replacement value (CRV) as reported to the Capital Advisory Board of $495 million. This makes the Oregon State Hospital among the highest replacement value of any single facility owned by the state. The Junction City campus is 229,816 sq. ft. with a current CRV of $180 million. The Pendleton Cottages facility consists of several older buildings with a total of 39,390 sq. ft. and a current replacement value of $10 million. OSH is at a crossroads where its facilities have reached an age where a robust long-term investment strategy is needed to ensure that it can effectively meet OHA's strategic plan to support all Oregonians in need of mental health treatment. This policy package provides the support OSH needs in the interim to ensure business continuity, and to reduce long-term escalation in capital outlay as building systems are added to the deferred maintenance backlog.	$1,720,156	$7,545,000	$-	**$9,265,156**	-	-
421	**Hospital Tax Renewal**	The hospital tax program administered by the Oregon Health Authority is crucial to funding the Oregon Health Plan (OHP), which provides approximately one-third of its total funds when combined with federal dollars. OHP offers essential medical, behavioral, oral health, and Health-Related Social Needs services to individuals at or below 138% of the federal poverty level, regardless of citizenship status, ensuring equitable health outcomes for low-income Oregonians. Without authorization to continue the hospital tax program, Medicaid stands to lose nearly $2 billion in funding. This loss would necessitate widespread cuts to benefits, services, and programs Oregonians rely on for their health needs. Extending the hospital tax program is essential to maintaining the quality and accessibility of OHP services for all eligible individuals, stabilizing the program and ensuring meaningful health care access for Oregonians in need.	($1,091,000,000)	$1,651,300,000	$1,424,700,000	**$1,985,000,000**	-	-
422	**Insurers' Tax Renewal**	Oregon Health Authority administers the Oregon Health Plan (OHP), which provides medical, behavioral, and oral health services and a Health-Related Social Needs benefit program for persons at 138% of the federal poverty level and below, regardless of citizenship status. The programs and services offered by the Oregon Health Plan are crucial to ensuring equitable health outcomes for Oregonians with low incomes. The Department of Consumer and Business administers the reinsurance program. The program is designed to stabilize rates for individuals purchasing insurance on the individual market, receiving federal funding through a waiver from the federal government. The program reimburses insurers for high-cost enrollees and spreads risk across the broader health insurance market in Oregon. Without extending the insurer tax program, these critical healthcare programs risk losing funding.	($133,891,664)	$170,215,962	$87,641,664	**$123,965,962**	-	-
423	**PEBB OEBB Program Integrity and Development**	The commercial insurance market has evolved considerably over the past decade, to the extent that we must seek new means to ensure that PEBB and OEBB members are getting the best possible deals for high quality, equity-based healthcare. The current budget limitation for consulting services for PEBB and OEBB has no funding for necessary RFP support, claims audits, clinical audits, or support for the Joint Health Equity Workgroup, and is underfunded for supporting joint PEBB/OEBB work through the Innovation Workgroup and Strategies on Evidence and Outcomes Workgroup. An increased limitation for consultant services would immediately allow the boards to schedule the clinical and claims audits, which are costly and require significant resources, but are critical to ensure benefit plans and services are being administered appropriately and legally. Further, it would enable both Boards to issue RFPs as necessary to bring the strongest vendors forward to focus on eliminating health inequities for all the PEBB and OEBB members they are responsible for. RFP's cost money and take a significant amount of time, but the return-on-	$-	$5,275,071	$-	**$5,275,071**	-	-
424	**State-Based Marketplace Eligibility and Enrollment Platform Phase II**	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 second 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 service experience for Oregonians. • Implements input from Oregon's various and diverse communities, including communities of focus, into technology and call center implementation. • Collects, analyzes, and stores enrollment data, including REALD/SOGI data to improve access to affordable coverage for oppressed communities	$-	$25,000,000	$-	**$25,000,000**	15	10.74
425	**Benefits Management System (OEBB-PEBB BMS) Replacement**	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 member experience and customer care. The new BMS would facilitate the potential collection of REALD & SOGI data and provide a mobile app experience for members, including those in underserved communities, easier access to enroll in benefits, utilize benefit tools and wellness programs, and make informed benefit choices. The new system will also include a Financial Module, improving carrier management and invoicing. 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 this replacement system is not complete prior to the expiration of existing vendor support in 2026.	$-	$6,188,956	$-	**$6,188,956**	3	1.62

Oregon Health Authority Policy Package for the 2025-27 Governor's Budget

POP #	Title	Description	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
426	**Ensuring High-Quality Care in Oregon Hospitals**	The purpose of hospital licensing regulation is to ensure safe, high-quality hospital care for people in Oregon. This is especially important for chronically ill individuals and individuals with disabilities, who proportionally use more hospital services, and for many historically underserved populations. In recent years the volume and severity of hospital complaints have increased. From 2017 to 2023, the number of complaints received about hospitals jumped over 130 percent, from 177 per year to 414. In 2023, OHA received and investigated 14 complaints, covering 12 different hospitals, alleging hospital noncompliance that put patients at risk of death or serious harm. The scope and complexity of hospital licensing has also increased with new state laws required for hospital licensing, and the opening of new services and new service types. The hospital licensing fee program has limited resources available to provide outreach, timely investigations, and assistance to individuals who speak a language other than English. Limited resources also hinder the program's efforts to assist in equitable emergency planning and disaster response, answer frequent queries from the public, and consult on regulatory solutions for hospital that best serve community needs.	$-	$1,025,426	($25,429)	**$999,997**	6	6.00
427	**Equitable Enforcement of Commercial Tobacco**	Tobacco is the leading preventable cause of death and disease in Oregon, costing the state $5.7 billion and over 8,000 lives every year. Moreover, the burden of tobacco use is not distributed evenly, falling heavily on Oregonians with low incomes, African Americans, Native Americans and Alaska Natives, and those who identify as LGBTQ+. This policy package would reduce youth access to harmful emerging oral nicotine products by ensuring all nicotine products are covered by the minimum legal sales age and other tobacco sales regulations. The policy package removes criminal penalties for persons who sell tobacco products or inhalant delivery systems. It also eliminates loopholes that allow for tobacco product access through home delivery and giveaway change machines. The bill could generate revenue if it closes the tax loophole for oral nicotine products made or derived from nicotine from any source. Department of Revenue estimates that the bill would generate $9,300,000 for the Oregon Health Authority, of which an estimated $8.4 million would go to the Oregon Health Plan and $900,000 would go to the Tobacco Use Reduction Account in the Public Health Division.	($8,400,000)	$9,300,000	$-	**$900,000**	-	-
550	**Behavioral Health Workforce Investments**	OHA aims to tackle the shortage of behavioral health professionals, especially in rural areas and SUD services, by attracting, retaining, and supporting a diverse, culturally competent workforce. This proposal offers financial incentives, reduces educational and certification barriers, and expands training access. It also invests in peer delivered services and a central resource hub for providers. Failure to fund this proposal would perpetuate workforce shortages, particularly in underserved and marginalized communities, leading to decreased access to essential behavioral health services, increased burnout among existing providers, and continued health inequities across Oregon.	$24,838,542	($1,427,215)	$838,673	**$24,250,000**	4	3.00
551	**Harm Reduction Clearinghouse & Tx Innovations**	To address the state's substance use, addiction, and overdose crisis, OHA proposes the Save Lives Oregon Initiative's Harm Reduction Clearinghouse. The Harm Reduction Clearinghouse provides essential harm reduction supplies to community organizations, community and Tribal health clinics and programs, uniformed first responders and jails, substance use disorder facilities, and Special District entities, such as rural EMS, hospitals, transportation, libraries and more. The work of the Save Lives Oregon's Harm Reduction Clearinghouse expands community access to lifesaving medications like naloxone and supports organizations to integrate harm reduction strategies into their work that help prevent overdose, infections, and injuries. The Save Lives Oregon Harm Reduction Clearinghouse also provides opioid overdose response kits to schools, colleges, universities, and school-based health centers.	$10,394,821	$-	$-	**$10,394,821**	2	1.50
552	**Residential+ Study**	OHA proposes expanding behavioral health residential treatment and support services to address insufficient infrastructure for substance use disorders, psychiatric treatment, and co-occurring needs across the state. The proposal aims to increase the capacity of residential programs for youth, young adults, and adults by adding new psychiatric residential treatment facilities and SUD treatment beds, focusing on mandated populations as well as regional and cultural diversity. The plan includes purchasing, constructing, or renovating facilities, stabilizing current providers, and supporting culturally and linguistically diverse services. For youth, the initiative will reduce long wait times for treatment and reliance on emergency departments. For adults, it will improve access to developmentally responsive licensed residential and SUD treatment and housing, emphasizing equitable distribution of funds to smaller, culturally specific providers, and those that serve the Aid and Assist population.	$100,000,000	$0	$0	**$100,000,000**	-	-
556	**CCBHC Expansion**	This POP is necessary to implement HB 4002, which mandates OHA to secure federal approval via a State Plan Amendment (SPA) for CCBHC program funding before the current demonstration expires, ensuring strategic leveraging of federal financial support for statewide expansion. OHA plans to integrate fifteen additional clinics in 2026, expanding beyond the existing twelve to meet the statewide requirement. Funding for this POP is needed to provide services at these 15 new clinics and to establish two crucial staff positions essential for supporting statewide expansion by ensuring Medicaid compliance, optimizing payment models, developing policies, coordinating programs and fostering collaboration. Without the funding in this POP, OHA cannot fulfill its statutory obligations, ensure compliance with federal regulations, and expand access to vital behavioral health services statewide, which is critical for Oregon's comprehensive mental health care delivery.	$14,096,922	$-	$33,708,292	**$47,805,214**	2	1.50
557	**Alcohol&Drug Policy Comm Sustainability**	The Alcohol and Drug Policy Commission (ADPC) aims to enhance the efficiency and effectiveness of substance use disorder (SUD) services in Oregon. Created in 2009, ADPC develops and implements a comprehensive addiction, prevention, treatment, and recovery plan for the state. This policy package would provide permanent funding for three positions within the ADPC, initially funded temporarily for a specific study in 2024. These positions are crucial for maintaining subject matter expertise, stakeholder communication, and research analysis. It also requests $225,000 for ongoing strategic plan contracts. Without these positions, ADPC will lack expertise and resources, impairing guidance on SUD practices, stakeholder communication, and data analysis. This can worsen health outcomes, increase disparities, and elevate the economic burden of SUDs in Oregon.	$750,181	$-	$92,682	**$842,863**	-	2.25
559	**Strengthening the SOCAC**	OHA aims to strengthen the System of Care Advisory Council (SOCAC) to address gaps in support for children with complex needs across various state systems, such as juvenile justice, child welfare, and health services. Established by Senate Bill 1 in 2019, SOCAC is a 25-member council tasked with improving state and local youth service systems through centralized policy development and planning. SOCAC focuses on enhancing service coordination, promoting culturally competent practices, and ensuring equitable access to services for youth. The council collaborates with state agencies, evaluates system effectiveness, and recommends improvements. To support SOCAC's legislative mandates, the policy package proposes sustained staff support for SOCAC's operations. Implementation is set to begin on July 1, 2025, with recruitment and onboarding processes for the new position commencing thereafter.	$571,098	$-	$-	**$571,098**	3	2.25
			($1,065,454,698)	**$1,884,916,023**	**$1,641,033,963**	**$2,460,495,288**	**79**	**64.98**

Oregon Health Authority & Oregon Department of Human Services
2025-27 Policy Package

Division:	Shared Services in support of all OHA and ODHS divisions
Program:	Office of Information Services, OHA Statewide Assessments & Enterprise-wide costs
Policy package title:	Mainframe Modernization
Policy package number:	201
Related legislation:	Senate Bill 5525 (2023) POP 203

Summary statement:

Over a million people in Oregon depend on an aging mainframe platform supported by a dwindling number of technical specialists. POP 203 was approved in 2023-25 to start moving from the mainframe to a more modern, flexible, and supportable technology that can meet the needs of constituents who expect and rely on ODHS to provide services reliably and securely. Moving off a 50-year-old platform requires a multi-biennium effort and this POP continues work that has already begun.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
ODHS	$2,286,048	$534,507	$3,653,408	$6,473,963	8	5.00
OHA	$734,146	$5,951,252	$223,773	$6,909,171	0	0.00
Total policy package:	**$3,020,194**	**$6,485,759**	**$3,877,181**	**$13,383,134**	**8**	**5.00**

Purpose

1. Why does OHA/ODHS propose this policy package and what problem is OHA/ODHS trying to fix or solve?

OHA continues to utilize mainframe computer systems that are over 50 years old. This limits the ability to meet legislative and customer/provider requests that impact the agencies' work. The outdated technology hampers efforts to ensure equitable health outcomes and efficient service delivery, affecting the communities ODHS|OHA serves and the ability to respond to health inequities effectively.

- Outdated technology is inflexible and cannot be modified easily for changing needs.
- There is a lack of mainframe skills available in the market; many state mainframe teams are relying on retirees to keep their systems working.
- There are few mainframe-based partners and solutions available to leverage compared to more modern, cloud-based platforms.
- The ODHS|OHA mainframe applications have been mostly developed in-house, meaning there is no expertise available in the market to support or extend them.

Benefits eligibility is still determined on the mainframe for several programs. Moving them to ONE will make it much easier for people in Oregon to apply and receive benefits from those programs.

2. What would this policy package buy and how and when would it be implemented?

This policy package will support the modernization of OHA's mainframe systems by funding the work through the 2025-27 biennium. The key components include:

- Identifying and procuring a new payments system that fully supports OHA's needs, addressing the resource and knowledge risks of the current in-house system.
- Moving remaining benefits determination from the mainframe to ONE, making them directly visible and accessible to people in Oregon, ensuring better access to health benefits.
- Planning for and modernizing other remaining systems and data on the mainframe to improve service delivery and support health equity initiatives.
- Software, hardware, servers, and contracted resources to support ongoing work.

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?

This policy package addresses inequities by improving technology infrastructure and customer interfaces to address existing gaps in accessibility, language access, and cultural context more readily. Modernizing dated technology makes it possible to provide services in the manner preferred by the individual.

Legacy technology can create significant barriers to eliminating health and human service inequities. Antiquated systems often operate in isolation, leading to fragmented or duplicative data spread across various programs and agencies. This fragmentation makes it difficult to bring datasets together to gain a comprehensive understanding of the needs of communities most harmed by health and human service inequities.

[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.

Legacy systems are often incompatible with newer technologies and standards, impeding data sharing and the connection between IT systems. This prevents coordination of care and service, particularly for people who require support from multiple providers and agencies.

Outdated technology can result in inefficient workflows and administrative processes, leading to delays and errors in delivering care and services. Significant technical constraints exist for modernizing legacy systems to be ADA and language accessible. These inefficiencies impact communities who already face barriers to accessing timely and appropriate care.

Quantifying results

4. What are the long-term desired outcomes?

Improved system performance that will lead to more accurate, complete, and timely services, payments to providers, and benefit issuance.

5. How will OHA 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?

OHA will measure the impact of this policy package on health inequities by collecting and analyzing customer satisfaction data, focusing on service accessibility and benefit issuance accuracy. Improvements in system performance and user experience will also be monitored to ensure that the modernization efforts are contributing to ODHS|OHA strategic goals.

How achieved

6. **What actions have occurred to resolve the issue prior to requesting a policy package?**

   POP 203 was approved for the 2023-25 biennium to start addressing the issues described above. OHA has initiated a project, recruited new staff, and contracted with consultants to start the work outlined in POP 203.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   No viable alternatives were identified that could achieve the goals of the modernization effort initiated in 2023-25 via POP 203.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   OHA programs consulted include Public Health, Behavioral Health, and Medicaid. ODHS has been consulted because this is a companion POP to ODHS's Mainframe Modernization POP.

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 changes to existing statutes or new statutes are required for this policy package.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Other state agencies, such as the Department of Administrative Services (DAS) and the Office of the State Chief Information Officer (OSCIO), would be involved in providing guidance and support for the IT modernization efforts.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

This policy package is not a direct response to any Oregon Secretary of State or internal audit findings.

Staffing and fiscal impact

Implementation date(s): July 1, 2024

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

Pricing assumes that:

- The positions from POP 203 are sufficient and no new positions are needed.
- Federal matching funds are available.

13. Will there be new responsibilities for OHA, ODHS, and/or Shared Services? Specify which programs and describe their new responsibilities.

The modernization effort will introduce new responsibilities for OHA's IT staff and business analysts, who will oversee the transition and implementation of new systems. Additionally, over time specific technical and business process responsibilities will change as the agencies reduce their activity on the mainframe and increase their activity on new platforms.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Modernizing the mainframe platforms and systems will not directly impact the caseload volume; however, it will make existing health services more visible and accessible to people in Oregon.

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 POP does not include any new positions beyond the ones already approved via POP 203.

16. What are the start-up and one-time costs?

Start-up costs for the continuation of this effort include vendor contracts and new software/hardware.

17. What are the ongoing costs?

Ongoing costs will cover software licensing, maintenance, and vendor support.

18. What are the potential savings?

Potential savings come from reduced staffing costs and decommissioning old applications.

19. What are the sources of funding and the funding split for each one?

New development work is priced at 10 percent General Fund and 90 percent Federal Funds Medicaid match. Ongoing support is priced at 25 percent General Fund and 75 percent Federal Funds. The Other Funds for the OIS POP request is “non-add” Other Funds limitation needed to spend the Cost Allocated funding (GF/FF) described above.

OHA total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$0	$0	$0	$0	0	0.00
Services & Supplies	$0	$5,818,400	$0	$5,818,400		
Capital Outlay	$0	$0	$0	$0		
Special Payments	$734,146	$132,852	$223,773	$1,090,771		
Other	$0	$0	$0	$0		
Total	**$734,146**	**$5,951,252**	**$223,773**	**$6,909,171**	**0**	**0.00**

ODHS total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$360,307	$472,844	$360,307	$1,193,458	8	5.00
Services & Supplies	$30,389	$11,034	$27,862	$69,285		
Capital Outlay	$0	$0	$0	$0		
Special Payments	$1,895,352	$50,629	$3,265,239	$5,211,220		
Other	$0	$0	$0	$0		
Total	**$2,286,048**	**$534,507**	**$3,653,408**	**$6,473,963**	**8**	**5.00**

Fiscal impact by program

	ODHS OEP	ODHS Shared Services – OFS	ODHS SAEC	OHA Shared Services – OIS	OHA SAEC	**Total**
General Fund	$384,538	$0	$1,901,510	$0	$734,146	**$3,020,194**
Other Funds	$0	$483,590	$50,917	$5,818,400	$132,852	**$6,485,759**
Federal Funds	$384,538	$0	$3,268,870	$0	$223,773	**$3,877,181**
Total Funds	$769,076	$483,590	$5,221,297	$5,818,400	$1,090,771	**$13,383,134**
Positions	6	2	0	0	0	**8**
FTE	3.00	2.00	0.00	0.00	0.00	**5.00**

Oregon Health Authority & Oregon Department of Human Services
2025-27 Policy Package

Division:	Shared Services in support of all OHA divisions
Program:	Office of Information Services (OIS): Information Security and Privacy Office (ISPO), OHA Statewide Assessments & Enterprise-wide costs
Policy package title:	Improve Information Technology (IT) Security and Privacy Posture
Policy package #:	202
Related legislation:	Not applicable

Summary statement:

The Information Security and Privacy Office (ISPO) supports both OHA and ODHS programs by providing assurances in the protection of agency regulated data, (Health Insurance Portability and Accountability Act, Personally Identifiable Information, Federal Tax Information, etc.) risk identification and mitigation, and the confidentiality, integrity, and availability of information for the communities whom OIS serves. ODHS|OHA remain responsible for the protection of their regulated data including the breadth, volume, scope, and associated governance, risk, and compliance of that data. Information, security, and privacy standards are much greater than most other state agencies; as the human impact of information security and privacy risks in government health and human services data is substantial, encompassing compromised privacy, financial harm, emotional distress, potential medical mismanagement, and erosion of public trust. ODHS|OHA must proactively invest in resources and tools to strengthen these essential areas, address Secretary of State audit gaps and mitigate privacy risks and vulnerabilities impacting both agencies.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
ODHS	$1,467,518	$97,835	$880,512	$2,445,865	-	-
OHA	$869,154	$3,869,840	$361,033	$5,100,027	4	2.00
Total policy package:	**$2,336,672**	**$3,967,675**	**$1,241,545**	**$7,545,892**	**4**	**2.00**

Purpose

1. Why does OHA/ODHS propose this policy package and what problem is OHA|ODHS trying to fix or solve?

This policy package supports goal #2 of the Oregon Department of Human Services (ODHS) & Oregon Health Authority (OHA) Strategic Plan – Strengthen Cybersecurity, Risk, and Privacy, which aims to strengthen cybersecurity and consider risk in the decision-making process. OIS supports both ODHS and OHA's programs by providing assurances in the protection of agency regulated data (HIPAA, PII, PHI, FTI, etc.); risk identification and mitigation; and the confidentiality, integrity, and availability of information for the communities served. ODHS|OHA remain responsible for the protection of their regulated data including the breadth, volume, scope, and associated governance, risk, and compliance of that data. Vendor-supported systems also fall under agency responsibility and the increase of third-party data breaches requires increased OIS support in partnership with vendors, programs, Enterprise Information Services (EIS)/Cyber Security Services (CSS), and the services OIS provides to Oregonians.

The aggressiveness and proficiency of "bad actors" intent on phishing, scamming and compromising organizations has increased and will continue to do so. The recent dramatic increase in remote access and expansive use of mobile devices to support telecommuting by ODHS|OHA employees heightens the need for rigorous controls and oversight. Over 70 percent of cybersecurity threats originate at endpoints, like email and mobile applications. The resources requested in this POP will focus on implementation of the six (6) Center for Internet Security (CIS) basic Security Controls (v7.1). Resources and funding in this POP along with finishing the implementation of the IT Asset Management of Hardware & Software project will allow us to achieve the statewide target of 40+ percent implemented and close the ODHS|OHA top audit finding which is inability to monitor the logs and periodical review the logs of suspicious behavior.

2. What would this policy package buy and how and when would it be implemented?

The policy package will allow ODHS|OHA to meet demands of the everchanging digital landscape, while allowing implementation of robust auditing and eDiscovery capabilities. Government agencies face increasing demands for transparency, accountability, confidentiality, integrity, and availability for the data Oregonians entrust the agencies with. The eDiscovery Program is the process of identifying, collecting, preserving, and producing electronically stored information in response to a request for production, these requests may come from a lawsuit, investigation, or public records request.

The package will buy technology and resources to improve visibility into the risk and vulnerability posture of data and information systems that serve approximately 1.5 million Oregonians. The 2023 third-party data breach presented several opportunities for improvement in protecting the data in ODHS|OHA's systems; in response, this request will improve the agencies' ability to effectively prevent, monitor, and rapidly respond to emerging threats and vulnerabilities with resources to address risk and audit findings. These risks include data breaches, identity theft, stolen funds, and unauthorized access, which may disproportionately affect vulnerable populations, such as individuals who are elderly, require ADA accessible technology, utilize language translation services, and lack access to internet.

	General Fund	**Other Funds***	**Federal Funds**	**Total Funds**
	62%	5%	33%	100%
New Staffing Request	$484,172	$42,807	$256,045	$783,024
Text/SMS Archiving, eDiscovery Service, Incident Response, and Support	$1,235,000	$108,000	$657,000	$2,000,000
Enhancing Compliance and Efficiency: Auditing and E-Discovery Software for IT and HR Audits	$617,500	$54,000	$328,500	$1,000,000
Estimated IT Security and Privacy Posture POP Total	**$2,336,672**	**$204,807**	**$1,242,724**	**$3,783,024**

* Excludes Office of Information Services Other Funds limitation need for Cost Allocation to OHA/ODHS

This policy package provides permanent positions as well as funding for additional software tools to enhance our detection and discovery capabilities. The intent is to begin implementation as soon as funding is available with a target of July 2025 to begin recruitment of positions and procurement of needed tools, in advance of onboarding new staff in September 2025.

The volume of highly private data and complexity of the system environments that house the data and compliance criteria that must be met in protecting the data remain the responsibility of ODHS|OHA. More effective mechanisms to protect and secure the environment are essential to mitigate future security and privacy incidents.

The specifics of the policy package are outlined below:

- **Text Archiving and eDiscovery Solution:**

  A robust text message archiving system is essential to meet several critical obligations:

  1. **Compliance with Archiving Regulations:** Government agencies must adhere to strict archiving regulations, including Open Records Acts, the Federal Records Act, and the Freedom of Information Act (FOIA). These laws require agencies to maintain easily accessible records of employee communications, including text messages, which can be provided to the public upon request.
  2. **Public Records Requests:** Efficiently fulfilling public records requests is crucial. A centralized text message archive ensures quick retrieval of relevant information, reducing the overall resource burden.
  3. **Legal Protection and eDiscovery:** Archiving text messages provides legal protection by preserving evidence for potential litigation. It also facilitates easier eDiscovery during legal proceedings.

4. **Increased Transparency and Accountability:** Citizens expect transparency from government agencies. Archiving text messages ensures transparency by allowing public access to relevant communications.
5. **Better Information Retrieval:** A well-organized archive enables efficient retrieval of historical text messages, supporting decision-making, investigations, and audits.

- **IT Auditing and E-Discovery:**

  With the implementation of a vendor solution, OIS will be able to meet several critical obligation requests we receive from Human Resources, Public Records, and business programs to assist with auditing and eDiscovery requirements:

  1. Compliance with Archiving Regulations: OHDS|OHA is governed by specific regulations that mandate the retention and management of electronic records. Auditing and eDiscovery services help ensure that agencies meet these legal obligations, such as those under the Freedom of Information Act (FOIA), and industry-specific regulations (e.g., HIPAA for health-related data).

  2. Preparedness for Legal Actions: ODHS|OHA must be prepared to respond to legal actions, including lawsuits or investigations. eDiscovery services enable agencies to efficiently locate, secure, and produce required documents during litigation or audits.

  3. Proactive Risk Assessment: Auditing services help identify and mitigate risks by providing insights into operational or security weaknesses before they become issues. This proactive approach reduces the potential for security breaches or data loss.

  4. Incident Management and Response: In the event of a security breach or data misuse, having an established auditing framework allows for a faster, more coordinated response, potentially limiting damage and reducing recovery time and costs.

5. Reduced Litigation Costs: eDiscovery services can help state agencies more efficiently manage the discovery process by quickly identifying relevant information, thus reducing the costs associated with manual document review and legal proceedings.
6. Transparency in Operations: Auditing processes ensures that all actions are logged and accessible for review, which supports transparency in governmental operations. This is critical for maintaining integrity within public services.

Dedicated positions and tools, including software, are necessary to address these risks and to be compliant with our regulatory compliance obligations and audit findings. These proposed solutions will:

- **Strengthen** Oregonian data privacy and protection through increased transparency, identity, detection, prevention, response, and recovery mechanisms.
- **Enhance** access to data in ODHS|OHA information systems for auditing, investigations, public records requests, and incident management.
- **Enable** integration with existing systems of record (e.g., document management, case management, or collaboration tools), which ensures cross-functional access and consistent retention practices.
- **Empower** users to archive their own text messages. A user-friendly interface allows employees to tag and categorize messages, ensuring accurate retention.

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?

The human impact of information security and privacy risks in government health and human services data is substantial, encompassing compromised privacy, financial harm, emotional distress, potential medical mismanagement, and erosion of public trust. ODHS|OHA face stringent information and privacy standards and remain responsible for the protection of the community's regulated data, including the breadth; volume; scope; and associated governance, risk, and compliance.

Preventing, detecting, and mitigating privacy and security incidents will continue to be critical as the integration of IT systems and data continues in both State Data Center and cloud environments. In 2023, attackers accessed over 1.5 million Oregon Health Plan (OHP) members' data through a third-party entity's data breach; although not specifically ODHS|OHA data breach, OHA provided significant oversight, advisory, and consulting resources throughout the breach to ensure that Oregonians received the support they needed and expected.

The recent dramatic increase in remote access and expansive use of mobile devices to support telecommuting by ODHS|OHA employees heightens the need for rigorous controls and oversight. The agencies need the ability to enhance their response to audit findings, public records requests for data, and data investigations throughout information systems and processes. The agencies need 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.

increase focus on improving preventative measures to protect the data that Oregonians have entrusted the agencies with.

This policy package directly supports two of the Governor's priorities by:

1. Ensuring ODHS|OHA's data is secure, private, and uncorrupted, the agencies support the "[creation] and [management of] a statewide data strategy to improve data analysis, data quality, information sharing, and overall decision-making to be done by the Chief Data Officer for the state."

2. Proactively managing system and data access, implementing automated tools to help track access, and increasing foundational security support such as proactive reviews of audit logs, the agencies support "[increasing] IT security by adding enhancements to the state's Enterprise Security Office, including improvements in intrusion and detection."

Quantifying results

4. What are the long-term desired outcomes?

- Improved and more proactive focus on protecting agency data increases the ability to maintain confidentiality of information. This leads to increased public trust of the agencies to provide accurate health information, leading to more reliable and comprehensive population-based health information.
- Increased compliance with CIS Security Controls provides increased functionality, protection, and capabilities. OIS is working toward the implementation of the Center for Internet Security (CIS) Controls and expanding requirements for ODHS|OHA to maintain a cyber and information security

program to secure the information assets under OIS control. EIS/CSS would like agencies at a minimum to meet a 40 percent implementation of the Basic 6 CIS Controls. Currently ODHS|OHA are at 31 percent.

- Utilizing tools and staff resources to provide more proactive information protection and privacy of agency data reduces the risk of data breaches. Data breaches not only carry significant financial penalties, but they deteriorate public trust in the agencies. If ODHS|OHA cannot safeguard the community's data, it will be significantly more difficult to acquire the data needed to provide services to Oregonians.
- This POP directly supports the “Manage and Mitigate Risk” OHA key performance measure (KPM).

5. How will OHA 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?

The increase in risk and privacy management from additional resources will improve the remediation of audit findings, decreasing the number and duration of open findings. This will enable the team to focus not just on critical risk findings, but also high and medium risk findings.

Enhancing agency information protection and ensuring highly confidential health data is protected is incumbent on ODHS|OHA. This policy package helps improve and remove barriers from reliable and trusted agency program resources containing, maintaining, and transmitting protected information and further promotes agency movement toward better digital and technology solutions that thereby drive a concerted and collaborative effort to address the needs of populations impacted by health inequities and inequitable access to systems and services.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OIS has reprioritized existing staff resources to focus on implementation of the Center for Internet Security (CIS) basic six (6) controls to protect Oregonians' regulated health related data (HIPAA, PHI, & PII etc.). However, repurposing staff has not been very effective as OIS already runs a lean program, and these staff have other duties to support business needs. We need dedicated staff to ensure that the proper security and privacy controls are in place to support and maintain normal business operational tasks.

7. What alternatives were considered and what were the reasons for rejecting them?

- **Text Archiving and eDiscovery Solution:**
  - **Manual Archiving:** Without a text archiving solution where messages are captured at the carrier-level, users are required to manually retain these records on their mobile device.
    - Apple iPhones (which are the state standard) do not allow users to easily migrate messages from their device to a system or record system or other permanent retention location. It is a very manual and time-consuming process that impacts employees' time and interrupts their ability deliver other services to the public they serve.
    - For legal eDiscovery, the only authoritative way to provide a forensic copy of messages is to have users surrender their physical device to legal teams to extract the data directly from the device itself. Since users cannot be prevented from deleting their text messages, this may not reveal a true forensic copy of all records and does not fully meet the discovery requirements in court, nor does it fully meet the Oregon Secretary of State's record retention requirements.

        - Surrendering the device when it is still under contract with the cellular carrier can also result in having to pay a full price for a replacement device for the user.

    - **Agency Record Retention Policy:** The implementation of the policy to require manual retention of text message information into another system of record does not typically meet the legal discovery and record retention requirements. Since the user may selectively choose what to archive and where to store it, this can lead to accusations of the employee or agency not recording messages that may increase risk to the employee or agency. Opposing councils may often attempt to seek a default judgement in legal proceedings due to the agencies' inability to produce the subpoenaed records for discovery.

      The alternatives noted above are not considered rejected, as this is our current practice. However, this current alternative practice is insufficient to meet the state's mandatory retention and the HR, legal, and public records mandatory requirements.

- **IT Auditing and eDiscovery:**

  Over the course of time, multiple OIS teams have been in the position to respond and provide various support with auditing and eDiscovery requests. Various technologies and processes such as Change Auditor have been utilized, but lack the scrutiny and depth required for most requests. As much of the agency has turned to remote work, the amount of auditing and eDiscovery requests have grown. The current tools and staff are not able to meet the agency requests from a technology or skill level required. Here are some of the alternative solution(s) and steps taken prior to requesting the policy package:

- **Issue Identification**: Problems with the current auditing and eDiscovery processes and technology were identified with requests coming in from incidents, audit requests, public records requests, and HR requests.
- **Current State Analysis**: Review of current technologies available and discovery of the deficiencies in accordance with the requests.
- **Benchmarking**: Research was conducted to determining best practices and reviewing how similar organizations handle auditing and eDiscovery requests.
- **Technology Evaluation**: Existing processes and technology solutions were reviewed. New technologies and resources will enhance auditioning and process.

The alternatives noted above are not considered rejected, as they are OIS current practice. However, this current alternative practice is insufficient to meet the state's mandatory retention and the HR, legal and public records mandatory requirements.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

It benefits both ODHS|OHA as well as community partners such as local Area Agencies on Aging (AAA). Feedback and findings from other government entities (Enterprise Information Services, Dept. of Homeland Security, Cybersecurity and Infrastructure Security Agency), Federal partners requirements, internal audit findings, federal partner findings, Information Security Risk Assessments, other state agencies', etc.) contributed to the ask in the POP.

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 amount of data, types of data, and protection requirements of ODHS|OHA require significant resources, time and tools to maintain. The more demands that ODHS|OHA put on the state Cyber Security Services group, the less those resources are available to other state agencies. This policy package enables ODHS|OHA to be more self-sufficient in maintaining data protection and managing risk.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

Yes. The Enterprise Information Services (EIS) assessment of ODHS|OHA implementation of the six (6) Center for Internet Security (CIS) basic Security Controls (v7.1) resulted in a 31 percent completion score, which is below the target 40 percent completion score requested by EIS. The Oregon Secretary of State will be auditing ODHS|OHA for compliance with implementation of Center for Internet Security (CIS) Security Controls (v8) in the future. Many of these have known existing gaps and will likely be identified as issues requiring remediation through this audit. EIS also released a Policy #107-004-052, Cyber and Information Security, stating that all agencies must, at minimum, implement the CIS Controls. OIS is working toward the implementation of those controls and expanding requirements for ODHS|OHA to maintain a cyber and information security program to secure the information assets under OIS control.

Staffing and fiscal impact

Implementation date(s): July 1, 2026

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

In addition to the four (4) positions outlined in question 15 below, this pricing also includes:

- Text/SMS Archiving, eDiscovery Service, Incident Response, and support.
- Auditing and eDiscovery Software for IT and HR Audits.

13. Will there be new responsibilities for OHA, ODHS, and/or Shared Services? Specify which programs and describe their new responsibilities.

No, this POP will enhance requests the Office of Information Services (OIS), which is part of Shared Services, receives from Human Resources, business programs, and public records requests. There are not dedicated staff nor tools for this work currently, which has made it difficult to meet timelines and requests OIS receives to perform these tasks in a timely manner. With the addition of the four (4) new permanent staff along with the expanded tool, OIS will be able to meet these additional auditing and eDiscovery requests and improve transparency, accountability, and compliance with the following regulatory compliance requirements:

- **Compliance with Laws and Regulations:** OHDS/OHA is governed by specific regulations that mandate the retention and management of electronic records. Auditing and eDiscovery services help ensure that agencies meet legal obligations such as those under the Freedom of Information Act (FOIA) and industry-specific regulations (e.g., HIPAA for health-related data). Government agencies must adhere to strict archiving regulations, including Open Records Acts,

the Federal Records Act, and the Freedom of Information Act (FOIA). These laws require agencies to maintain easily accessible records of employee communications, including text messages, which can be provided to the public upon request.

- **Preparedness for Legal Actions**: ODHS/OHA must be prepared to respond to legal actions, including lawsuits or investigations. eDiscovery services enable agencies to efficiently locate, secure, and produce required documents during litigation or audits. Archiving text messages provides legal protection by preserving evidence for potential litigation. It also facilitates easier eDiscovery during legal proceedings.
- **Proactive Risk Assessment**: Auditing services help identify and mitigate risks by providing insights into operational or security weaknesses before they become issues. This proactive approach reduces the potential for security breaches or data loss.
- **Incident Management and Response**: In the event of a security breach or data misuse, having an established auditing framework allows for a quicker, more coordinated response, potentially limiting damage and reducing recovery time and costs.
- **Reduced Litigation Costs**: Automated eDiscovery services provide quicker process and response times for identifying relevant information, thus reducing the costs associated with manual document review and legal proceedings.
- **Transparency and Accountability:** Auditing processes ensure that all actions are logged and accessible for review, which supports transparency in governmental operations. This is critical for maintaining integrity within public services. A well-organized archive enables efficient retrieval of historical text messages, supporting decision-making, investigations, and audits. Citizens expect transparency from government agencies. Archiving text messages ensures transparency by allowing public access to relevant communications.

- **Public Records Requests:** Efficiently fulfilling public records requests is crucial. A centralized text message archive ensures quick retrieval of relevant information, reducing the overall resource burden.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No, there will be no changes.

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.

Classification	Type (Perm/ LD/Existing)	Job Title	Effective Date	Development or M&O?	Work Description
ISS8	Perm New	Enterprise Architect	07/01/2026	☐ Planning or Development Duration: # months ☐ M&O ☐ Both Dev. Duration:	Drive the successful integration and modernization of health IT systems, align IT architecture with business objectives, and ensure compliance with regulatory standards.
ISS8	Perm New	Senior System Administrator and Automation Programmer	07/01/2026	☐ Planning or Development Duration: ☐ M&O ☒ Both Dev. Duration: 6-9 months	Assist vendor with implementation of system and perform agency-side technical system administration, database management, and

Classification	Type (Perm/ LD/Existing)	Job Title	Effective Date	Development or M&O?	Work Description
					complete system maintenance and support. Create and maintain interfaces and scripts.
ISS8	Perm New	Senior Systems Analysts	07/01/2026	☐ Planning or Development Duration: ☐ M&O ☒ Both Dev. Duration: 9-12 months	Assist vendor with implementation of system and perform agency-side technical system administration, database management and complete system maintenance, and support. Create and maintain interfaces and scripts.
ISS8	Perm New	Senior Cyber Risk and Compliance Assessor	07/01/2026	☐ Planning or Development Duration: # months ☐ M&O ☐ Both Dev. Duration:	Support ODHS|OHA's security, regulatory compliance, and vulnerability management programs in areas such as software development, access and control methodologies, operations, continuity planning, and incident response.

16. What are the start-up and one-time costs?

The estimated start-up and the one-time cost for the two solutions will be approximately $3 million. This includes initial implementation services, advanced operational vendor support, platform and user/device licensing. More accurate pricing will be available once a solution is selected through the state procurement process.

17. What are the ongoing costs?

This is a new solution, and the estimated annual ongoing cost will be $1.5 million. This will include advanced operational vendor support, platform and user/device licensing. More accurate pricing will be available once a solution is selected through the state procurement process. There will be ongoing cost for the four (4) permanent positions as well.

18. What are the potential savings?

With the implementation of the solutions and the recruitment of the four (4) new permanent positions, the agencies will be able to improve response time to requests on compliance, public records requests, legal protection, and e-Discovery. The agencies will be able to lower the risks by responding to security breaches and data misuse effectively and in turn reduce litigation costs by quickly identifying relevant information. Agencies will gain the capability to proactively assess risks and prepare for potential legal actions.

19. What are the sources of funding and the funding split for each one?

Cost allocated at 61 percent General Fund, 6 percent Other Funds, and 33 percent Federal Funds.

OHA total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$0	$750,716	$0	$0	4	2.00
Services & Supplies	$13,101	$3,013,764	$5,442	$3,032,307		
Special Payments	$856,053	$105,360	$355,591	$1,317,004		
Total	**$869,154**	**$3,869,840**	**$361,033**	**$5,100,027**	**4**	**2.00**

ODHS total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Special Payments	$1,467,518	$97,835	$880,512	$2,445,865	0	0.00
Total	**$1,467,518**	**$97,835**	**$880,512**	**$2,445,865**	**0**	**0.00**

Fiscal impact by program

	ODHS SAEC	OHA Shared Services – OIS	OHA SAEC		Total
General Fund	$1,467,518	$0	$869,154		**$2,336,672**
Other Funds	$97,835	$3,762,868	$106,972		**$3,967,675**
Federal Funds	$880,512	$0	$361,033		**$1,241,545**
Total Funds	$2,445,865	$3,762,868	$1,337,159		**$7,545,892**
Positions	0	4	0		**4**
FTE	0.00	2.00	0.00		**2.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Equity & Inclusion
Program:	Civil Rights, Learning, and Inclusion Division
Policy package title:	Required Inclusive & Supportive Access
Policy package number:	406
Related legislation:	Title VII Civil Rights Act, ADA, GINA, ORS Chapter 659A, SOS Audit, Governor's priorities, DOJ Regulation on Digital Accessibility, HHS CR Regulations

Summary statement:

This policy package outlines long needed strategic investments that are necessary to achieve 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 OHA's health equity definition. This package outlines necessary investments to bolster current service levels as well as resources to meet upcoming regulatory requirements including the U.S. Department Of Justice's requirement for comprehensive digital accessibility; the ongoing requirement to provide facilities and services that are meaningfully accessible to our employees and the public alike regardless of their language abilities and disability status; and to establish and steward a work environment that is respectful, professional and in alignment with people's wellbeing.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$1,894,022**	**$165,727**	**$307,778**	**$2,367,527**	**5**	**5.00**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. **What problem is OHA trying to fix or solve?**
   This policy package would purchase positions with subject matter expertise to build and steward OHA's internal capacity to provide statutorily required and meaningfully inclusive services and facilities for OHA employees and the public, including language access, disability access, digital access and equitable access that is not hindered by a person's protected class status, lived experience, or personal identities.

   To advance health equity for all Oregonians, we need a workforce that can accomplish that task. The barrier to health equity addressed by this section of the POP is that the people doing the work to advance Oregonians' health do not all have the necessary skills or knowledge or both to integrate equity practice into their work. Equity and inclusion are constantly evolving disciplines, and it requires education to develop OHA staff's skills to take action on health equity in a way that will meaningfully move us toward the 2030 strategic goal. Solid grounding in the equity and inclusion field requires dual expertise in both teaching and equity analysis. Federal and state requirements as well as a Secretary of State (SOS) audit identified the need for high quality and consistent training across the state, including OHA. Presently in the Equity & Inclusion Division (E&I) there are two positions responsible for implementing OHA's Equity Training Program. Recognizing the gap in resourcing, OHA approved non-budgeted FTE. The need for equity expertise is increasingly required in legislatively mandated work including racial impact statements for programs, legislation, and administrative rules. OHA needs a highly developed equity-skilled workforce to do the work that the people, Legislature, and Governor of Oregon require of us.

   The risks of not obtaining foundational resources will result in OHA failing to meet legislatively driven timelines around filling new positions and starting up new programs, since operations functions are

critical in supporting the completion of these time-sensitive tasks. Building a centralized infrastructure for the division has far-reaching impacts on the primary systems of the agency, the state enterprise, and the entire state of Oregon. With the E&I Division being the agency's lead for health system transformation under the OHA strategic goal of eliminating health inequities in Oregon by 2030, it is mission critical to ensure the division's positions are fully staffed and that functional systems, structures and processes are in place so that staff leading transformational health equity work have resources and support to focus on legislatively-driven requirements, legal mandates and program goals. E&I Division has historically not received necessary investments to develop a centralized operations structure and meet long-needed supports in training and development for our staff and other partners strategically and consistently. If approved, this package would model the OHA health equity definition and right-size the division's resources, to establish internal capacity for managing a growing agency with more employees, higher demands and an increasing volume of business operations and activities. This investment would recognize and reconcile at least one injustice the division has historically experienced.

Discrimination & Harassment Free Workplace & Services to the Public Strategic Response

This initiative supports bringing on additional experienced and knowledgeable equity and inclusion professionals who are subject matter experts in stewarding supportive and respectful work cultures for OHA staff, including disciplines such as civil rights, disability access, digital access and equity and inclusion generally. By providing proactive 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.

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

Communities across Oregon are culturally and linguistically diverse and that diversity continues to increase within the many programs across OHA including the Oregon Health Plan (OHP). All information generated by OHA need to be made available in multi-modal and multi-lingual formats. OHA continues to receive feedback from OHP members, community partners, healthcare interpreters, and medical staff that language access support is inconsistent and unsupported across the Medicaid healthcare system as well as all state systems. OHP members cannot consistently make appointments, attend appointments, communicate with medical staff, communicate with pharmacy staff, read critical health related documents in languages other than English. Currently OHA has one position dedicated to language access. Additional staffing and programmatic resources are necessary to coordinate this vital and detail-intensive work.

Universal Accessibility in Agency Communications

Achieving health equity begins with communication. OHA's primary source of communication with the public is through electronic and digital communication. OHA's digital and electronic communication such as websites, public facing documents, social media content, desktop applications, mobile applications, multimedia content, and general electronic content are not a consistently reliable sources of accessible information for people with disabilities, people who use assistive technology or people who communicate in a language other than English. We have a foundational responsibility to the people living in Oregon to provide accessible information across all our digital technologies and assets. Not only is it a core agency function, it is a requirement under

OHA policies [1]and federal requirements such as Title VI of the Civil Rights Act of 1964, Section 508 of the Rehabilitation Act (Section 508), Web Content Accessibility Guidelines (WCAG) and the U.S. Department of Justice Guidance on Title II of the Americans with Disabilities Act, and most recently US DOJ's promulgated regulation on digital accessibility requirements for governments that must be implemented by April 24, 2026.[2] To illustrate the need for positions with subject matter expertise related to digital testing and remediation, OHA has over 80,000 PDF files on its websites and servers, with very few remediated for accessibility. Inaccessibly created or non-remediated PDFs are difficult or impossible for assistive technology users to navigate. A digital accessibility team would provide the strategy and expertise for the content audit to determine remediation, archival, or removal.

Universal Access in OHA Facilities

OHA employees, community partners, service recipients, and members of the public are not able to fully use OHA facilities due to physical design issues that require remediation. In addition, facility signage (or lack thereof), restroom design, common area design and other physical spaces are not designed to be responsive or assistive to people who are non-English speaking, experience disabilities, have diverse gender identities, or other specific needs. OHA facilities are not equipped to support the safety of employees with disabilities in the event of an emergency or disaster requiring sheltering in place or accessible evacuation. Simultaneously, ODHS│OHA Facilities is unable to facilitate building and facility upgrades or adjustments to respond to the needs of all people in Oregon. Understanding that this is a capital expenditure, it is nonetheless necessary, and the state's

[1] Digital Accessibility in Content Creation and Sharing - https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/me010-029.pdf

Digital Accessibility in Hardware, Software and Systems - https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/me010-030.pdf
[2]

to-date non-compliance exposes the enterprise to high risk in terms of harm to people, fines or adverse findings, and misalignment with the priorities of Oregon and the agency. How can we be the Oregon Health Authority when our own facilities and services are out of the literal and figurative reach of our employees and members of the public? This request must be done in an informed phased approach and this request must be approved so that we can start developing the plan and budgeting that must occur.

Language Access

Our communities across Oregon are culturally and linguistically diverse and that diversity continues to increase within the many programs across OHA including OHP and Healthier Oregon. All information generated by the OHA need to be made available in multi-modal and multi-lingual formats. We continue to hear from OHP members, community partners, healthcare interpreters, and medical staff that language access support is inconsistent and unsupported across the Medicaid healthcare system as well as all State systems. OHP members cannot consistently make appointments, attend appointments, communicate with medical staff, communicate with pharmacy staff, read critical health related documents in languages other than English. Currently OHA has 1 FTE dedicated to language access. That is woefully insufficient.

2. What would this policy package buy and how and when would it be implemented?

The Civil Rights, Learning and Inclusion (CRLI) Section of the Equity and Inclusion (E&I) Division, fulfills numerous essential and foundational pieces of statewide and agency priorities with responsibility for key strategic imperatives across the enterprise. Working from an anti-racism framework as the foundation, professionals who work in this section develop, implement, coordinate,

monitor and evaluate strategies to promote and advance health equity with constant attention to policy, programs, system, and environmental solutions that are people-centered, transformational in nature and strategic and sustainable in application. To that end, the work of the section is highly collaborative, receiving significant direction from and providing accountability to people with lived experience and the communities in which people who experience the most inequities belong. This work, much of which is statutorily or legislatively required, necessitates extensive collaboration and communication across OHA divisions, the Governor's Office, Legislators, coordinated care organizations (CCOs), Oregon DOJ, OFCCP, U.S. HHS, and other municipal, state and federal partners.

CRLI plays a foundational and leading role in advising agency executives, health system partners including the CCOs, workforce partners, policymakers, and federal, state and municipal entities to eliminate health inequities, improve health outcomes for all people in Oregon, and remove institutional and historic barriers experienced most commonly by people in priority populations, while also managing significant internal and external civil rights responsibilities.

This policy package would establish positions with subject matter expertise (SME) to develop, implement and refine OHA practices and procedures to authentically demonstrate our strategic goal so that our facilities and activities are meaningfully and inclusively accessible to every person who lives in Oregon, whether an OHA employee, OHP recipients or members of the public. This POP also includes services and supplies to ensure that OHA staff are highly trained and supported to do their important work for an employer that is respectful, supportive, and staffed with resilient and healthy people. This POP would start to buy compliance with many of the state and federal requirements related to civil rights, employment, public services, language, and disability access including digital accessibility. This POP would buy us risk mitigation, positive public perception, and

positive movement towards achieving our strategic goal. To align with the Governor's Budget this POP seeks 5 new positions from the original 9 positions sought in this policy package.

- Senior Civil Rights Operations & Policy Strategist (Operations & Policy Analyst 4): This position will be the primary investigator on complex matters addressing thematic and systemic issues and barriers experienced by people within OHA (employees, volunteers, interns, and externs) and external to OHA (members of the public). The work encompasses evaluating, analyzing and developing policy and procedure which aligns with federal and state civil rights laws as well as support the agency's strategic goal of eliminating health inequities in Oregon by 2030. This role advises agency leadership of issues and concerns and provides recommendations to address gaps and barriers within OHA. This position will lead the work to implement new DOJ and HHS rules related to civil rights, accessibility and language access, along with other federal statutes, policies and guidance.

- Civil Rights Intake Specialist (Operations & Policy Analyst 1): This position will perform intake on new E&I complaints in order to ensure timely responses to OHA staff, manage investigation files, assist Civil Rights Strategists with document production, coordinate with OIS on case management software, review current and proposed policies to ensure they are up to date and track investigation status.

- Digital Accessibility Coordinator (Operations & Policy Analyst 3) & Global Disability Coordinator (Operations & Policy Analyst 3): These positions advise on and implement the strategy for work required in accordance with new digital accessibility federal rule, the U.S. Health and Human Services rule, and Section 1557 of the Affordable Care Act. These positions ensure

development and scaling of a language access program and accessibility standards in technology procurements, identify and implement accessibility solutions for websites and publications, provide co-creation services for OHA digital accessibility content.

- Digital Accessibility Specialist (Operations & Policy Analyst 2): This position will review and remediate existing content and websites and coordinate accessibility testing by native users of assistive technologies to identify compliance improvements for prototypes and verify compliance of deliverables.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[3] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

OHA has worked to center health equity in all its work and programs and still has more to accomplish 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 this POP outlines necessary investments to maintain current service levels in addition to meeting upcoming regulatory requirements including US DOJ's requirement for comprehensive digital accessibility in two years' time. OHA's ongoing but yet unmet requirement to provide facilities and services that are meaningfully accessible to our employees and the public alike regardless of their language abilities and disability status, and to establish and steward a work environment that is respectful, professional and in alignment with people's wellbeing. This policy package represents the next phase of long overdue investments necessary to achieve Oregon and the agency's imperative

[3] 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.

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 that meets or exceeds our state and federal statutory and regulatory requirements. Many of the initiatives included in this POP are statewide requirements as prescribed by federal mandates. They are included in CRLI Section's POP as one of E&I's submissions because the responsibility and expertise for this work is assumed by and held within E&I. That E&I submits this POP speaks to E&I's broad responsibilities and high level of expertise. The impact of funding (or not) this POP will have agency- and statewide consequences and specifically supports OHA strategic goals:

Goal 1: Access to affordable care for all: Ensure 100% of people in Oregon have easy access to affordable healthcare, prioritizing communities disproportionately harmed by racism, discrimination, and other forms of oppression.

Goal 4: Build OHA's internal capacity and commitment to eliminate health inequity: Provide OHA staff the training, support and tools necessary to partner with communities and recognize, rectify and reconcile the racism and other forms of discrimination and oppression that undermine the health, wellbeing and opportunities of people across Oregon.

Quantifying results

4. What are the long-term desired outcomes?

Long-term outcomes of this policy package include developing, sustaining and supporting an agency workforce equipped to center equity and anti-racism in their work. This outcome aligns with agency's leadership's objective to ensure that equity is practiced consistently throughout the agency leading to increased workforce satisfaction, productivity and engagement. These internal outcomes will lead to

improved services and care for the people in Oregon to help eliminate health inequities. Ultimately there is also a cost reduction related to less turnover, fewer internal investigations and fewer litigations allowing the agency to invest its resources in sustainable service improvements for staff and the people in Oregon.

5. How will OHA measure the impacts on health inequities of this policy package?

Impacts of this policy package would be measured through employee engagement and cultural climate assessments as well as data related to investigations and complaints; employee retention, separation, and promotion; and other risk and audit assessments. Practicing sustained equity-based workforce development can also be measured in employee and applicant data that is disaggregated per REALD+SOGI requirements. When working proactively on compliance and meaningful accessibility, inclusion and education matters the agency practices proactive and strength-based approaches to supporting the workforce and service recipients. There are foreseeable savings as the work prevents litigation and rework when accessibility and compliance are appropriately and consistently resourced. Training and workforce equity programs also mitigate lawsuits and rework as the workforce is well informed on policy compliance and accountability. Lastly, an organization that promotes and supports healing and resiliency for the workforce sees less staff stress and burn-out that leads to missed work, physical illness, and emotional/psychological harm that is a result of racism and trauma.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

E&I has previously submitted POPs and received partial funding of one POP and a negotiated redistribution of agency positions in the 21-23 budget cycle. E&I has not received full funding of POP requests in this area despite the agency's growing recognition and subsequent reliance on E&I's SME. E&I has collaborated with external partners (NW ADA and PSU, for example) to leverage

existing programs to improve OHA's work. E&I has revised position descriptions to add additional job duties to current staff. For all intents and purposes, there is no more triaging, adding duties, lean practices or pilot programming to do what must be done. OHA must make the investment to do the fundamental and required work that the agency and state have neglected to do to date. Our federal partners have signaled that they are taking their funding authority seriously and have embarked on unprecedented audits of language access (FDA grant) and civil penalties and consent decrees with other states about states' noncompliance with digital, physical and language accessibility.

7. What alternatives were considered and what were the reasons for rejecting them?

As stated in response 6 above, E&I has exhausted all available alternatives to supporting this work. The alternative to not receiving the resources to do this required work is to accept that OHA will be in violation of its state and federal statutory and regulatory requirements and will fall short of OHA's strategic goals and priorities.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

To the extent possible, we have collaborated with ODHS, DAS and Shared Services, as well as internal partners including CPOP, Ombuds Program, Communications, PCS, and equity teams throughout OHA. Frankly, the timelines for the POP deliverables have meant limited opportunities for meaningful collaboration. That said, there is community partner and advocacy support for these requests as demonstrated in repeated requests for the provision of these services and advocacy for increased capacity to provide the same. There is no known opposition.

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 POP does not require changes to existing statutes or the development to new statutes. That said, much of the work captured in the POP is responsive to newly promulgated federal regulatory requirements (US DOJ digital accessibility, HHS civil rights and language access).

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

The work this policy package would support affects the entire state, therefore all state, tribal and/or local government agencies would be affected. CRLI's work is internal and external. It affects everyone who works for OHA, including every volunteer, board, and commission member. It affects every person who receives services from OHA including OHP members and the public. It affects partners and providers who deliver healthcare services. Everyone and everything mentioned above relies upon and partners with this work. With full funding for this POP, OHA would be positioned to be more effectively and efficiently responsive to needs and able to proactively support our partners and the public.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

Yes. This policy package is in part in response to the 2020 Oregon Secretary of State audit on workplace investigations.

Staffing and fiscal impact

Implementation date(s): July 1, 2025

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

- We assume that position descriptions for newly established positions can be reviewed and established through DAS and the OHA Human Resources process in a timely manner with positions ready to recruit within 6 months of the biennium.
    - Five positions will already be established by DAS and filled as non-budgeted positions prior to the start of the 2025-27 biennium; this is due to the urgency and volume of work facing this unit.
- We assume ongoing agency commitment to the goal of eliminating health inequity by 2030 as outlined in the OHA strategic plan.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Yes. Several new federal administrative rules were finalized this year:

- On April 24, 2024, the Federal Register published the Department of Justice's final rule updating its regulations for Title II of the Americans with Disabilities Act (ADA). The final rule has specific requirements about how to ensure that web content and mobile applications (apps) are accessible to people with disabilities. Digital accessibility is a pilar of advancing health equity for Oregonians. Accessibility often applies to individuals with disabilities, and in the lens of digital accessibility, the barriers are compounded for individuals with intersectional identities. This new federal rule applies to websites, online services, and electronic documents,

with specific compliance deadlines. The state must comply by April 24, 2026. The rule requires enhancements for access to government services and information for individuals with disabilities, providing legal and financial incentives for organizations to comply. It promotes an inclusive digital environment based on principles of equal access and non-discrimination.

- U.S. Health and Human Services rule updates - This rule, titled *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, advances equity and bolsters protections for people with disabilities under Section 504 of the Rehabilitation Act (Section 504). This important Final Rule is HHS's latest action in furtherance of Executive Order 14091, entitled Further *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. A rule titled *Health and Human Services Grants Regulation* to reaffirm the prohibition on discrimination on the basis of sex.

- Section 1557 of the Affordable Care Act – final rule for the implementation of the nondiscrimination requirements of Section 1557.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Yes, it is reasonable to anticipate that the growing OHA workforce and the increased enrollment in OHP will lead to increased demand for the services and resources included in this POP. Quantifying what that increase in work will be is difficult to ascertain beyond a general statement that with more people – whether more employees or more OHP members – necessarily means higher demand.

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 POP would buy FTE with SME to develop, implement and refine OHA practices and procedures to authentically demonstrate our strategic goal so that our facilities and activities are meaningfully and inclusively accessible to every person who lives in Oregon, whether an OHA employee, OHP recipients or member of the public. There are a total of 5 new permanent positions needed for this policy package; the number of months the positions are funded are noted.

- 1 OPA4 – Senior Civil Rights Ops & Policy Strategist (24 months): This position will be the primary investigator on complex matters addressing thematic and systemic issues and barriers experienced by people within OHA (employees, volunteers, interns, and externs) and external to OHA (members of the public). The work encompasses evaluating, analyzing and developing policy and procedure which aligns with federal and state civil rights laws as well as support the agency's strategic goal of eliminating health inequities in Oregon by 2030. This role advises agency leadership of issues and concerns and provide recommendations to address gaps and barriers within OHA. This position will lead the work to implement new DOJ and HHS rules related to civil rights, accessibility and language access, along with other federal statutes, policies and guidance.

- 1 OPA1 – Civil Rights Intake Specialist (24 months): This position will perform intake on new E&I complaints to ensure timely responses to OHA staff, manage investigation files, assist Civil Rights Strategists with document production, coordinate with OIS on case management software, review current and proposed policies to ensure they are up to date and track investigation status.

- 2 OPA3 – (1) Digital Accessibility Coordinator & (1) Global Disability Coordinator (24 months): These positions advise on and implement the strategy for work required in accordance with new digital accessibility federal rule, the US Health and Human Services rule, and Section 1557 of the Affordable Care Act. These positions ensure development and scaling of a language access program and accessibility standards in technology procurements, identify and implement accessibility solutions for websites and publications, provide co-creation services for OHA digital accessibility content.

- 1 OPA2 – Digital Accessibility Specialist (24 months): This position will review and remediate existing content and websites and coordinate accessibility testing by native users of assistive technologies to identify compliance improvements for prototypes and verify compliance of deliverables.

16. What are the start-up and one-time costs?

Not applicable.

17. What are the ongoing costs?

The ongoing costs are estimated at $2.4 million. This includes costs for:

- Increasing staff support to 5 additional full-time, permanent positions to ensure adequate support for the scope of work outlined in this policy package.
  - Five positions will already be established by DAS and filled as non-budgeted positions prior to the start of the 2025-27 Biennium; this is due to the urgency and volume of work facing this unit including the U.S. Department of Justice's promulgated regulation on digital accessibility requirements for governments that must be implemented and in compliance by April 24, 2026.

- Costs for contractors to provide training to maintain core competencies in Civil Rights investigations; DEI training; training to service providers, boards, and volunteers.
- Costs for translation and interpretation services to ensure all information provided is culturally and linguistically appropriate per the AFLAS policy.
- Costs for travel to conduct Civil Rights investigations throughout the state, as well as attend statewide meetings and trainings.
- Costs for licensing for Alternative Dispute Resolutions continuing education for certification and knowledge maintenance.
- Costs for usability testing for Global Disability that includes a diverse and inclusive usability testing pool and required hardware and software
- Costs for software and technology solutions needed to perform work, including specific accessible hardware and software that is needed to support the work of the Accessibility, Inclusion, and Education Unit.

18. What are the potential savings?

It is reasonable to anticipate that with increased capacity to proactively provide accessibility, civil rights, learning and inclusion services that agency expenditures will shift from reactive outlays (litigation, remedial measures, fines) to proactive and transformational work (learning and development, presentations nationally and locally as breakthrough leaders, partnerships and relationship building with individuals, entities, and communities with whom OHA has not consistently engaged).

19. What are the sources of funding and the funding split for each one?

The Equity and Inclusion division is based in Central Services, and this work is on behalf of the entire agency. We use the most updated agency-wide cost allocation plan (CAP) to distribute costs to all agency-wide available revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds for all costs.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$1,068,206	$93,468	$173,583	**$1,335,257**	5	5.00
Services & Supplies	$825,916	$72,259	$134,195	**$1,032,270**		
Capital Outlay						
Special Payments						
Other						
Total	**$1,894,022**	**$165,727**	**$307,778**	**$2,367,527**	**5**	**5.00**

Fiscal impact by program

	Central Services				Total
General Fund	$1,894,022				**$1,894,022**
Other Funds	$165,727				**$165,727**
Federal Funds	$307,778				**$307,778**
Total Funds	$2,367,527				**$2,367,527**
Positions	5				**5**
FTE	5.00				**5.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Health Policy & Analytics
Program:	Health Care Market Oversight (HCMO)
Policy package title:	Health Care Market Oversight Program Funding Support
Policy package number:	407
Related legislation:	ORS 415.500 et seq

Summary statement:

Requests General Fund to support the Oregon Health Authority's (OHA) administration of the Health Care Market Oversight (HCMO) program in the 2025-27 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 POP requests funds for program staff and operating costs, including Department of Justice (DOJ) expenses.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$2,648,565**	**$466,688**	**$0**	**$3,115,253**	**2**	**4.54**

Purpose

1. 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 entities 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 (HCMO) 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 and advancing health equity. 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 problem is the HCMO budget – including fees – does not support the costs of running the program. Not only was HCMO not adequately staffed initially, but the number of HCMO transactions has increased over time. Specifically, in the 2021-23 biennium, it became clear that the fiscal analysis had underestimated costs needed to launch and administer the program, primarily related to legal support from the Department of Justice and Special Assistant Attorney General (SAAGs). The original fiscal analysis and proposed staffing model also proved insufficient to launch and administer the program – additional FTE including a manager, an economist, and policy and program analyst support were needed. Further, in 2022, the Hospital Association of Oregon filed a lawsuit against the program and OHA is responsible for all Department of Justice costs related to the lawsuit.

The solution to this problem and the purpose of this POP, is to hire additional staff, fully fund current staff, and fund additional support from DOJ. Through the HCMO program, OHA reviews and approves health care mergers and acquisitions in Oregon, ensuring that health care transactions support statewide goals related to cost, quality, access, and equity. HCMO does not just focus on cost and market impact of health care consolidation; equity is a core component of all transaction analyses and reviews, and the program supports robust public and community engagement. Without this POP 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.

2. What would this policy package buy and how and when would it be implemented?

The policy package would provide General Fund in the 2025-27 biennium to cover HCMO program costs, including staff, DOJ costs, and community engagement efforts. Staff and DOJ supports are already in place and implementation is already in progress; the POP provides sufficient funding for ongoing work, which includes:

- Conducting 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, conducting qualitative and quantitative analyses, and making determinations about whether the transaction should be approved, approved with conditions, or rejected.
- Conducting follow-up reviews of approved transactions one, two, and five years after the deal is completed.
- Conducting a robust public input process for transaction reviews, including engaging interested parties from the health care industry and advocate groups, using inclusive best practices to solicit comments and input from the public, developing public facing-materials to build

awareness and transparency, and convening community review boards, comprising patients, plan members, and community members to inform reviews and provide recommendations about whether to approve transactions.

- Administering 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.
- Responding to legal challenges, including the Hospital Association of Oregon lawsuit and appeal.
- Conducting a study of the impact of health care consolidation in Oregon every four years, pursuant to ORS 415.510. Per statute, the first study will be conducted in 2026 and will analyze the impact of consolidation on costs for consumers and payers, quality of care, population health, and health outcomes.

HCMO is exploring a change to the fee structure to better support the program costs and may propose a fee schedule change in this POP at a later date.

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 to strengthen access to affordable care for all by ensuring all people in Oregon have easy access to affordable health care, prioritizing communities

[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.

disproportionately harmed by racism, discrimination, and other oppression. Implementing and enforcing Oregon's Health Care Market Oversight program is a key activity in OHA's Strategic Plan.

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, 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 measures quality outcomes and access to care, stratified by community and patient demographics, including race, ethnicity, age group, gender, and geography,

as available. OHA also examines 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. HCMO began collecting fees for transaction reviews on January 1, 2023 as directed in statute. However, because the volume and timing of reviews is unpredictable, and because not all of HCMO's statutorily required work is currently covered by fees, General Fund is needed to cover program expenses.

HCMO is charged with conducting one-, two- and five-year follow up reviews for each reviewed transaction as well as preparing a state of consolidation report to the Legislature every four years. In addition, HCMO also routinely meets with entities to provide guidance and discuss transactions prior to the entities filing and beginning the review process. These additional program functions are not covered in the current HCMO fee schedule. HCMO conducted a time study in September 2023 and found that staff spent approximately 70 percent of their time on HCMO reviews, which is work that would ideally be covered by fees. The remaining 30 percent of time was spent on follow-up reviews and other HCMO work.

OHA requested a POP for the 2023-25 biennium that included General Fund to support this program. In the Legislatively Adopted Budget, the POP included Other Funds only and HCMO is currently unfunded other than fee revenue.

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 and OHA began collecting fees for transaction reviews beginning January 2023. Through rulemaking, OHA established a tiered fee structure of fees, avoiding fees that are too high for entities to abide. Per ORS 514.412, HCMO fees are to be proportionate to the size of the parties to the transaction. Due to the unpredictability of how many reviews will be conducted, the size of entities party to a transaction, and the type of reviews, however, funding the program completely with fees is not a viable option.

OHA plans to revisit fee amounts in the future with a better understanding of the number and type of transactions that may come in over time; however, given the unpredictability of number and timing of transaction reviews as well as other HCMO statutorily required work (see above); it is unlikely that future fees would be sufficient to cover all operating costs.

Based on current projections, the HCMO fee schedule would have to be raised significantly to fully cover transaction reviews and other HCMO work. Entities will likely strenuously object to major changes to the fee schedule and potentially bring additional legal challenges against the program (further increasing operating costs).

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, 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

OHA's current fee schedule for transaction reviews; any fees the program collects in the 2025-27 biennium will be used to offset General Fund budgeted to cover program expenses.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No. OHA is already responsible for operating the Health Care Market Oversight program.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No. 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 increased FTE for the program's four existing part-time permanent staff positions and establish two existing limited duration positions as full-time, permanent positions to appropriately support HCMO's ongoing work. OHA is also requesting two new permanent Operations & Policy Analyst (OPA) 2 positions for ongoing, permanent work for the program.

Current staffing	Proposed Staffing	Change
Two part-time OPA **4**s	Two full-time OPA 4s	Add 1.30 FTE, no new positions
One part-time Economist 3	One full-time Economist 3	Add 0.62 FTE
One part-time Research Analyst 4	One full-time Research Analyst 4	Add 0.62 FTE
	Two full-time OPA 2s	Establish two new positions, 2.00 FTE

The work to be performed by the positions in the proposed staffing model is as follows:

- One OPA 4 position to lead and oversee program policies and processes, transaction reviews, and the study of health care consolidation.
- One OPA 4 position to oversee program administration, operations, community engagement and health equity, and vendor contracts.
- One existing Research Analyst 4 position and one existing Economist 3 position to analyze data and support transaction review analyses.
- Two OPA 2 positions to support ongoing transaction reviews.

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.

Staffing costs include four permanent positions, two limited duration positions and additional FTE from a manager, health care economist, and other staff as needed to support transaction reviews.

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 necessary support from DOJ to review transaction decisions, assist with pre-filing technical assistance, support rules updates, and other legal questions related to operating and enforcing this regulatory program.

18. What are the potential savings?

Any fees the program collects in the 2025-27 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?

This policy package includes General Fund and Other Funds supported by fees.

Oregon Health Authority: 2025-27 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$1,849,445	$(501,022)	$0	**$1,348,423**	2	4.54
Services & Supplies	$799,120	$967,710	$0	**$1,766,830**		
Capital Outlay						
Special Payments						
Other						
Total	**$2,648,565**	**$466,688**	**$0**	**$3,115,253**	**2**	**4.54**

Fiscal impact by program

	HPA				Total
General Fund	$2,648,565				**$2,648,565**
Other Funds	$466,688				**$466,688**
Federal Funds	$0				**$0**
Total Funds	$3,115,253				**$3,115,253**
Positions	2				**2**
FTE	4.54				**4.54**

Oregon Health Authority
2025-27 Policy Package

Division:	Medicaid
Program:	1115 Medicaid Waiver Strategic Operations
Policy package title:	Medical Benefits for Incarcerated Individuals
Policy package number:	408
Related legislation:	H.R. 2617 (FCAA, 2023)

Summary statement:

Transforms health care access and support within Oregon's carceral system by funding the service delivery of the 1115 Reentry Demonstration Waiver. Ensures adequate OHA staffing, technical assistance, and best practices for implementation, enhancing service delivery and equity. Without funding, these efforts stall, risking no availability of state budget for service costs, causing delays in CMS compliance, hindering technology integration, and preventing the development of essential health care benefits for populations experiencing incarceration. This shortfall would exacerbate health disparities, impeding progress towards health equity in Oregon's prisons and reintegration into community-based services thereafter. Funding also includes building a similar benefit package for Tribal members who may not opt into CCO enrollment for 1115 coverage to create parity of benefits offered.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$14,290,185**	**$0**	**$49,725,345**	**$64,015,530**	**7**	**5.75**

Purpose

1. What problem is OHA trying to fix or solve?

Oregonians in prisons and jails suffer from a lack of access to some essential health services; widely varying standards of treatment protocols for medication-assisted treatment and basic behavioral health; modern systemic racial and gender injustices; and disproportionate health care disparities for youth, people of color, and individuals most impacted by social determinants of health, such as literacy and housing. For example, in Oregon, **10 percent** of incarcerated individuals are Black, while Black individuals make up less than **2 percent** of the state's total population. Following a similar trend, **6 times** as many Black youth are incarcerated in Oregon as are white youth.

Individuals in state or local custody also face a critical challenge upon incarceration: their federal Medicaid coverage is terminated, requiring the state to cover their health care, which increases the state's health care costs and leads to widely varying standards of coverage across county jails. This "inmate exclusion" not only disrupts essential medical care but also hinders successful transition and reintegration into society upon release, contributing to higher recidivism rates. When individuals do release from prisons and jails, they report being overwhelmed, confused, and hopeless on how to navigate society, especially as they face systemic resistance to basic needs like housing and employment and contend with consequences from the lack of continuous medical care for chronic diseases or life-long substance use disorders. This cycle leads to hundreds of preventable deaths in Oregon, with a significantly higher mortality rate (12.7 times) and overdose death rate (100 times) within two weeks post release from prison (Binswanger et al., 2007).[1] Committing to Medicaid's forthcoming coverage of individuals who are incarcerated under H.R. 2617 (Federal Consolidated

[1] Binswanger, I., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison--A high risk of death for former inmates. *The New England Journal of Medicine, 356*(2), 157-165. https://doi.org/10.1056/NEJMsa064115

Appropriations Act (FCAA), 2023) and Oregon's 1115 Reentry Demonstration Waiver, as detailed in this POP, offers the opportunity to intervene and reduce these preventable deaths.

Oregon must prepare to effectively implement the upcoming required changes of federal law within our state's carceral and health care systems and, with this policy package, commit to the expanded coverage implied by the 1115 Reentry Demonstration Waiver. Recent federal legislation, H.R. 2617 (FCAA, 2023), marks a pivotal shift. Starting in 2025, Oregon will be required to offer pre-release Medicaid enrollment and a limited benefit package to support continuity of care for youth up to the age of 21 and former foster care up to the age of 26.

By 2026, these reforms will extend to individuals entering custody while enrolled in the Oregon Health Plan (OHP), requiring seamless suspension and re-activation of benefits upon release. Oregon's CMS-negotiated Standard Terms and Conditions for the 1115 Reentry Demonstration Waiver will expand coverage and services, enhancing support for individuals of all ages for up to 90 days pre-release of transitioning from carceral settings, including vital Health-Related Social Needs services like housing and nutrition benefits. In addition, the 1115 Medicaid Waiver (2022 to 2027) will progressively implement Health-Related Social Needs services, expanding to include adults and youth transitioning from carceral settings and those discharged from an Institute for Mental Disease (IMD). Eligible individuals impacted by the 1115 Reentry Demonstration Waiver will gain access to additional HRSN services, such as housing support and food benefits, to aid in successful community reintegration. Additionally, the Mink-Bowman Settlement mandates Medicaid to facilitate enrollment and care coordination for individuals transitioning from the Oregon State Hospital, an IMD, some of whom will move to county jails where they can access services under the 1115 Reentry Demonstration Waiver.

OHA must enhance its claims processing and data exchange platforms to accommodate the complexities of Medicaid enrollment and coordination within a variety of carceral settings with various

benefit packages. This involves coordinating health care delivery through facility-based and in-reach providers employed by state, county agencies, or contracted entities. The implementation impacts operations at Department of Corrections facilities, Oregon Department of Human Services eligibility systems and staff, Oregon Youth Authority detention centers, Oregon Health Authority's claims and data exchange platforms, county jails, coordinated care organizations, Fee-for-Service care coordination entities, and local community providers.

2. What would this policy package buy and how and when would it be implemented?

Service Delivery State Match

This POP is necessary to fund the state match of the Medicaid dollars for service delivery of the 1115 Reentry Demonstration Waiver. Without the state's committed match to service dollars, OHA cannot launch 1115 Reentry Demonstration Waiver benefits, which are designed to interrupt one of the most vulnerable windows of transitions for individuals in carceral settings: their release back to the community. Oregon's General Fund match to waiver benefits will provide, for the first time in history, Medicaid coverage for up to 90 days prior to release, meaning individuals will receive life-saving services like medication-assisted treatment, case management of housing benefits, clinical consultations, and CCO enrollment to ease their transition, all while still incarcerated. These dollars will make a significant impact in disrupting the hundreds of overdoses that occur when individuals leave jails, plus interrupt the harmful cycle of recidivism due to inadequate health services and care coordination prior to an individual's release.

Implementation Support and Capacity Building to Match Federal Dollars

Oregon is requesting CMS approval to use Designated State Health Programs (DSHP) to support the planning and infrastructure needed to implement changes across state and county systems. Other Funds and Federal Fund limitation will be needed to support the use of DSHP dollars. The $115.5 million will fund carceral facilities to outfit for billing systems, data information exchange

systems, newly instated protocols and procedures, staffing and staff training, modifications to physical space limitations, and any other eligible one-time costs of initial build-out to provide the benefits of the 1115 Reentry Demonstration Waiver.

Project Management

OHA will require ongoing Project Management support for implementation planning, change management, and go-live activities via contractors. This includes day-to-day project management for dozens of sub-workstreams necessary to implement the complexity of implied program/policy, contractor, data, system, and personnel change management.

Data and Systems

OHA must invest in the infrastructure necessary to support the improved and continued delivery of behavioral health, housing and substance use prevention, treatment and recovery services to Oregonians. In 2025-27, the agency will be positioned to further invest in data infrastructure that will facilitate integration of data from across the currently siloed data environments within OHA as well as amongst key strategic intra-agency partners and community and external partners. Key data sets, such as public health-managed data pertaining to substance use prevention and overdose, are currently not readily available for analysis with behavioral health data managed in the OHA Data Environment (ODE, formerly the Behavioral Health Data Warehouse). There are planning efforts underway to estimate the level of effort needed to ingest these data along with additional beneficial datasets managed by the Public Health Division (PHD) and other areas of the agency into the ODE in order to improve analytical capabilities that will provide deeper insights into client services. These integrations will enable OHA to better identify opportunities for improvement in services as well as to identify health inequities.

This POP includes requests for the resources needed to develop a data environment to incorporate new data integrations from other agencies and more agency-managed data sets and thus continue the de-siloing of OHA data. Specifically, staff must be brought on to manage the technical requirements, data sharing agreements, reporting infrastructure and design, development and testing coordination, architecting, ingestion and ongoing management of additional datasets as well as the implementation of data quality and management tools that will support an integrated data environment. These tools include but are not limited to those that support the following functions: data indexing, data quality, data cataloging and inventory management, and analytics.

Staff positions required for the Compass and OIS Teams supporting the Oregon Data Environment are detailed in POP #553 Behavioral Health Data Requirements and must be included in future estimates if POP #553 does not move forward.

Policy, Program Design and Program Operations Staffing

This POP entails a position request of 7.00 FTE, which includes permanent authority for existing non-budgeted Operations & Policy Analyst 4 positions, additional policy analysts to support the implementation of all benefits across all carceral facilities, plus positions to support the data and system changes necessary to newly share health information data and booking/releasing/eligibility to and from carceral settings, community-based providers, CCOs, and OHA.

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?**

   In Oregon, People of Color, especially Black, African Americans, and individuals affiliated with Tribes—whether unenrolled, holding Tribal ties outside of Oregon, or enrolled in the Nine Federally Recognized Tribes within Oregon—are disproportionately affected by health care disparities and incarceration. This includes unjust racial prejudice in routine medical care to racial profiling during the act of substance use or possession, housing discrimination, as well as disproportionate rates of incarceration due to the former. OHA has named the goal of eliminating health care inequities by 2030. Addressing disparities in the carceral system through services aimed at preventing unnecessary deaths and recidivism aligns with this goal and will positively impact the overall health of all Oregonians.

   The vision for what creates a more equitable transition of care upon release of a carceral facility must be led by community members with lived experience of incarceration. Some examples we've heard from local Oregonian advocacy groups, such as OHSU Richmond Clinic's Health Equity and Leadership at Richmond (HEAL-R) program, which includes leaders who have experienced incarceration entail the following: ensuring safe transitions of care where an individual is supported with services before they leave the facility to make the first 24 hours less overwhelming; ensuring that there are clear distinctions of roles between carceral guards and health care providers; ensuring continuity of Medication Assisted Treatment and pharmaceutical medications to reduce disproportionate overdose; being connected to safe and sober housing, though harm reduction

[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.

approaches are also valued; and ensuring that bureaucracies, such as lost documentation, stops in coverage, and other enrollment/eligibly factors do not interfere with an individual's smooth transition back to the community. With the additional staffing support from this POP, OHA's carceral benefit program team can ensure the building of policies, programs and rules are shaped by community input.

Additionally, this POP would provide staffing that will enhance data integration and service delivery, aiding compliance with H.R. 2617 (FCAA, 2023) and alignment with the 1115 Reentry Demonstration Waiver. This will ensure that marginalized communities, often disproportionately affected by health disparities, receive improved access to essential health care services, including behavioral health, housing support, and substance use prevention and treatment. Developing a robust data infrastructure will facilitate data integration from various siloed environments within OHA and across partner agencies. This integration is crucial for gaining comprehensive insights into public health and behavioral data, enabling OHA to identify and address underlying health inequities effectively. By analyzing these datasets more holistically, OHA can pinpoint areas for service improvement and allocate resources more equitably, advancing its mission to promote health equity across Oregon.

The staffing positions designated for technical management, data integration, and analytics will oversee the technical requirements, data sharing agreements, and implementation of data quality tools necessary for maintaining a robust and integrated data environment. By addressing systemic barriers and enhancing data-driven decision-making, OHA will be better positioned to reduce health disparities and promote health equity statewide.

Quantifying results

4. What are the long-term desired outcomes?

The long-term desired outcome for the 1115 Reentry Demonstration Waiver includes the reduction of recidivism and overdose for individuals transitioning in and out of the carceral system, especially for incarceration due to substance use disorders, severe and persistent illness, and racial profiling. Oregonians, especially people of color, die at disproportionate rates of overdose as they cycle through the jail system, often due to a lack of access to continuous medication-assisted treatment or general case management that helps individuals navigate reality after incarceration. Because the 1115 Reentry Demonstration Waiver focuses on a required service-delivery-level of critical care (MAT, 30 days of medications in hand, and case management for integrated health services), the benefit should effectively disrupt the high rates of overdose and re-incarceration within the 24 hours to two-week period after release. Aside from life-saving services, the benefit will also help establish more continuous services, such as CCO enrollment, health-related social need services, housing, employment help and more services that allow an individual to stabilize within the community. Establishing and enhancing community reintegration of service delivery, which is more cost-effective for the state, is another desired outcome and the result of reducing recidivism.

Effective policy alignment across state agencies and facilities will also streamline health care delivery, enhance operational efficiency within the carceral system, and promote sustainable system improvements beyond initial implementation phases. Collaboration among state agencies, local governments, health care providers, and community organizations will ensure seamless implementation and long-term sustainability of health care reforms and policy changes. This includes enhanced data integration and service delivery that ensures continuous access to essential health care services for individuals transitioning from carceral settings to communities. By addressing social determinants of health and supporting successful community reintegration, these efforts aim to reduce recidivism rates. Integrated data will play a pivotal role in these efforts by enabling evidence-

based decision-making, improving program effectiveness, and identifying emerging public health needs and disparities in real time.

Ultimately, Oregon's comprehensive 1115 Reentry Demonstration Waiver approach to address social determinants of health as individuals leave carceral settings aims to create a more equitable, efficient, and supportive health care and criminal justice system, benefiting both individuals in custody and the broader community. In the long term, this could result in lower recidivism and better outcomes for Oregonians transitioning to and being supported in their communities.

5. How will OHA measure the impacts on health inequities of this policy package?

The Centers for Medicare and Medicaid Services (CMS) will issue Evaluation and Monitoring guidance for both H.R. 2617 (FCAA, 2013) and 1115 Reentry Demonstration Waivers, which OHA will report on annually. This guidance has not yet been released, but anticipated areas of measurement include:

- Number of beneficiaries served and types of services rendered
- Administration of screenings to identify individuals who qualify for pre-release services
- Utilization of applicable pre-release and post-release services
- Provision of health or social service referral pre-release
- Participants who received care management pre-release and were enrolled in care management

In addition to these process measures, OHA may consider adding state-specific outcome measures that track:

- Health care disparities of individuals receiving services via Medicaid encounter data
- Subjective testimony of individuals in both jail and prison settings on the effectiveness of pre- and post-release benefits

- Rates of recidivism/overdose
- Health outcome data for co-occurring disorders most common in Oregon populations experiencing incarceration
- Number of individuals remaining integrated in community-based services/maintaining housing/employment, etc.
- CCO incentive measures which incentivize care coordination for individuals transitioning from carceral settings

Finally, CMS has set overall demonstration milestones, which could translate to potential process or outcome measures for this program:

- Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated
- Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions to the community
- Promoting continuity of care
- Connecting to services available post-release to meet the needs of the reentering population
- Ensuring cross-system collaboration

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Pilots to provide on-site enrollment in safety net programs

The Oregon Department of Corrections is currently launching a pilot with the Oregon Department of Human Services, in partnership with the Oregon Employment Department and Oregon Workforce Partnership to implement WorkSource Reentry sites in all 12 DOC facilities across the state. These are spaces for adults in custody to access employment supports before release. The physical spaces

also present an opportunity for additional wraparound supports, including accessing benefits like OHP and SNAP via out-stationed human services staff.

In one of DOC's WorkSource Reentry pilot facilities, Warner Creek Correctional Facility in Lakeview, ODHS and DOC are piloting such an effort. ODHS eligibility workers visit Adults in Custody (AICs) weekly to enroll or re-enroll interested individuals in benefits leading up to release. Other ODHS staff make warm hand-offs to staff in communities to which individuals are released. More time and evaluation are needed, but partners expect the pilot to reduce the administrative burden experienced by DOC application assistance staff and improve AIC customer experience by leveraging ODHS expertise and resources. Additional benefits of out-stationing ODHS staff in DOC facilities:

- Ability to make entries directly into the ONE Eligibility System and connect releasing AIC with additional benefits (e.g., SNAP).
- Familiarity with benefits operations and can provide tailored consultations to help AIC navigate their individual benefits and needs.
- Support for dual-eligible individuals who qualify for Medicaid and Medicare.
- Reducing duplication of interviews needed for OHP and SNAP by having one interview session for all relevant benefits.

ODHS' Central Processing Unit staff at 5509/VEC currently processes OHP and SNAP applications for justice-involved individuals using centralized eligibility staffing.

To support this pilot and the upcoming expansion of OHP enrollment in carceral facilities, ODHS is submitting a POP to increase staffing to meet new demands (Phase 1) while a plan is developed for localized staffing to out-station at DOC facilities (Phase 2).

Data exchange and integration

In addition to building out the Oregon Data Environment (ODE) to support behavioral health services, Oregon must implement infrastructure to support its commitment to providing new health-related social need (HRSN) benefits for Medicaid members experiencing critical life transitions. OHA must be able to bidirectionally exchange data and integrate new types of information across federal, state, and county agencies to comply with federal guidelines and successfully deliver services to historically and contemporarily underserved populations.

To accomplish this, OHA is working towards developing an integrated, cloud-based data environment that supports the bidirectional data exchange needed for delivery of HRSN services with the capability to scale and support additional data sharing with additional partners. To date, engagement with 1115 Medicaid Waiver HRSN colleagues has taken place to understand the various partners and data elements that will be necessary according to CMS-approved Special Terms and Conditions. OHA is renewing its contractual agreement with Snowflake, a cloud-based data storage and analytics service. A prototype will be implemented to demonstrate feasibility, and a work order will be submitted to pursue contractor support in the development of a landscape assessment, architecture requirements, and high-level roadmap for the HRSN data environment. This will provide OHA with insights into how users interact with the data environment and how it meets business requirements so that the minimum viable product can be adjusted and scaled to be utilized as an established data exchange system to deliver HRSN benefits.

7. What alternatives were considered and what were the reasons for rejecting them?

H.R. 2617 (FCAA, 2013) regarding services in a carceral setting and the 1115 Reentry Demonstration Waiver are the first attempts in U.S. history to waive the federal inmate exclusion for Medicaid coverage. This POP will be the first in Oregon to allocate General Fund service dollars, DSHP spending authority for capacity building for the carceral system and expanded staffing to support the carceral expansion team.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Oregon State Hospital, city/county jails, Department of Corrections, Oregon Youth Authority, county juvenile detentions, Oregon Department of Human Services, coordinated care organizations, County Mental Health Programs (CMHP), Federally Qualified Health Centers, Tribal Healthcare Centers/BH, county commissioners, Alcohol and Drug Policy Commission and County Public Health Programs.

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. Several Oregon Revised Statutes reflect the inmate exclusion prohibitions that will be effectively lifted at the time H.R. 2617 (FCAA, 2013) goes into effect. The list of known statutes is included below, and a full list is pending from DOJ:

- ORS 411.447
- ORS 414.025

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

- Behavioral and Public Health state offices will be impacted. The passage of HB 4002, which issues recriminalization of possession, is expected to impact the number of individuals being incarcerated. BH investments and partnerships designed to increase community-based service delivery from House Bill 4002, such as Certified Community Behavioral Health Clinics (CCBHC), CMHPs, and Measure 110 Behavioral Health Resource Networks (BHRN) providers can facilitate strategies to help divert from future incarceration. Medicaid services are provided pre-release. Public Health departments across the state partner with jails to provide services

such as family planning and STI testing. Additionally, the Alcohol and Drug Policy Commission will be issuing MOUD grants that could help create glidepaths for carceral facilities to build public health services for individuals who are receiving services while incarcerated. Intentional planning and integration of public, behavioral, and Medicaid initiatives will affect overall health outcomes for individuals experiencing incarceration.

- ODHS is impacted by the additional staff impact of processing enrollment/benefits, and subsequent data systems change requests, for individuals who are receiving services while incarcerated.
- ODE could be impacted by youth transitioning back to schools with potential Medicaid-payable school-based services or screenings/assessments starting/continuing during incarceration.
- Tribal governments are also affected, as the benefit package is designed to be covered by Medicaid, and therefore, a majority of individuals will receive care coordination through CCOs. Because Tribal members may opt out of CCO enrollment, additional benefits offered through FFS will be designed to create parity of benefits offered. If a Tribal jail re-opens in Oregon, Tribal health directors may want to partner with that jail to offer services of the 1115 Reentry Demonstration Waiver; the jail would need to complete a readiness assessment for waiver benefits. Even if the Tribal jail does not re-open, Tribal health directors may wish to partner with jails and prisons to coordinate care for their members.

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): 7/1/2025; 1/1/2026; 7/1/2026; 1/1/2027

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

The assumptions affecting this pricing include but are not limited to:

- The number of individuals released from a carceral setting each month
- The length of time services are provided, up to 90 days prerelease
- The per person, per service unit cost for each service category
- The utilization for services provided
- Staffing needed to coordinate, implement, analyze, and assist with enrollment services.

The assumptions regarding caseload were based on the number of individuals released annually from Department of Corrections likely to be Medicaid eligible based on DOC estimates, the number of youth released from Oregon Youth Authority custody annually who are likely to be Medicaid eligible based on OYA estimates, and a projection for county jail populations based on the limited data provided to the state when an OHP member is taken into custody of a county jail.

Similarly, assumptions about utilization levels were estimated from the most comparable existing services within DOC and OYA to the waiver benefit package, with special consideration of the limited populations that currently receive those services. One example is that DOC provides case management, but only to a highly-acute population currently; this difference in utilization was estimated to account for the entire benefit-eligible population (all individuals 90 days prior to release) receiving a broader set of case management services. Estimates for county jails include the

assumptions that average length of stay is roughly 14 days (even less for youth), and as such utilization levels would be much lower than prisons.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

OHA's current program team assigned to the 1115 Reentry Demonstration Waiver would be expanding, assigning additional roles to the existing teams. These roles will include:

- Policy analysis responsible for guiding overall programmatic development; program policy/development specific to Transition Populations, leading rules changes, partner-specific relationship building, compliance with federal monitoring protocols, alignment with federal policy
- Overall engagement planning/communications project management
- Enrollment/application assistance

Additionally, the Office of Data Strategy & Operations would support data system change request/infrastructure build, which includes:

- Change management contractor
- ONE System, set up benefit package
- MMIS System Changes and the development of PERC codes and new, limited benefit packages for eligible members

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

The increase in Medicaid eligibility will lead to increased client volume at any given point in time for CCOs and Medicaid providers, whether in-house to the facility or from a community-based

organization doing in-reach. Carceral facilities anticipate needing additional staffing of application assistance for OHP enrollment, which will translate to higher case panels for BH, PH, and dental providers. The readiness assessment phase of the program implementation in fall of 2024 will determine how many additional staff will be needed across facilities to absorb the impact. Community-based organizations will see an increase in their panels for diverting or providing care-coordination services to individuals before and as they release from carceral settings. CCOs will see the same rise in their client volume at any given point of time, since individuals who were incarcerated were not formerly eligible for the 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 POP would establish 7 new positions, which includes permanent authority for existing non-budgeted Operations and Policy Analyst 4 positions (NBP), additional policy analysts to support the implementation of all benefits across all carceral facilities, plus positions to support the data and system changes necessary to newly share health information data and booking/releasing/eligibility to and from carceral settings, community-based providers, CCOs, and OHA.

Policy, Program Design and Program Operations Staffing

Enrollment Coordinators (two Operations and Policy Analyst 2s): Provider enrollment services staffing to support the increase in provider enrollment that will occur across all carceral facilities and all providers operating within carceral systems and submitting claims through MMIS.

Carceral Expansion Program Lead (Operations and Policy Analyst 4) – *NBP Current:* This position is responsible for the strategic integration of H.R. 2617 (FCAA, 2023) provisions (pre-release enrollment in Medicaid and in-reach services with a rolling go-live beginning 1/1/25 with

impacts to county and state youth and adult-serving facilities) with other Medicaid services for individuals in carceral settings. This position will coordinate the development of implementation plans and state plan amendments resulting from the 2023 and 2024 FCAA, including developing options for leadership decisions resulting in changes to OAR, CCO Contract, FFS Third Party Administrator Contracts, guidance documents, system change requests, and data requirements across OHA, Oregon Youth Authority, and Oregon Department of Corrections. This position works closely with the Waiver Transition Populations Lead.

Interagency Implementation Lead (Operations and Policy Analyst 4) – *NBP Rotation:* This position will be responsible for managing and overseeing the implementation of changes at the Oregon Youth Authority, and ensuring there is sufficient planning capacity to develop and operationalize program requirements with Subject Matter Experts in OYA.

Carceral System Engagement Lead (Operations and Policy Analyst 3): This position will be responsible for coordinating the engagement activities to support readiness, implementation planning, and implementation across all 36 counties, DOC facilities and OYA detention centers. This will include managing relationships with key leaders in county government, county behavioral health systems, county public health systems, leadership of DOC and OYA facilities, Coordinated Care Organizations and Fee-for-service care coordination contractors to ensure all impacted facilities and providers are aware of changes and are prepared to operationalize new program requirements.

MMIS Business Systems Unit Team Staffing (supporting the MMIS change requests):

Data Initiatives Coordinator (Operations and Policy Analyst 2): This position will be responsible for collection of data from source systems as well as the Medicaid Management Information System (MMIS) in order to create integrated reports around medical eligibility and benefits for incarcerated

individuals. This position will be responsible for data gathering and compilation for reporting purposes to business partners, community partners, and agency leadership. This position will also provide oversight of any MMIS system enhancements needed to support accurate data reporting and will be involved in system testing to ensure a successful implementation of any changes within the MMIS that support the carceral informed program. This position will oversee system changes requiring new codes and benefit packages for eligible members.

Senior Data Analyst (Operations and Policy Analyst 3): This position will be responsible for providing oversight and direction for data gathering for the carceral program that is specifically contained within the Medicaid Management Information System (MMIS). This position will work collaboratively across multiple State agencies to create data models that support policy and program decisions within the Oregon Health Authority. This position will also be responsible for creating predictive data models based on MMIS data and supporting systems. This position will work to enhance data mining by analyzing historical and current data and support future decision-making regarding the carceral program. As the Senior Data Analyst, this position will work collaboratively with the Data Initiatives Coordinator in the assessment of current data.

- Change management contractor
- ONE System, set up benefit package
- MMIS System Changes and the development of PERC codes and new, limited benefit packages for eligible members

16. What are the start-up and one-time costs?

Start-up and one-time costs are for capacity building.

17. What are the ongoing costs?

Ongoing costs are positions and program services provided to individuals.

18. What are the potential savings?

Potential savings are indeterminant.

19. What are the sources of funding and the funding split for each one?

The funding split for Personal Services is 58 percent federal Medicaid funds and 42 percent General Fund. The funding split for Services and Supplies is 64 percent Federal Funds and 36 percent General Fund. The Special Payments for capacity building will claim a 50 percent federal match on the expenditures and use $57.8 million in new DSHP revenue to cover the state share. OHA is planning on spending $75.1 million Total Funds in 2023-25 and the remaining $40.4 million in 2025-27.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$593,023		$781,186	**$1,374,209**	7	5.75
Services & Supplies	$1,618,445		$2,664,375	**$4,282,820**		
Capital Outlay						
Special Payments	$12,078,717		$46,279,784	**$58,358,501**		
Other						
Total	**$14,290,185**		**$49,725,345**	**$64,015,530**	**7**	**5.75**

Fiscal impact by program

	Medicaid				Total
General Fund	$14,290,185				**$14,290,185**
Other Funds	$0				**$0**
Federal Funds	$49,725,345				**$49,725,345**
Total Funds	$64,015,530				**$64,015,530**
Positions	7				**7**
FTE	5.75				**5.75**

Oregon Health Authority
2025-27 Policy Package

Division:	Oregon State Hospital
Program:	Technology Services
Policy package title:	EHR and Information Technology (AVATAR)
Policy package number:	409
Related legislation:	OAR 333-505-0050, related to Medical Records; Sections of ORS 442 related to required records and reporting functionality; Sections of ORS 441 related to staffing requirements and reporting for hospitals.

Summary statement:

The components within this POP are essential to delivering clinical care and meeting Centers for Medicare and Medicaid Services (CMS) requirements at the Oregon State Hospital (OSH). This POP contains enhancements that promote the safety and wellbeing of patients, ensure data integrity of patient health records, efficient management of hospital staffing and scheduling and identification and analysis of risk factors affecting patients and staff. This request will replace an outdated version of OSH's EHR that will no longer be supported in 2025.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$3,100,000**	**$0**	**$0**	**$3,100,000**	**4**	**1.89**

Purpose

1. What problem is OHA trying to fix or solve?

Serving the OSH population requires foundational infrastructure investments within the spectrum of Information Technology to efficiently provide patient care, as well as manage hospital operational needs. Where possible, this includes streamlining and updating systems to support appropriate care and treatment by mitigating the risks of disjointed and/or unavailable information expected in the medical record. Additionally, required data such as REALD and SOGI would be simpler to collect and appropriately disseminate, along with incident and infection tracking. Evolving technology provides OSH with one of the biggest tools to assist employees in providing quality care, treatment, and service effectively and efficiently in an environment that promotes safety, security and overall wellness. It also allows management to detect issues before they balloon into larger systemic problems.

Electronic Health Records (EHRs) contain the medical and treatment history of patients and allow access to evidence-based tools that providers can use to make decisions about patient care. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. The current version of OSH's EHR is obsolete, and the vendor is no longer supporting enhancements or upgrades. OSH requires an EHR that is vendor supported and customizable to accommodate psychiatric care needs.

Scheduling staff in a 24/7 mental healthcare hospital presents complicated and unique challenges. Changes to patient care requirements result in continuously changing staffing levels with little to no advanced awareness. Staff assignment is based on qualifications that include competencies,

credentials, and familiarity with the unit and/or patient. Coverage for schedule gaps is accomplished through a pool of voluntary resources or mandated overtime.

Additionally, tracking and allotting the time worked in a health care setting also poses a challenge for staff and managers due to the fluid nature of the work environment. Employees work assignments are such that they are repeatedly coming, going, and moving from area to area. This continuous movement makes it difficult to capture an accurate picture of actual coverage and hours worked.

2. What would this policy package buy and how and when would it be implemented?

This POP would buy updates and enhancements for three software systems utilized across the hospital.

1. Electronic Health Record (EHR) Modernization – this component of the POP is for an updated version of the hospital's EHR system, AVATAR PM. The version currently in use is discontinuing and will not be supported by the vendor in the 2025-27 biennium.

2. Workforce Management Enhancement – this component of the POP would enhance the hospital's timekeeping and staffing software to ensure compliance with House Bill 2697 (2023), relating to nurse staffing laws. It would improve staffing management processes.

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?**

   An EHR can help achieve health equity through minimizing cultural and linguistic barriers that may impede patient-clinician communication. It enables the collection and analysis of relevant data such as REALD and SOGI to drive actions in patient care that diminish or eliminate inequities inherent in current systems. In addition, patients may not be able to fully articulate their medical history or may have limited language proficiency which hinders the hospital's ability to provide quality patient care. Having a system that does not capture and report on health equity measures is not adequate.

Quantifying results

4. **What are the long-term desired outcomes?**

   Investing in the software enhancements presented in this POP will support processes that ease CMS and the Joint Commission (TJC) compliance, early detection of issues, and overall streamlined operations. Additionally, the collection of accurate and timely data will direct actions which reduce or eliminate health inequities.

   The **Electronic Health Record Modernization** is a required investment to continue basic hospital function, as the current EHR vendor has implemented a new web-based version, adding additional functionality and automation, enhancing processes, and reducing time currently spent in documentation. This includes automating redundant functions, enhancing data collection, increasing

[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 scope of interoperability with other behavioral and clinical institutions, and amplifying the productivity of current staff. The version the hospital currently uses is no longer supported.

The **Workforce Management** component will enhance the management of hospital staffing, and aid in ensuring that staffing plans are met. This is a critical component in meeting the requirements established by House Bill 2697 (2023), relating to staffing committees and staffing plans.

5. How will OHA measure the impacts on health inequities of this policy package?

The requested package items form three (3) legs of the health equity tool set. OSH and OHA will be able to utilize disaggregated and aggregated patient data from the EHR to measure certain health outcomes by analyzing trends and creating actions. The Workforce Management System (WMS) enables OSH to meet critical staffing requirements and OARs so that employees can focus on key actions, based on data, to reach health equity objectives. These actions will be tracked and compared prior and during the life of this package against several possible outcomes:

- Stable and supported EHR:
  - System downtime
  - REALD and SOGI data availability
- Recruit and retain our workforce using the Workforce Management System to track and schedule clinical staff to meet regulatory requirements:
  - Percent of shifts meeting staffing requirements

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OSH has attempted to utilize information from our current systems to reduce health inequity and meet our mission and vision. Many of these efforts rely on manually collected data, memory of staff, systems with limited data extraction capabilities, and most of the systems do not share information easily. Therefore, many of our actions were based on data which did not include elements of SOGI or REALD and plans and objectives were limited to the extent of information available.

7. What alternatives were considered and what were the reasons for rejecting them?

EHR: OSH has been making incremental updates to the system the past 13 years. Though these updates are necessary for day-to-day operations of the hospital and meeting its objectives, they are inadequate to making fundamental improvements in our patient care processes nor do they keep up with changing needs and mandated requirements.

Time Management System: OSH engages in a manual process using MS Excel spreadsheets to allocate and track staffing assignments. This current system is neither efficient or effective and has limited reporting capabilities because everything must be tabulated by hand.

These are critical systems with data platforms that are fragile and unsustainable, placing the organization at risk.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Not applicable.

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.

Yes.

Enhancements to the EHR are required because day to day operations currently require additional time and effort to navigate the program and lead to potential data entry issues, such as data being placed in incorrect fields as new functionality is incorporated, or in direct time lost by clinicians spent entering information or notes in a non-intuitive system rather than treating patients. This was identified in The Joint Commission audit in October 2021 Finding/Standard LD.01.03.01 EP5, determined the following:

“Observed in HR File Review at Oregon State Hospital (2600 Center Street, NE, Salem, OR) site. The information management system for patient care records and human resource records were slow and cumbersome for staff to navigate which impeded the survey progress. Staff acknowledged difficulty accessing needed information.”

Staffing and fiscal impact

Implementation date(s):	October 1, 2025
End date (if applicable):	Limited Duration staffing expiration and project completion expected December 31, 2026

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. Shared Services currently supports these systems and their support will migrate from the old solutions to the upgraded systems.

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.

Limited Duration OSH resources needed will total four positions and 1.89 FTE, as described below.

- One (1) full time, 15-month limited duration Research Analyst 3 who will be the chief Report Writer. They will identify and update 400+ reports that require revisions prior to migration in the EHR. They will work with the OPA 3s to develop and implement new reports.

- One (1) full time, 15-month limited duration Operations & Policy Analyst 3 performing the lead Business Analyst role. They will support clinical staff in developing the forms, widgets, tables, and specialized application functions in the EHR.
- One (1) full time, 6-month limited duration Operations & Policy Analyst 3 performing the lead Clinical Informaticist role. They will lead the clinical staff in developing application roles, developing new processes, and creating training modules for the EHR.
- One (1) full time, 9-month limited duration Mental Health Registered Nurse whose role will be the subject matter expert for all elements of hospital, clinical processes, and procedures. They will work with the OPA3s to implement the application testing regimen.

Locums/contracted resources will be funding necessary for two part-time non-employee positions, as described below.

- One (1) part-time Locum Psychiatrist who will be the subject matter expert in developing roles and procedures for the staff doctors.
- One (1) part-time contract agency Social Worker who will develop processes, procedures, and training for the social worker and treatment services staff.

16. What are the start-up and one-time costs?

Most of this policy package will be installation, implementation, configuration, and support of the related technology components. The Workforce Management System Modules will consist of entirely software and professional services expenses related to the products. The configuration of the EHR upgrade will require additional employee or locum/agency expenses to ensure the product will integrate correctly within OSH's practices, as well as some user testing. The total 2025-27 biennium expenses are $3.1 million.

- The EHR Modernization project will cost $2,357,967 for the 2025-27 biennium. This project will consist of $534,609 for LD positions; $442,000 for non-employee resources; $705,500 for software implementation and support; and $675,858 in professional services related to the vendor installation and support.
- The Workforce Management System Modules will total $742,033 for the 2025-27 biennium.

17. What are the ongoing costs?

Ongoing costs are related to the ongoing licensing or maintenance of the technology investments. The total ongoing expenses are $420,788 for the 2027-29 and subsequent biennia.

18. What are the potential savings?

There are no direct budgetary savings. However, particularly related to the Workforce Management components, these infrastructure investments will help OSH manage and plan for staffing occurrences that could otherwise lead to more dramatic budgetary overspend.

19. What are the sources of funding and the funding split for each one?

This proposal is entirely General Fund.

Oregon Health Authority: 2025-27 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$502,891	$0	$0	$502,891	4	1.89
Services & Supplies	$2,597,109			$2,597,109		
Capital Outlay						
Special Payments						
Other						
Total	**$3,100,000**	**$0**	**$0**	**$3,100,000**	**4**	**1.89**

Fiscal impact by program

	OSH				Total
General Fund	$3,100,000				**$3,100,000**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$3,100,000				**$3,100,000**
Positions	4				**4**
FTE	1.89				**1.89**

Oregon Health Authority
2025-27 Policy Package

Division:	Public Health Division
Program:	Office of the State Public Health Director
Policy package title:	Public Health Modernization
Policy package number:	410
Related legislation:	House Bill 3100 (2015); House Bill 2310 (2017), Senate Bill 965 (2023)

Summary statement:

Since 2013, Oregon has been on a path to fundamentally transform the public health system to ensure essential protections for every person in Oregon. A modern public health system is equity-focused and accountable for improved health outcomes. The groundwork laid with early investments in public health modernization have better prepared Oregon to respond to public health threats, including the COVID-19 pandemic and cyclical events due to Oregon's changing climate. However, each new public health threat and event highlights gaps in the public health system's capacity to adequately serve communities at greatest risk of harm.

This policy package provides an incremental increase in funding to implement the key priorities selected by the Oregon Public Health Advisory Board (PHAB). This critical funding will be used to address system-wide gaps that prevent Oregon from making progress toward eliminating health inequities, specifically within immunization rates for children and older adults.

Not funding this policy package 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:	**$2,000,000**	**$0**	**$0**	**$2,000,000**	**0**	**0**

Purpose

1. What problem is OHA trying to fix or solve?

Oregon communities continue to face new and increasingly complex public health threats. These public health threats do not impact all people equally. Communities of color, tribal communities and people with low income continue to experience an unjust burden of disease, are more exposed to environmental hazards and have lesser access to resources (e.g., access to care and culturally responsive interventions). People in rural areas of Oregon also often have less access to resources and challenges in accessing health-protective services.

Oregon's public health system is underfunded, and as a result lacks sufficient capacity to prepare communities for public health events that cause harm to human health. The United Health Foundation completed a recent analysis of public health funding investments and ranked Oregon among the bottom half of states, at 28 out of 50.[1] *(Analysis reflected state and federal funding for 2021-22).* For comparison, California ranked #10, Washington ranked #16, and Idaho ranked #18. Additionally, Oregon's public health system is facing stagnant and reducing Federal investment in the very programs that people in Oregon rely on the most – sexually transmitted infection prevention services, access to immunizations and communicable disease investigation and prevention.

The Trust for America's Health recently released a national review of public health preparedness indicators in the *Ready or Not* report, such as drinking water safety, and ranked Oregon's performance in the low tier, leaving people in Oregon vulnerable to communicable disease, climate events and other emerging public health threats. Among other Western states, Washington's

[1] America's Health Rankings (2023). 2023 Annual Report. Available at: https://www.americashealthrankings.org/explore/measures/PH_funding.

performance was in the high tier, Idaho's was in the middle tier, and California's was in the low tier.[2] Washington State has invested heavily in their state public health modernization effort, with $324 million allocated for the 2023-25 biennium.[3]

In recent years communicable diseases like mpox and highly pathogenic avian influenza have emerged. Cases of congenital, primary and secondary syphilis continue to increase every year, with devasting affects for families. Oregon saw a 1750 percent increase in congenital cases from 2014-2022—there were 0 cases in 2013 and 37 in 2022. As of 2022, 26 counties reported a syphilis diagnosis in a pregnant person and 19 counties have reported a case of congenital syphilis. Routine vaccination rates fell precipitously during the pandemic, leaving people vulnerable to preventable diseases such as influenza and measles. In recent years, people in Oregon have experienced negative health affects due to a rapidly changing climate. Extreme wildfires have displaced families and produced wildfire smoke and dangerous air for weeks across entire regions of the state. In the summer of 2021, more than 100 people died due to extreme heat, most of whom were elderly, isolated and living with low incomes. These events will become more common and extreme as climate change continues to accelerate.

Proposed Solution:
Oregon is on a path toward achieving a modern public health system that is accountable for eliminating health inequities, prepared to respond to complex and emerging threats, prioritizes populations disproportionately affected by inequities in prevention and response efforts, and

[2] Trust for America's Health (2024). Ready or Not: Protecting the Public's Health From Diseases, Disasters and Bioterrorism. Available at: https://www.tfah.org/report-details/ready-or-not-2024/.

[3] Washington State Department of Health (2023). Foundational Public Health Services. Available at: https://doh.wa.gov/sites/default/files/2024-01/810018-FPHSArchives.pdf.

improves health outcomes. To support OHA's goal to eliminate health inequities by 2030, 2023-2025 public health modernization efforts focused on expanding investment in community partnerships; developing a public health workforce that is adequately trained, responsive, and valued; and continuing to support locally relevant interventions to reduce threats to health from communicable diseases and climate events. Oregon has already seen the benefits of public health modernization investments in community partnerships; in 2023, OHA was able to mobilize the existing network of funded community-based organizations (CBOs)for emerging public health issues. CBOs mobilized to provide culturally specific community outreach for mpox vaccinations and support well water testing and mitigation in the Lower Umatilla Basin Groundwater Management Area.

This policy package provides an increase in funding to maintain and build on progress to date, allowing OHA, federally-recognized Tribes, local public health authorities (LPHAs), CBOs, and other public health partners to continue a focus on communicable disease prevention, specifically immunization rates in children and older adults, emergency preparedness and climate resilience. Maintaining the current focus allows OHA and partners to review implementation nearly a decade into the initiative and make improvements based on the forthcoming 2024 costing and capacity assessment findings (available in November 2024).Maintaining the current focus will also help offset the significant decrease in federal COVID response funding to OHA and LPHAs that is negatively impacting local workforce capacity (i.e., mitigating the "boom and bust" of public health funding cycles and supporting rising labor costs that have not kept up with federal funding).

2. What would this policy package buy and how and when would it be implemented?

The policy package supports maintenance of special payments for the following types of strategies that are essential for boosting immunization rates in children and older adults.

<u>Engaging with communities most affected by health inequities:</u>

- Robust partnerships between OHA, LPHAs and CBOs in every area of the state to seamlessly provide critical public health information that is culturally and linguistically responsive;
- Direct engagement with communities to ensure that public health interventions are developed and implemented with communities;
- Outreach and educational opportunities conducted by LPHA and CBO partnerships to increase vaccine access and climate resilience;
- Support for training of and continuing education for the public health workforce.

Identifying, responding to, and planning for communicable disease and environmental health threats:

- Specialized staff, local and state, and improved surveillance systems to quickly identify and respond to communicable disease and environmental health threats;
- Local and statewide interventions to increase routine vaccination rates;
- Infection prevention trainings, resources and technical assistance for long-term care facilities and other organizations that serve vulnerable populations;
- Training and technical assistance for health care providers on strategies to increase vaccination rates.

Shared accountability across sectors:

- Engagement across sectors to address structural causes of health inequities related to increasing routine vaccination rates.
- Coordination with health system partners to align priorities and metrics that, over time, results in reduced morbidity and mortality and reduces health care costs.
- Coordination across state and local agencies, and community organizations to address the social determinants of health; and

- Coordination across public health, hospitals, and other partners to bring together multiple sources of situational awareness data to understand complex and emerging public health issues and facilitate coordinated responses across sectors.

Budget
An additional investment of $2 million above current modernization funding levels supports special payments to LPHAs, federally-recognized Tribes and CBOs.

Special Payments

- Special payments to LPHAs and CBOs to implement local work.

LPHAs

- Implement strategies from health equity plans developed during the 2023-25 biennium.
- Increase access to influenza vaccination for residents of long-term care facilities.
- Increase the percent of Vaccines for Children providers that participate in quality improvement to increase childhood vaccination rates.

Tribes, Urban Indian Program and the Northwest Portland Area Indian Health Board

- Further development of tribal health data, assessment, and epidemiology infrastructure for the purposes of tribal health assessments, tribal health improvement plans and other decision-making to improve community health.
- Continued implementation of new or expanded prevention and health promotion programs and activities.
- Implementation of tribal environmental public health programs

CBOs

- Increase in educational materials provided in multiple languages and formats.

3. How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[4] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?

A modern, equity-centered and outcomes-focused public health system is vital for achieving equitable health outcomes.

Since the 2017-19 biennium, OHA-PHD leveraged state investments in public health modernization with federal grants and restructured existing positions to the extent possible to expand the reach and impact of the legislative investments in public health modernization. Over the last four biennia, the majority of the funds have been allocated to local public health authorities, Tribes, the Urban Indian Program and the Northwest Portland Area Indian Health Board, and community-based organizations to reach communities most likely to experience health inequities and are disproportionately impacted by emerging health threats. Resources have laid the foundation for communicable disease control, emergency preparedness, climate and health and health equity.

In addition to the types of work described previously, the following work in the current biennium advances Oregon's goal of eliminating health inequities by 2030:

- OHA is working with Oregon's Public Health Advisory Board (PHAB) to develop a Modernization Health Equity Framework and Public Health System Workforce Plan.
- All LPHAs are required to develop a local climate and health plan and local health equity plan by the end of the biennium.

[4] 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.

- PHAB finalized Modernization accountability metrics that reflect priority health outcomes (e.g., reducing syphilis rates) and process measures related to data-informed decision-making, community partnerships, and strategic communications. PHAB's accountability framework includes demonstrated reductions of gaps in health outcomes across racial and ethnic groups.
- OHA and LPHAs are conducting a public health modernization costing and capacity assessment, which will provide an updated understanding of progress made since initial investments in 2017 including in foundational work to achieve health equity.

This policy package continues investments in Oregon's public health system, and will help accelerate, health outcomes identified in OHA's Strategic Plan, Goal Area #3. Connections to the plan include:

"Foster environments that equitably promote health and well-being, especially among communities most impacted by health inequities by expanding access to 1) safe and accessible housing; 2) healthy food and nutrition; 3) climate resilience; and 4) preventive health services."

- Public health modernization funding supports system-wide approaches for climate resilience and increasing access to preventive health services, including immunizations.
- Since 2021-2023, public health modernization provided the first-ever statewide funding for communities to begin addressing the impacts of climate change on population health, including through hiring specialized positions at OHA and within local public health authorities (LPHAs), federally-recognized Tribes, and community-based organizations (CBOs).
- In 2023-2025, LPHAs are using public health modernization funding to develop local climate and health plans and begin or accelerate work with partners to implement these strategies, which are vital for community planning and preparedness.

"Facilitate capacity building and workforce development to address population health inequities".

- Central to public health modernization is the concept that a trained and responsive public health workforce is critical to providing essential services in every Oregon community.
- In 2023, public health modernization funding supported more than 300 positions in LPHAs, including more than 80 new staff focused on communicable disease prevention, more than 30 focused on climate and health and more than 25 dedicated to community outreach. In addition, 69 CBOs were funded by Modernization to support culturally responsive public services in collaboration with LPHAs.

OHA Strategic Plan health outcome priorities: reduced heat-related emergency department visits and hospitalizations and heat-related deaths; reduced non-infectious (i.e., wildfire smoke-related) respiratory emergency department visits, hospitalizations and deaths; reduced rates of congenital, primary and secondary syphilis; increased childhood immunization rates; increased adult (aged 65 and older) influenza vaccination rates.

The metrics listed above are also public health accountability metrics selected by PHAB, with current funding used to conduct public health interventions to make progress toward these metrics by 2030.

Quantifying results

4. What are the long-term desired outcomes?

The above referenced OHA Strategic Plan outcome priorities are directly connected to public health modernization's long-term desired outcomes established by the Public Health Advisory Board as part of a framework for accountability for OHA and LPHAs in implementing strategies in the Public Health Modernization focus areas. With additional investments in modernization we anticipate:

1. **Two year old vaccination rate to increase to 80% by 2030.** (baseline 69%, 2022)
2. **Adult influenza vaccination rate for adults aged 65+ to increase to 70% by 2030.** (baseline 59%, 2022)

5. How will OHA measure the impacts on health inequities of this policy package?

OHA reports data on health outcome indicators and process measures annually. Health outcome indicators are reported by race and ethnicity and county or region. In addition to achieving overall improvements in health outcome indicators by 2030, PHAB's metrics framework also requires **demonstrated reductions in gaps in outcomes** across racial and ethnic groups.

Beginning in June 2025, LPHAs are eligible to receive **incentive payments based on performance** on accountability metrics.

OHA also collects and reports on impacts of modernization funding to LPHAs and CBOs through twice annual activity and expenditure reporting, which includes funded work with communities that are disproportionately impacted by health inequities.

OHA also funds an **ongoing, comprehensive evaluation** of public health modernization investments to identify successes and areas for improvement.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In the 2017-19, 2019-21, 2021-23 and 2023-25 biennia, OHA-PHD leveraged federal grants and restructured existing positions to expand the reach and impact of legislative investments in public health modernization since 2017. OHA has demonstrated the ability to strategically use all available funding to reach statewide goals, as shown through the ability to pivot funding staffing and other resources during the COVID-19 pandemic. In each biennium, the vast majority of funds have directly reached communities through special payments to LPHAs, federally recognized tribes and CBOs.

Distribution of legislative investments since 2017, in millions:

	2017-19	2019-21	2021-23	2023-25
LPHAs	$3.9	$10.3	$33.4	$50.35
Tribes and NARA	-	$1.1	$4.4	$9.7
CBOs	-	-	$10	$26.95
OHA	$1.1	$4.2	$12.8	$20.3
Reproductive Health Network	-	-	-	$3.4
Inflation				$1.5
Total	**$5.0**	**$15.6**	**$60.6**	**$112.2**

In each biennium, OHA has followed recommendations made by PHAB on priorities for the level of funding received, with expansions in focus areas, strategies and partners funded with each subsequent investment.

The current funding level has reduced gaps in funding for communicable disease control, emergency preparedness and climate and health but is below the level of funding estimated to fully implement requirements for public health modernization in ORS 431.131-145.

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; however, federal investments are insufficient to cover the demands of new work. 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, has guided this policy package by setting overarching priorities.

OHA-PHD has engaged with the Coalition of Local Health Officials, local public health authorities, community-based organizations and federally-recognized tribes on the priorities addressed through 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.

This policy package does not require statutory changes or a new statute.

This policy package provides funding to fulfill requirements in ORS 431.131-145.

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 provides an incremental increase in funding for tribal governments, local public health authorities and community-based organizations. This increase in funding is used to fulfill requirements in ORS 431.131-145, as executed through intergovernmental agreements and grant agreements.

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, 2025

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

OHA-PHD uses estimates of funding needed for foundational programs from the 2016 public health modernization assessment. Based on these estimates, Oregon has reduced, but not closed, gaps in funding for communicable disease prevention, emergency preparedness and climate resilience. Therefore, PHAB has recommended to continue to invest in these areas with focus on demonstrating improvements in related accountability metrics.

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 expanded responsibilities include:

- Support community outreach and listening sessions, systemic integration of community feedback and technical assistance, guided by the PHD Equity Office.
- Technical assistance and subject matter expertise, including data analysis, on population strategies addressing physical activity and nutrition.
- Infrastructure for survey modernization and inclusive data collection systems.
- Engagement across OHA divisions to ensure alignment and collective impact.

Equity and Inclusion Division

OHA-PHD would continue partnership with the OEI on REAL-D and SOGI data efforts and coordination on public health equity work overall.

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 an minimal increase in the level of service to residents of Oregon and visitors through increased investments subsequent improvements to LPHAs, federally-recognized

tribes and CBOs. A $2 million investment results in an increase in per capita spending of $0.46. With an increased investment through this policy package, OHA-PHD expects broader services throughout the state, with focus on immunization rates for children and older adults.

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 new staffing is funded by this POP. Existing resources and staffing will be redirected from current work to serve these functions.

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 contracts for workforce development, program evaluation, grants management, legal fees, data system upgrades, translations, interpretation and ADA accessibility tools. Ongoing costs include special payments to local public health authorities, community-based organizations, federally recognized Tribes, the reproductive health provider network, community-based organizations, and Multnomah County for Program Design and Evaluation Services staffing. Other ongoing costs include software license, phone services, in office rental costs, IT maintenance and operations.

18. What are the potential savings?

Investments in public health saves lives.

A 10 percent increase in Oregon public health departments' per capita spending would lead to[5]:

- Lowering infant mortality by an estimated 15 fewer infant deaths each year
- Lowering diabetes deaths by an estimated 16 fewer diabetes deaths each year
- Lowering heart disease deaths by an estimated 202 fewer heart disease deaths each year
- Lowering cancer deaths by an estimated 88 fewer cancer deaths each year

Investments in public health save money.[6]

- A $1 investment in local public health generates a **return on investment of about $67 to $88**.
- A $1 investment in childhood vaccinations provides the United States a **return on investment of $10.90**.
- For all children born between 1994-2018 who were vaccinated, the US **saved nearly $406 billion in direct medical costs and $1.88 trillion in total society costs.**
- Sexually transmitted infections that escalate to pelvic inflammatory disease result in **additional treatment costs of $1,167 per case. Public health interventions play a critical role in reducing these complications** and preventing STIs.

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[5] Solet, D., & Boles, M. (2016). The health and economic benefits of public health modernization in Oregon. Oregon Health Authority Program Design and Evaluation Services. Retrieved from https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9959.pdf

[6] Brown, T. T. (2016). Returns on investment in California county departments of public health. American Journal of Public Health, 106(8), 1477-1482.
Vaccinate Your Family. (2020). Vaccines Are Cost Saving. Retrieved from https://vaccinateyourfamily.org/why-vaccinate/vaccine-benefits/costs-of-disease-outbreaks/
Association of State and Territorial Health Officials. (2019). National STD Trends: Key Information for Public Health Leadership. Retrieved from https://www.astho.org/ASTHOReports/National-STD-Trends-Key-Information-for-Public-Health-Leadership/

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	$2,000,000			**$2,000,000**	0	0.00
Services & Supplies						
Capital Outlay						
Special Payments						
Other						
Total	**$2,000,000**	**$0**	**$0**	**$2,000,000**	**0**	**0.00**

Fiscal impact by program

	Public Health				Total
General Fund	$2,000,000				**$2,000,000**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$2,000,000				**$2,000,000**
Positions	0				**0**
FTE	0.00				**0**

Oregon Health Authority
2025-27 Policy Package

Division:	Equity and Inclusion
Program:	Regional Health Equity Coalitions (RHEC)
Policy package title:	Regional Health Equity Coalition Expansion
Policy package number:	411
Related legislation:	Senate Bill 70 (2021)

Summary statement:

Sustaining and growing the RHEC program provides expertise and assistance to the state to demonstrate and carry out regionally appropriate, concerted efforts to address issues of inequity across Oregon. This program is one of OHA's key mechanisms for meaningful community engagement and creates a direct link between the agency and those the agency serves. This policy package increases funding for existing RHECs, expands the total number of RHECs to work toward greater statewide representation, and increases OHA staffing to ensure sufficient grantee support.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$3,640,000**	**$39,316**	**$73,018**	**$3,752,334**	**2**	**1.38**

Purpose

1. What problem is OHA trying to fix or solve?

Senate bill (SB) 70 (2021) mandated that OHA work with Regional Health Equity Coalitions (RHECs) and “ensure that it has adequate staffing to support grantees through ongoing technical assistance, contract administration, program planning, and daily operations.”

RHECs are autonomous coalitions that are made of grassroots community members and representatives from culturally specific community-based organizations who work to identify what the most important health equity issues are in their region for communities of color. Once they identify those priorities, then they work to develop solutions to address systemic and institutional racism through policy and systems change. RHECs work with their communities to identify the needs and create 3- to 5-year strategic plans to address what has been identified and implement solutions. Each community will have different needs and will require different solutions based on their community priorities.

Sustaining and growing the RHEC program provides expertise and assistance to the state to demonstrate and carry out regionally appropriate, concerted efforts to address issues of inequity across Oregon. This program is one of OHA’s key mechanisms for meaningful community engagement and creates a direct link between the agency and those the agency serves.

The fact that health inequities continue to persist is evidence that status quo efforts lead by dominant culture organizations, agencies, and institutions remain largely ineffective in addressing health inequities. This points to the need for innovative approaches with communities harmed by inequities leading and informing efforts to address structural racism.

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. The RHECs have expertise based in lived experience to operationalize health equity through policy and systems change efforts to 1) identify the most concerning, regionally-specific health inequities, and 2) develop meaningful solutions to improve the health and wellness of all communities.

RHECs are struggling to not only keep up with their current grant deliverables but also the high number of requests they receive each year to participate in health equity efforts such as involvement in initiatives, councils and committees; and provide technical assistance and consultation to improve health equity. More resources are needed not only for each existing RHEC, but also to ensure statewide representation as there are still 15 counties without RHEC representation. We continue to hear from several unrepresented communities, most of whom are in rural and remote regions, that they need and want this representation but need resources to actualize this goal**.**

2. What would this policy package buy and how and when would it be implemented?

Resources would be used to fund:

- Two positions within each RHEC, funded by the grant administered to RHECs, to continue the expansion of RHECs statewide.
- It would also support increasing resources to existing RHECs, adding three new RHECs to move the program closer to statewide representation. These additional coalitions grow the ability of community members to participate in the policy making process to address health inequities across the state.

- Additionally, the POP would fund two new positions within the Equity and Inclusion Division RHEC program: an RHEC Systems Strategist and RHEC Program Coordinator. These positions would ensure sufficient support to grantees and overall program coordination.

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?

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 who are most harmed by inequities leading and informing efforts to address structural racism. The RHECs have expertise based in lived experience to operationalize anti-racist frameworks with regard to policy and systems change efforts and to 1) identify the most critical and regionally-specific health equity issues, 2) 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 (Oregon Death 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.

[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.

This program aligns with the agency's strategic goal to eliminate health inequities and is one of the few key mechanisms that are directly focused on this objective to address institutional and structural racism and discrimination to improve equity in Oregon.

Additionally, this has touchpoints with strategic planning goal areas 1-4. For example:

Goal area #1: has included advocating for legislation such as Cover All Kids, contributing to Healthier Oregon efforts, and participating in the development of 1115 Medicaid waiver concepts.

Goal area #2: RHEC have provided connection to behavioral health services for gender-diverse communities, as well as advocating for policies that promote investments and improvements in the behavioral health system.

Goal area #3: RHECs work across the social determinants of health to address inequities not just in the clinic but also in safe housing; access to food; mobilized during crises such as wildfires and COVID to distribute PPE, vaccines, food, water, air purifiers, housing assistance, and even provide feedback to OHA on language access and highlight areas and communities that were not receiving the services they needed; etc. This was not the intended function of RHECs, but because they have community relationships, they were able to more effectively and efficiently meet needs.

Goal area #4: Feedback and consultation provided by RHECs have contributed greatly to the agency's learning around meaningful community engagement and the elimination of inequities over the years. This has included highlighting the gaps and barriers to promoting health equity in policies, systems, and procedures.

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" (that is, the most urgent or impactful issues in their region) and developing more effective solutions with fewer unintended negative 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?

Absent General Fund constraints, the RHEC program would request a Research Analyst 4 position as part of this policy package for the 2025-27 biennium. However, existing research positions within the Equity and Policy section of the E&I Division can be made available to support to the RHEC program for research and a robust and culturally appropriate program evaluation to examine program impacts. Evaluation will likely happen through a combination of process measures and outcome measures that will be developed in partnership with RHECs. Methods will 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), whenever possible.

Due to emerging research regarding place-based investment, it is expected that 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 will likely utilize a collective impact framework (CIF). This effort works to build on community strengths and assets and align existing resources toward a common 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?

The program has attempted to leverage grant funds, however, these opportunities come with many directives and requirements. Many of these do not align with the RHECs' communities' goals and priorities and risk mission drift. Additionally, other funding streams are not flexible enough to allow for the range of expenditures needed for the customized approach of each coalition. The RHECs also work to leverage other funding streams and generate revenue through training, consultation and technical assistance. However, much of their services remain free of cost due to the dire need and lack of resources in many communities. These options are not supporting the capacity needed to conduct this work in the state.

Additionally, there have been attempts to request this support in policy package (POP) 410 (2023), Senate Bill 564 (2023), and a resource request that was supported by the Governor's Office in 2024 session that did not get approved.

7. What alternatives were considered and what were the reasons for rejecting them?

The 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. It is believed that five new coalitions are needed for statewide coverage. However, due to budget limitations in this biennium, resources are only being requested for three additional coalitions.

Related to E&I 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 do this important work effectively carry out this important work and the legislative mandates.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

All current RHECs support this request. They have been advocating for this expansion since the 2023 session where they introduced SB 564 for expansion, but the bill did not pass. In the 2024 session, RHECs brought forward the request again, and with Governor's Offices support, OHA put forward a rebalance request to this end and at the request of Sen. Steiner. Unfortunately, the request was not approved and therefore OHA would like to bring this back.

In addition to support from RHECs, there is also support from several CCOs including IHN, CareOregon, Trillium, AllCare, and COHO. There's also support from Oregon Nurse's Association, CLHO, NAACP (Corvallis), Strengthening Rural Families, We Can Do Better, Interfaith Movement for Immigrant Justice, HIV Alliance, Community Outreach, Inc., and Comunidad y Herencia Cultural. There is no opposition that we are aware of.

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 could enhance resources for interested Tribal Governments through Tribal set aside. It also boosts opportunities for local and county governments and health systems, including coordinated care organizations (CCOs), to partner with RHECs and to receive technical assistance and training to build capacity related to health equity and the social determinants of health.

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, 2025

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

The following assumptions impact the pricing of this policy package:

- Based on our previous experience it will take at least 6 months to select and establish 3 new RHECs. These six months will include time to conduct meaningful community engagement, develop a Request for Applications (RFA), review applications, and provide notice of awards, while working with the Office of Contracts and Procurement and CBOs to support community engagement.
- Given the limited General Fund available for the 2025-27 biennium, this pricing includes approximately $120,000 per current RHEC per year for sustainability bringing the total annual grant amount to $270,000. Data shows to be truly sustainable and make as much of an impact as they can, RHECs would need approximately $227,000 for sustainability per RHEC per year, which would bring the total annual grant amount to $377,000.
- We assume that position descriptions can be reviewed and established through DAS and the OHA Human Resources process in a timely manner with positions ready to recruit within 6 months of the biennium.
- Positions will be strategically phased in over the biennium, with one position recruited first and funded for 18 months and the other position recruited in succession and funded at 15 months.
- We assume ongoing agency commitment to the goal of eliminating health inequity by 2030 as outlined in the OHA strategic plan.

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.

Two new permanent positions are being requested 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 number of months funded is noted below. The positions are as follows:

- RHEC Systems Strategist (Operations & Policy Analyst 4, 18 months)
  This position works closely with the RHEC Analysts to provide support and gather information related to systems changes needed to address health inequities internally and externally. The position addresses policy and systems barriers, and develops policies, procedures and systems to address barriers and works with cross-sector partners to do the same.

- RHEC Program Analyst (Program Analyst 4, 15 months)
  This position will be responsible for building community and organizational capacity to address health equity through developing and coordinating funding partnerships between E&I and partner organizations. The position will coordinate all aspects of the RHEC program, providing communications and logistical support directly to RHECs, monitoring contract deliverables, ensuring compliance with contracts and other support contracts, and collecting and reviewing site visit data and writing reports on progress and activities.

16. What are the start-up and one-time costs?

Not applicable.

17. What are the ongoing costs?

The ongoing costs are estimated at $3.8 million. This includes:

- Funds to support the RHEC program's expansion by developing 3 new RHECs across the state.
- Established RHECs would receive grants in the amount of $120,000 per coalition every 12 months to support their efforts.
- Costs to increase OHA staff support to two additional 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,
- Costs for software.
- Costs for travel and supporting cross-learning opportunities among coalitions during activities like our Spring Gathering.

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.

The 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?

The Equity and Inclusion division is based in Central Services, and this work is on behalf of the entire agency. This policy package is priced using the most updated agency-wide cost allocation plan (CAP) to distribute costs to all agency-wide available 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 which are funded at 100 percent General Fund.

Oregon Health Authority: 2025-27 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$338,763	$29,641	$55,050	$423,454	2	1.38
Services & Supplies	$3,301,237	$9,675	$17,968	$3,328,880		
Capital Outlay	-	-	-	-		
Special Payments	-	-	-	-		
Other	-	-	-	-		
Total	**$3,640,000**	**$39,316**	**$73,018**	**$3,752,334**	**2**	**1.38**

Fiscal impact by program

	Central Services				Total
General Fund	$3,640,000				**$3,640,000**
Other Funds	$39,316				**$39,316**
Federal Funds	$73,018				**$73,018**
Total Funds	$3,752,334				**$3,752,334**
Positions	2				**2**
FTE	1.38				**1.38**

Oregon Health Authority
2025-27 Policy Package

Division:	Equity and Inclusion
Program:	Equity & Policy section
Policy package title:	Operationalizing Equity in Health Systems
Policy package number:	412
Related legislation:	SB 790 (2001); HB 3650 (2011); SB 1580 (2012); HB 3407 (2013); HB 2024 (2015); HB 2419 (2015); HB 2304 (2017); HB 2359 (2021); HB 3352 (2021); HB 2002 (2023); HB 4002 (2024); The Civil Rights Act of 1964; The Affordable Care Act 1557.

Summary statement:

This POP is focused on building organizational equity infrastructure through strategic investments needed to create and operationalize equitable health services delivery system across the full health spectrum: physical, behavioral, and oral health. Each of the component of this POP offers opportunities for strategies, functions, and meaningful deliverables that will drive OHA's work towards eliminating health inequities by 2030.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$588,118**	**$0**	**$0**	**$588,118**	**3**	**2.38**

Purpose

1. What problem is OHA trying to fix or solve?

Since the initial passage of House Bill 3650 (2011), Senate Bill 1580 (2012), House Bill 3311 (2012) and House Bill 3407(2013), legislative bills such as House Bill 2088 (2019) that are designed to train Traditional Health Workers (THWs) in Oregon, approve training organizations, and increase integration and utilization of THW's in health systems and community settings have also passed. In addition, with the renewal of the Coordinated Care Organization (CCO) 2.0 Contract Implementation, OHA's Traditional Health Worker Commission has proposed policy recommendations focused on better integration of the THW workforce in their respective service regions. Since 2017, Oregon's THW workforce has increased from 900 to over 6,000 people (as of 2022). There has also been an increase in the number of organizations providing training to this workforce to meet health care workforce shortages. We have over 65 OHA approved training programs of which 14 of those are culturally specific training providers. As of April 1, 2024, the program has recently implemented public applicant portal which allows every applicant to submit their applications using this platform.

In addition to this, a component of this POP is focused on developing Doula Hubs, which seeks to address health inequities of doula access by supporting and building doula hubs to fully address the Maternal Child health and infant mortality gaps in Oregon. A constant challenge reported by doulas and doulas advocates is navigating the complicated billing process and lack of community-based billing hubs to support doulas. Doula hubs are a business, agency, or community organization approved by the state of Oregon as a TYPE09 or TYPE 09-059 (doula specific only) billing provider. The doula hubs allow groups of doulas registered as traditional health workers to bill together instead of as being individuals. Individual doulas or doula hubs having contractual relationships with CCOs is a means of addressing both the low reimbursement rate and ongoing difficulties with fee for service

billing, but doulas report CCOs show varying willingness or understanding of the role of doulas. Creating doula hubs serve as an organizational model that collaborate with area care providers and coordinated care organizations to establish a referral system and client-doula matching, providing supervision of and coordination for doulas, and a centralized liaison for families, doulas, and providers. Research proves having access to a doula decreases anxiety, improve birth outcomes and reduces the rate of surgical birth (cesarean birth, or C-section) often associated with high medical costs. As well as providing greater access to doulas for Medicaid recipients, doula hubs will also support the development of a professionalized doula workforce, provide a centralized entity for providers and payers to establish relationships, provide continuing education and peer collaboration and supervision; and address concerns that may arise around member care. Hubs can also serve the community through the offering of a variety of services including lactation support, childbirth and parenting education, postpartum support, and serve as a community resource center for birthing persons.

2. What would this policy package buy and how and when would it be implemented?

The Operationalizing Equity in Health Systems request will build OHA's organizational equity infrastructure and create an equitable health services delivery system by allocating 3 positions and resources. This POP offers opportunities for strategies and meaningful deliverables that will drive OHA's work towards eliminating health inequities by 2030. The POP further integrates and implements the legislative mandates of the Traditional Health Worker Program. In addition, the POP will create Doula Hubs to support the doula workforce in Oregon, which contributes towards addressing maternal and child health inequities.

1. This POP will fund the following positions THW Program Implementation
    - Traditional Health Worker Program Coordinator (Program Analyst 3), 18 months
    - CCO Innovation & Implementation Strategist (Operations & Policy Analyst 3), 15 months

- Health Equity Workforce Administrative Specialist (Administrative Specialist 2), 24 months

The THW program consists of eight types of worker roles: Community Health Workers, Doulas, Personal Health Navigators, Addiction and Mental Health: Peer Wellness Specialists, Peer Support Specialist, Family Support Specialists, Youth Support Specialists, and Tribal Traditional Health Workers. With the exponential growth of Traditional Health Workers which now stands at almost 7,000 active registrant with 8144 Active certification, more capacity in OHA's THW Program is needed to fully implement the vision of robust integration of THWs in Oregon's health systems, work with CCOs and in Tribal Traditional health worker initiatives, to achieve all the above stated policy efforts. As such, there is a need to add staffing positions in OHA's THW Program. This work also supports OHA's strategic goals 1, 2, 3 and 4 by supporting the transformation of behaiviorol health, Fostering healthy families and environment, increasing access to culturally responsive health care services as well as building Statewide capacity to eliminate health inequities. Hence, the policy option package introduces 3 positions to support the growing work of the Traditional Health Worker program.
The funding requested will support the following three positions:

1. Traditional Health Worker Program Coordinator (PA3)

This position will serve as a point of contact for THWs working with statewide THW workforce, health systems and networks CCOs, Community based organizations and statewide THW associations and culturally specific organizations to implement program goals and objectives. Position will administer grants for hubs to support them set up payment models and infrastructure support for Medicaid billing and expansion of doula care. The Coordinator will support statewide training organizations and workforce recruitment and retentions strategies to address maternal child health inequities to support OHA meet its 2030 goals of eliminating health disparities.

2. CCO Innovation &Implementation Strategist (OPA3)

This position will support the Traditional Health Worker Commission's policy priorities to fully coordinate the integration and utilization of THWs into CCOs in Oregon, to ensure the delivery of high-quality, culturally responsive care and CCO contract deliverables. This role will coordinate and support division engagement processes with CCOs and deliverable evaluation activities for CCO THW deliverables including CCO annual plans implementations, THW workforce integration and utilizations data and supporting payment models plan for workforce sustainability and retention.

3. Health Equity Workforce Administrative Specialist (AS2)

By legislations and rules, OHA is mandated to process application for state certification for the THWs and the THW Program continues to receive approximately 200 applications per month. This role will add crucial administrative support to THW certification processes; staffing support to advisory councils and working committees; THW registry date entry and produce registry reports; respond to inquiries regarding traditional health worker services, including certification process.

2. 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 POP proposes multiple components of work that explicitly link to all four OHA strategic plan goals by building organizational equity infrastructure and creating equitable health services delivery system across the full health spectrum: physical, behavioral and oral 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.

Focus on health equity need to be intentional. To that end, this POP takes a pragmatic approach in aligning with OHA's health equity definition calling for actions for the distribution and redistribution of resources and power. The narrative sections below illustrate how each component contributes to achieving these goals.

1. Access to affordable care for all: Ensure 100% of people in Oregon have easy access to affordable health care, prioritizing communities disproportionately harmed by racism, discrimination, and other forms of oppression.
2. Transform behavioral health: Build a behavioral health system that works for every child, teen, adult and family who's experiencing a mental health or substance use issue by expanding integrated, coordinated, culturally and linguistically responsive behavioral health services when and where people need them, guided by people with lived experience.
3. Foster healthy environments: Foster environments that equitably promote health and well-being, especially among communities most impacted by health inequities, by expanding access to: 1) safe and accessible housing; 2) culturally appropriate healthy food and nutrition; 3) climate resilience; and 4) culturally and linguistically responsive preventive health services.
4. Build OHA's internal capacity and commitment to eliminate health inequity: Provide OHA staff the training, support and tools necessary to partner with communities and recognize, rectify and reconcile the racism and other forms of discrimination and oppression that undermine the health, well-being and opportunities of people across Oregon.

Quantifying results

3. What are the long-term desired outcomes?

Short-term outcomes (2-4 years):

- THW workforce utilization trend increases; payments to THWs increase; and impact of THWs within CCO population.
- CCO provider networks increasingly align with population and care needs of members in geographic service areas.
- Care options and delivery are increasingly aligned with member's need, language, and cultural preferences.

Long-term outcomes (5+ years):

- THWs are an active component of care team for OHP members, delivering culturally competent navigation, education, and coordination to ensure member health and social needs are met.
- THW-delivered services correlate with decreased utilization of services in clinical setting and improvement in health status of population.
- Workforce across all care domains has capacity and diversity to deliver patient-centered, culturally appropriate care.
- Measurable decrease in health inequities (increase access/utilization and improved quality measures)

4. How will OHA measure the impacts on health inequities of this policy package?

We will be using assessment and evaluation measurement tools that capture progress on the following areas:

- Percent of THW workforce utilization trend increases; payments to THWs and HCIs increase; and impact of THWs and HCIs within CCO population.
- Percent of care options and delivery that are increasingly aligned with member's need, language, and cultural identity.

- Percent of THWs that are an active component of care team for OHP members, delivering culturally competent navigation, education, and coordination to ensure member health and social needs are met.
- Percentage of THW-delivered services correlated with decreased utilization of services in clinical setting, community-based organization and improvement in health status of population.
- Increase wages to a competitive level among trained THWsstatewide.
- Percentage of CCO THW provider networks increasingly align with population and care needs of members in geographic service areas.

How achieved

5. What actions have occurred to resolve the issue prior to requesting a policy package?

To date, the THW program has experienced a tremendous increase of workforce from 900–7,000 of active regsitrant/certifications and increase of training organizations to 65 trainings of which 14 of those are culturally specific organizations. We continue to see growth of both workforce; health system needs that exceeds the current staffing resources available to the program to meet this growth. In addition, we have implemented 16 THW CCOs integration and utilization plans for THW workforce, payment models, and data reports and through current CCO contracts, OHA requires all CCO members, based upon their health needs, have access to certified Traditional Health Workers (THWs), who are part of the member's care team in clinical and community-based settings, to ensure members have improved access to appropriate services. The THWs, as a part of the member's care team, must participate in processes affecting the member's care and service needs. To meet all these, requires full CCO implementation and support for program to meet this growth. We have also set Tribal THW Program to implement tribal trainings, Tribal workforce and health system integration of the Tribal workforce. There is a need to fully implement this program goals and current resources

of having one PA3 tribal staff is not sufficient resource to meet the need of the tribal workforces and programs.

6. **What alternatives were considered and what were the reasons for rejecting them?**

   We tried to work with THW Commission, CBOs, statewide workforce associations and partners to address barriers and challenges to meet the growing expansion of the THW workforce. We have worked with external organizations like CCOs to fill the gaps and other resources but the demand for more workforce that is reflective of Oregon's diverse population continues to grow as result, we are over capacity to meet the growing needs for workforce and members.

7. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   We have received feedback from the Traditional Health Worker Commission, Traditional Health Workers and Medicaid members who are still struggling to get culturally responsive care as provided by community health workers, Doulas, peer and family support specialists, as required by state statute. Statewide THW workforce associations, workgroups, Tribal governments continue to bring increased awareness to workforce shortages, recruitment and retentions to OHA programs and how to create sustainable programs that meet our current workforce issues.

8. **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.

9. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

As a result of the implementation of these policy package, there will be increase expansion of workforce to meet the growing shortages of workforce in Oregon, which align with initiatives that support Tribal and Local governments agencies.

This will support doula hubs to create infrastructure for doula hubs to support doula workforce in Oregon to increase doula services to Oregon members.

10. 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, 2025
End date (if applicable):	Not applicable

11. What assumptions affect the pricing of this policy package?

The following assumptions impact the pricing of this policy package overall:

- Position descriptions can be reviewed and established through DAS and the OHA Human Resources process in a timely manner with positions ready to recruit by JaJuly 1, 2025.
- With the exception of one Health Equity Workforce Administrative Specialist position that is currently being filled as a non-budgeted position due to the critical need to support this work,

positions will be strategically phased in over the biennium, with one position recruited first and funded for 18 months and the other position recruited in succession and funded at 15 months.

- Ongoing agency commitment to the goal of eliminating health inequity by 2030 as outlined in the OHA strategic plan. The ability to address workforce shortages to meet growing needs from members regarding THW and services.
- Applications will be processed in real time, accurately, and efficiently, which will allow the THW workforce to focus on providing services to members.
- We continue to see an increase demand of languages access and the high quality of interpretation services including languages of lesser diffusion.
- We will be able to build infrastructure for workforce like doula hubs to have robust support that will increase access to doula for members to meet the growing needs of maternal child heath.

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.

We anticipate the following impacts to services provided by the programs outlined in this policy package:

- Reduction of wait times for services rendered to client populations as result of more providers being enrolled in our systems.
- Increases in provider diversity in our system.

- CCOs have more opportunities to support workforce recruitment and retentions and sustainability.

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 POP would fund three new full-time, permanent positions across the programs and workstreams outlined in this proposal. The number of months included for 2025-27 is noted below. Descriptions of the positions can be found under question 2 above.

- Traditional Health Worker Program Coordinator (Program Analyst 3), 18 months
- CCO Innovation & Implementation Strategist (Operations & Policy Analyst 3), 15 months
- Health Equity Workforce Administrative Specialist (Administrative Specialist 2), 24 months

16. What are the start-up and one-time costs?

There are no one-time costs.

17. What are the ongoing costs?

The ongoing costs for all work outlined in this policy package are estimated at $588,118 in Total Funds, which includes the following:

- Three positions to ensure adequate support for all programmatic work outlined in this proposal.
- Continuation of the THW Tribal Training Program

18. What are the potential savings?

There are many anticipated savings to the health system that research has shown comes from investment in the transformational work associated with this policy package. Specific citations are available upon request and examples of returns on investment are provided below.

There have been various studies conducted on the positive return on investment in THWs. These studies have concluded that there is ample evidence for a sizeable net benefit and the health care cost savings did not exceed the cost of intervention THWs contributes substantial improvements in patient care team productivity and outcomes for patients. A study by the American Medical Association on Community Health Workers says, “Community Health Worker Integration into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home”. There was a net savings of $1,135 per patient and $170,213 annually generated by each CHW.

In a study by the National Health Law Reform, despite spending more on health care, the U.S. leads in negative maternal outcomes compared to other countries of similar economic standing. It was estimated that maternal morbidity cost $6.6 billion in lost productivity nationwide over a 5-year period. Strategies to reduce mortality and morbidity and associated cost must include developing a robust Doula workforce and providing accessible Doula services. “Doula support is a well-researched and evidence-based pathway to improve pregnancy outcomes and experiences, and reduce medical interventions related to birth”.

19. What are the sources of funding and the funding split for each one?

The Equity and Inclusion division is based in Central Services, and this work is on behalf of the entire agency. We use the most updated agency-wide cost allocation plan (CAP) to distribute costs to all

agency-wide available revenue sources. The estimated fund splits are 80 percent General Fund, 7 percent Other Funds, and 13 percent Federal Funds for all costs.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$448,118	$0	$0	**$448,118**	3	2.38
Services & Supplies	$140,000	$0	$0	**$140,000**		
Capital Outlay						
Special Payments						
Other						
Total	**$588,118**	**$0**	**$0**	**$588,118**	**3**	**2.38**

Fiscal impact by program

	Central Services				Total
General Fund	$588,118				**$588,118**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$588,118				**$588,118**
Positions	3				**3**
FTE	2.38				**2.38**

Oregon Health Authority
2025-27 Policy Package

Division:	Oregon State Hospital
Program:	Treatment Services
Policy package title:	Native Services
Policy package number:	414
Related legislation:	**Federal:** Indian Religious Freedom Act (IRFA) of 1978. Indian Health Care Improvement Act (IHCIA)-Public Law 94-437 **State:** Oregon SB 770

Summary statement:

The purpose of this request is to establish a permanent Native Services program by establishing six positions that would provide native services spiritual and recovery practices at OSH on both the Salem and Junction City campuses.

Providing equitable native services is federally required as stated in the Indian Religious Freedom Act (IRFA) of 1978 and the Indian Health Care Improvement Act (IHCIA)-Public Law 94-437.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$211,729**	**$0**	**$0**	**$211,729**	**6**	**2.93**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. What problem is OHA trying to fix or solve?

Oregon State Hospital (OSH) is required to make Native Services available to patients. For years OSH has contracted with staff to provide these services to patients. Contracting is no longer an option due to the lack of availability of contractors and the need to expand the program to meet the need of the approximately 740 patients that reside at the hospital at any given time.

The demand for native services exceeds OSH's ability to provide them. Provided services include sweat lodge sessions, smudge ceremonies, "talking circles", group council, and other indigenous arts and crafts. These services are provided at both the Salem and Junction City campuses. Currently, OSH only has one position (1.00 FTE) who serves as the Elder and program coordinator. That one position is supplemented by limited duration positions who provide services equating to 3.50 FTE. With this program operating on a total of 4.50 FTE, OSH is unable to provide these necessary services at both the Salem and Junction City campuses. Ceremonies such as the sweat lodges are gender-specific and must be led by OSH staff of the same gender. Many of the ceremonies take between 8 and 12 hours from start-to-finish; there is not enough FTE to meet the needs requested by patients.

The Oregon State Hospital is a foundational component of behavioral treatment and stabilization for many under-represented or oppressed groups of people, as those groups also must contend with the stigma of behavioral health in addition to the discrimination faced by their peers. This package blends all four strategic plan components by offering accessible care in a culturally appropriate way to not only members of tribal communities, but to all patients who are interested and can use the principles in their own path to wellness. This both fosters healthier environments and transforms

behavioral health care outside of traditional, purely clinical models, while eliminating health inequities through the inclusion of care provided with input and support from the Native community, including members of the Federally recognized Tribes in Oregon.

Providing native services to the patients at OSH aligns with the OHA's 10-year goal to eliminate health inequities. Other spiritual and religious practices and services are provided to patients at OSH, and the natives at OSH require equitable treatment in their health care provision. The tribal liaisons will be creating a goal in the OHA strategic plan that OSH believes continues to support the need for equitable spiritual services to all people at OSH.

2. What would this policy package buy and how and when would it be implemented?

This policy package would establish and fund six positions that would provide native spiritual services to the patients with tribal spiritual needs. There are currently around 740 patients on two campus, Salem and Junction City. Of those positions, four would be allocated to the Salem campus and two to the Junction City Campus. They would provide services including sweat lodge sessions, smudge ceremonies, "talking circles", group council, native specific veterans support, native specific co-occurring treatment, and other indigenous arts and crafts. The native services positions are also essential in being present to protect sacred items during unit searches and other security related events.

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 helps OSH's indigenous population that has been impacted by health inequities and generational trauma. This package furthers OHA's mission and align with its strategic plan by helping to achieve healthy tribal communities with focusing on providing equitable resources for patients with native services needs as we do for patients who require other Christian or religious needs. Reconciling that other religious practices at OSH have been served by permanent staff, and native services practices have been provided by contractors and limited duration positions is essential in achieving equitable health outcomes.

Quantifying results

4. **What are the long-term desired outcomes?**

   The long-term desired outcomes are to provide services for OSH's indigenous population to address generational trauma and serve as a cornerstone to health and wellbeing of patients who have been subjected to oppression and injustice. The rituals and ceremonies provided by the Native Services department offer patients a way of remaining connected to their cultural heritage as well as practices that are essential in their recovery.

   Having a permanent staff of Native Service Providers would allow service delivery in sweat lodge sessions, smudge ceremonies, "talking circles", group council, native specific veterans support,

[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.

native specific co-occurring treatment, and other indigenous arts and crafts to the 740 patients on both the Salem and Junction City campuses that need native services.

5. How will OHA measure the impacts on health inequities of this policy package?

OHA's goal of connecting all Oregonians to care is a metric that could be included related to this POP. Also, the goal to achieve healthy tribal communities. In addition, in speaking with a tribal liaison, they are working on a tribal goal for the OHA strategic plan and is working on a legislative concept to include tribal affiliation in the REAL-D data (REAL-D T).

OSH is updating their fundamentals map to include metrics related to provision of care and how it provides this care to underserved populations. In addition, delays in service delivery could be tracked and the patients serviced can be tracked to show improvement in both.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Three full time and one part-time (3.50 FTE) limited duration positions have been created to allow provision of native services spiritual practices for the patients at OSH on the Salem and Junction City campus.

7. What alternatives were considered and what were the reasons for rejecting them?

Continuing with contracted services was considered. Providing contracted services for an essential service provision is not equitable as other spiritual practices are being provided by permanent positions at OSH. It is not an option to continue with limited duration positions as it is not financially sustainable and does not provide consistency in provision of native services spiritual practices.

Providing inconsistent services through contractors and limited duration positions does not align with the OHA strategic plan to eliminate health inequities, achieve healthy tribal communities, and connecting all Oregonians with the care they need.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   None but OSH has discussed this issue with OHA's Tribal Affairs Director.

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 may be affected by this policy package as additional resources will improve OSH's native service provision of care. The patients may become more connected to tribal services that would allow them to connect once they discharge to their tribal communities.

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, 2026

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

- Classification used for budging purposes is Chaplain.
- Start dates for new positions will be staggered across the 2025-27 biennium, with three positions starting January 1, 2026 (18 months), one position starting October 1, 2026 (10 months), and April 1, 2027 (3 months).

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Additional staff at OSH will impact recruitment and employee relations responsibilities as they play a role in hiring and maintaining qualified employees. These are not new responsibilities, but additional due to the increase of positions.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Currently there is a two-to-three-week delay before a patient can receive a requested service. For OSH's indigenous population, these services are pivotal in addressing generational trauma and serve as a cornerstone to health and wellbeing of patients who have been subjected to oppression and injustice. The rituals and ceremonies provided by the Native Services department offer patients a way of remaining connected to their cultural heritage.

Sweat lodge services have not yet resumed since the pandemic has ended. Due to native services resourcing, resuming sweat lodge has been challenging. Junction City patients have had difficulty accessing native services and have had delays in receiving services. This POP would decrease caseloads for the native services providers and increase access for patients to obtain service delivery.

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 request is for six additional positions classified as chaplains to implement this policy package. Previously, the organization supplemented native services treatment delivery through contracted positions. Contracted positions were difficult to fill and find individuals that met the requirements need for provision of native services. Currently, OSH has transitioned to 3.50 FTE limited duration positions that are providing native services to the patients at OSH. These will end in 2025.

16. What are the start-up and one-time costs?

Not applicable.

17. What are the ongoing costs?

Position costs are estimated at $649,147 for six positions classified as Chaplains. These costs would be offset by the available budget set aside in Services and Supplies ($437,418) that is currently supporting the limited duration positions performing this work. With that offset, the total request for the 2025-27 biennium is $211,729 General Fund and position authority for six positions (2.93 FTE).

The 2027-29 costs would be the full biennial costs of the additional positions, which would total $1,308,819. Assuming the reduction in Services and Supplies carries forward into the 2027-29 biennium (approximately $437,418), the total net cost would be $871,401 General Fund.

18. What are the potential savings?

None known.

19. What are the sources of funding and the funding split for each one?

This package is General Fund only.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$613,698	$0	$0	$613,698	6	2.93
Services & Supplies	($401,969)	$0	$0	($401,969)		
Capital Outlay						
Special Payments						
Other						
Total	**$211,729**	**$0**	**$0**	**$211,729**	**6**	**2.93**

Oregon Health Authority: 2025-27 Policy Package

Fiscal impact by program

	OSH				Total
General Fund	$211,729				**$211,729**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	**$211,729**				**$211,729**
Positions	6				**6**
FTE	2.93				**2.93**

Oregon Health Authority
2025-27 Policy Package

Division:	Public Health Division
Program:	Environmental Public Health
Policy package title:	Domestic Well Safety Program
Policy package number:	415
Related legislation:	Not applicable

Summary statement:

This policy package will support ongoing OHA obligations to protect residents of the Lower Umatilla Basin Groundwater Management Area (LUBGWMA) from high levels of nitrate in their domestic well water and increasing demands statewide from rural residents experiencing water insecurity due to contaminated drinking water from their domestic wells. The package includes an increase of $3.2 million above the 2023-25 General Fund service levels of $3 million for education, outreach and community engagement, including for health consultations, statewide; and in the LUBGWMA pay for testing and kitchen-tap treatment systems; cover Oregon Department of Human Services field operations to collect and transport water samples for laboratory testing, cover paid media expenses, develop and maintain case management data systems, and contract with Morrow and Umatilla local public health authorities and local community based organizations to support residents in accessing safe water services.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$3,225,146**	**$0**	**$0**	**$3,225,146**	**8**	**8.0**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. What problem is OHA trying to fix or solve?

OHA's Domestic Well Safety Program (DWSP) is increasingly called upon to respond to residents in rural areas across the state at risk of health impacts from contaminated drinking water from their domestic wells. Currently, at the direction of Governor Kotek and the 2023 legislative assembly, OHA is leading the immediate public health intervention to provide safe water services to LUBGWMA residents at risk for, or with confirmed high nitrate in well water including: outreach and education, free well water testing, free drinking water delivery - funded by the Oregon Department of Human Services (ODHS) - and where effective, free water kitchen-tap treatment system installation. OHA and ODHS are carrying out this work in close collaboration with county local public health authority and community-based organization partners, which OHA is funding.

Historically, OHA's DWSP role was funded by federal grants and limited to outreach and education about well stewardship and, when funding allowed, processing of well testing results mandated by the state's Domestic Well Testing Act (ORS 448.271) requiring property sellers to test wells for nitrate, arsenic and e. coli at time of real estate transactions and report results to OHA. OHA would share this data with local public health authorities and the Oregon Dept. of Environmental Quality and use data to focus outreach and education efforts.

With the LUBGWMA response, OHA has had to stand up direct safe water services delivery that requires substantial and ongoing staffing, contracting and data systems investments. OHA anticipates having to deliver services in the LUBGWMA over the next decade at least while local jurisdictions identify options for expanding existing or establishing new public water systems as durable safe water solutions. At the same time, OHA anticipates growing demands from across rural

Oregon for evaluation of health risks from domestic wells as drought and other climate change-driven hazards (wildfires, floods) impact the quantity and quality of rural residents' drinking water supplies and exacerbate well impacts from onsite septic systems and nearby industrial or agricultural land uses.

2. What would this policy package buy and how and when would it be implemented?

This package provides additional staffing that OHA established for the LUBGWMA response through unbudgeted positions in 2023-25 and currently unmet staffing needs as OHA has learned what is needed to deliver safe water services in the LUBGWMA. Specifically, this includes position authority and funding to make permanent limited duration or temporary staff brought on board during the 2023-25 biennium due to workload (Compliance and Regulatory Manager 1, Epidemiologist 1, Operations and Policy Analyst 1) and two additional positions needed to address current unmet needs and meet increased LUBGWMA and statewide domestic well demands in the future (Program Analyst 3, Fiscal Analyst 1). The package also increases services and supplies for an existing interagency agreement with ODHS for contracted field staff and contracts to pay existing water testing, water treatment and communications and media vendors. The majority of the package is for ongoing staff and contract expenses.

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, and aligned with OHA's strategic goal to eliminate health inequities by 2030 as well as the OHA strategic plan goal to foster environments that keep people healthy and equitably promote well-being, especially in communities that have been socially and economically marginalized.

There are an estimated 350,000 active wells in Oregon. When this estimate is coupled with Oregon census estimates for household size, it suggests that approximately 23% 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. This package provides OHA with the capacity to respond not only to the

[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.

intensive response in the LUBGWMA, but to increasing domestic well crises in other parts of the state (see for example, Oregon.gov/CrookCoWells)

With respect to the LUBGWMA in particular, in 2023 OHA and partners were able to identify 3,300 households that depend on domestic wells for drinking water (a previously unknown number). This area of the state tends to be more ethnically diverse, with higher representation of Latino/a/x/e and American Indian/Alaskan Native populations and with a higher poverty rate than the state as a whole.

This POP would improve awareness of domestic well users statewide about contaminants of concern, recommended sampling and referrals to accredited professionals, leading to decreased exposure to contaminants and improved general health outcomes. For the LUBGWMA, this work would accomplish provision of free well water sampling and free water treatment for people impacted by levels of nitrate above health action levels in their drinking water, access to free bottled water delivery through ODHS, and the outreach and education needed to alert residents to health risks from their well water and how to access safe water services.

Quantifying results

4. What are the long-term desired outcomes?

In the LUBGWMA, that residents who depend on domestic wells for their drinking water have their water tested and have access to alternate water supplies if their water tests high for nitrate. Statewide, that OHA is able to be responsive with information needed about health risks from contaminants in domestic well water and how to address them, from the level of individual residents, to local and Tribal public health authorities, to state natural resource agencies charged with

groundwater responsibilities, to local and state elected officials developing policy on this growing concern affecting rural residents of the state.

5. How will OHA measure the impacts on health inequities of this policy package?

The clearest and most direct measure of equity will 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 and the role of genetic and lifestyle causes of disease, it is difficult to measure health impacts of nitrates and most other contaminants in drinking water. For nitrate, acute outcomes from short term exposures (primarily fetal and infant mortality from methemoglobinemia, also some birth anomalies) are rare and chronic outcomes (thyroid, respiratory conditions, stomach and bladder cancer) are difficult to ascribe to individual causes. 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?

OHA has documented implementation of the LUBGWMA response in quarterly updates to the Legislative Fiscal Office since OHA first obtained funding from the Legislative Emergency Board in September 2022, followed by the legislative appropriation in the 2023 session of Governor Kotek's $3 million funding request. These investments have built a Domestic Well Safety Program primarily focused on the LUBGWMA response of outreach and education, well testing, water provisioning (through ODHS), treatment system installation, and resourcing of local partners to support safe water services, as well as responding to Governor's office, legislative committee, county commissioner,

and general public requests for information and support about domestic well safety in the LUBGWMA and statewide.

7. What alternatives were considered and what were the reasons for rejecting them?

OHA's actions in the LUBGWMA also arose in part from a response to expectations set by the US Environmental Protection Agency (EPA) after the federal agency received a petition from environmental organizations under the enforcement provision of the Safe Drinking Water Act. That provision gives EPA broad latitude to issue legal orders to entities (state, local, or private) to take actions where drinking water is endangering public health. OHA asked EPA for funding to help address concerns but EPA has offered no funding.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

OHA and ODHS are partnering with the Governor's Office, the Departments of Agriculture, Environmental Quality and Water Resources, Morrow and Umatilla County health departments (receiving OHA funding), and six community organizations (the first four of which are OHA grantees): Doulas Latinas, Eastern Oregon Center for Independent Living, Euvalcree, National Center for Alternatives to Pesticides, Oregon Rural Action, and H2O-EO or Water for Eastern Oregon. OHA and ODHS meet biweekly in a LUBGWMA Public Health Project Leaders collaborative meeting with ODHS, the local public health authorities and the community-based organizations to guide development and implementation of all program elements.

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 governments (county public health authorities) are receiving funding to support this work. This package will allow OHA to continue to provide well water test results data to inform the work of Morrow and Umatilla County planning departments that are developing a strategy for extension of existing or establishment of new public water systems. OHA data can highlight promising areas where clusters of residents could feasibly be served by such public water systems.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

Not applicable.

Staffing and fiscal impact

Implementation date(s): July 1, 2025

End date (if applicable): N/A

12. What assumptions affect the pricing of this policy package?

Position pricing assumes step 3 based on current limited-duration staffing. For LUBGWMA vendor costs, assumptions are 3,300 households in the area that are dependent on domestic wells. Pricing

also based on the need for five new positions, contracts with external vendors and interagency agreement for ODHS to provide services to OHA.

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 by partners, well sampling and water treatment, and media and direct mail vendors. Office of Information Services will need to maintain and expand existing information systems.

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.

In the 2023 legislative session, OHA received one Program Analyst 2 (1.0 FTE), one Natural Resource Specialist 4 (0.5 FTE), and one Public Health Educator 2 (0.5 FTE) that will continue to support the program. In addition, OHA received one Operations and Policy Analyst 4 (1.0 FTE); however, OHA has transferred that position to ODHS to lead field operations in the LUBGWMA.

This package will add the following five permanent, full-time positions:

- Compliance and Regulatory Manager 1 (CRM 1) to oversee a newly established Healthy Waters Unit including seven Domestic Well Safety Program staff (three provided in the 2023 session and four requested in this POP) as well as two other water and health related staff positions established by the 2023 Legislature to stand up state-funded harmful algae blooms advisory (one

full-time Research Analyst 3) and contaminated fish consumption advisory (one full-time Program Analyst 2) programs respectively.

- Policy Analyst 3 (PA3) to coordinate program delivery across internal and external partners and lead strategic communications to support transparency and accountability for the delivery of services in the LUBGWMA and support interagency responses to emerging domestic well crises statewide.
- Epidemiologist 1 (Epi 1) to conduct health and demographic (race, ethnicity, language and disability) studies on program equity, research health record data to evaluate population-level health outcomes and provide general data query development and other data support.
- Operations and Policy Analyst 1 (OPA 1) to develop and implement systems for program operations and administration systems for delivery of safe water services and partner engagement.
- Fiscal Analyst (FA1) to support budget preparation, expenditure tracking, cost forecasting, extensive invoicing and contracting.

16. What are the start-up and one-time costs?

The program is underway and all costs are ongoing at this point.

17. What are the ongoing costs?

Ongoing costs are for OHA staff, ODHS contracted field staff via interagency agreement, contracts with two local public health authorities and (currently) four community based organizations, contracts with environmental testing laboratories, water treatment system installation and maintenance vendors, paid media and communications consulting and production of outreach materials for partners (flyers, yard signs, refrigerator magnets, tabling banners etc.)

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 entirely General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$1,876,615	$0	$0	**$1,876,615**	8	8.00
Services & Supplies	$1,348,531	$0	$0	**$1,348,531**		
Capital Outlay						
Special Payments						
Other						
Total	**$3,225,146**	**$0**	**$0**	**$3,225,146**	**8**	**8.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Medicaid, Health Policy Analytics
Program:	Healthier Oregon, OHP Bridge
Policy package title:	Healthier Oregon: Reinvesting Oregon Health Plan (OHP) Bridge Savings
Policy package number:	417
Related legislation:	House Bill 3352 (2021)

Summary statement:

Transitions qualifying individuals from Healthier Oregon to OHP Bridge. Seeks to secure $75 million per year in federal funds. Reinvests $60.3 million in savings after offsetting the $2 million cost of for IT system updates to facilitate the transition. The timing of this transition remains unknown, but the target effective date is July 1, 2026.

In the absence of this policy package, the state would forgo $130-160 million in federal funds per biennium. This package recommends reinvesting $54 million General Fund into Healthier Oregon and offers $6 million General Fund savings to be available to fund other investments in the Oregon Health Plan (OHP). This package continues benefit coverage for these members as they are currently covered with OHP.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**($18,131,796)**	**$0**	**$42,863,403**	**$24,731,607**	**0**	**0.00**

Purpose

1. What problem is OHA trying to fix or solve?

The Healthier Oregon program has successfully expanded health care access to over 80,000 Oregonians, including individuals with varying immigration statuses who would not typically qualify for Oregon Health Plan (OHP) benefits. Beginning in July 2024, OHP Bridge further expanded no-cost coverage to adults with incomes below 200 percent of the federal poverty level (FPL) who would otherwise be eligible for Marketplace tax credits.

A subset of individuals (approx. 10,000) in Healthier Oregon would also qualify for OHP Bridge, including individuals subject to the five-year waiting period and individuals present via student and employee visas. This creates an opportunity for the state to enroll these individuals in OHP Bridge, using funds from the federally funded OHP Bridge – BHP Trust Fund rather than General Fund.

Unlike Healthier Oregon, OHP Bridge does not cover long term services and supports (LTSS) or Health Related Social Needs (HRSN). With this policy option package, OHA intends to transition this population from Healthier Oregon to OHP Bridge, while ensuring they continue to receive the full Healthier Oregon service package including LTSS and HRSN. This maximizes federal funding for the Healthier Oregon population in alignment with the program's authorizing statute, House Bill 3352 (2021), without clawing back services for this population. By transitioning this population from Healthier Oregon to OHP Bridge, the state would secure an additional $130-160 million in federal funds per biennium to cover this population, freeing up $130-160 million in Healthier Oregon costs.

2. What would this policy package buy and how and when would it be implemented?

Transitioning Healthier Oregon members to OHP Bridge is a strategic move that offers the potential for low upfront costs becoming significant future savings. This POP would buy approximately $2.0 million General Fund in IT system updates to facilitate the transition, leading to the future savings.

These future savings could be reinvested back into Healthier Oregon. Future savings and BHP costs were calculated assuming a July 1, 2026, effective date.

POP Component	General Fund	Federal Funds	Total Funds
HOP to BHP Savings	($62,343,648)	($13,333,354)	($75,677,002)
Future Investment	$54,343,648	-	$54,343,648
BHP Cost	-	$75,677,002	$75,677,002
HRSN Benefits HOP to BHP	($12,131,796)	($19,480,245)	($31,612,041)
IT Enhancements (one-time)	$2,000,000	-	$2,000,000
Grand Total	**($18,131,796)**	**$42,863,403**	**$24,731,607**

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 policy package of transitioning qualifying individuals from Healthier Oregon to OHP Bridge presents a nuanced approach to addressing health care access and equity in Oregon. Healthier Oregon expands coverage to approximately 80,000–100,000 low-income adults. There are an estimated10,000 individuals in Healthier Oregon who would otherwise qualify for Marketplace tax credits. This POP transitions them from Healthier Oregon to OHP Bridge without jeopardizing their benefit package. This aligns with the Oregon Health Authority's (OHA) mission to promote equitable

[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.

health care access. This move can potentially reduce disparities by providing no-cost health care to a demographic often facing financial barriers. Moreover, securing an additional $130-160 million in federal funds per biennium by covering these individuals predominantly through OHP Bridge allows for strategic reinvestment in health care services, aiming to improve health outcomes and address social determinants of health.

Quantifying results

4. What are the long-term desired outcomes?

By leveraging federal funds, the policy seeks to ensure Oregonians have consistent access to essential health care services, mitigating financial barriers to care over time. Financial sustainability in Oregon's health care system is also a key goal, achieved through efficient resource allocation and potentially reducing uncompensated care costs. This policy package allows for the state to reduce General Fund spending by maximizing federal investment and maintaining a sustainable state-based program that has helped over 80,000 people in Oregon. By ensuring this population maintains access to LTSS and HRSN, this policy continues to prioritize the elimination of health disparities. Ultimately, these outcomes align with the strategic goals of the Oregon Health Authority (OHA) to improve health care system performance, advance health equity, and foster a healthier population throughout the state.

5. How will OHA measure the impacts on health inequities of this policy package?

This policy package falls in line with other OHP health inequity measures, including those used for OHP Medicaid individuals. OHA will continually monitor health inequities among both OHP Bridge

and Healthier Oregon members, both internally and through our coordinated care organization (CCO) partners.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In 2023, Healthier Oregon expanded eligibility to members of all ages and immigration status, bringing the total number of adults and children from around 20,000 prior to the initial launch of Healthier Oregon in July 2021 to 80,000 as of April 2024. During this time, the OHA has applied LEAN management strategies to efficiently and effectively provide care and resources to individuals. OHA has integrated community-identified strategies through continuous community-involved engagement. The agency used third-party academic consultation and formed workgroups that have identified best practices in program delivery, prioritizing existing resources to focus on mitigating barriers to care and increasing facilitators to better quality health.

OHA has provided federal match guidance and continues to look for ways to maximize federal funds for the Healthier Oregon population. This policy package is one of the many significant ways to do just that.

7. What alternatives were considered and what were the reasons for rejecting them?

Unlike Healthier Oregon, OHP Bridge does not cover the full OHP Plus service package – it does not cover long-term services and supports (LTSS) or HRSNs. In the absence of this policy package, the state would need to either forgo the $130-160 million in federal funds per biennium, or reduce the service package for this population. The lack of federal and General Fund savings could render

Healthier Oregon unsustainable. This proposal prioritizes optimal utilization of Federal Funds while still benefiting the Healthier Oregon program members by preserving quality services for all OHP members, regardless of their immigration status.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   OHA's Community Partner Outreach Program (CPOP) consistently receives positive feedback from community partners about the Healthier Oregon program. The OHP Bridge team, which includes individuals from across the agency, is leading the transition of the overlap group. Discussions with CCOs have highlighted the importance of this policy package in maintaining their services, with approximately 97 percent of Healthier Oregon members receiving care through CCOs. OHP Bridge is also administered through CCOs. OHA worked with the Centers for Medicare & Medicaid Services (CMS) to ensure Healthier Oregon meets the Minimum Essential Coverage (MEC) requirements needed to allow for this wrap around program. Additionally, the Oregon Department of Human Services (ODHS) administers Long-Term Services and Supports (LTSS) and is a close partner to OHA.

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, only rule changes. However, in the absence of this POP, state statute through HB 3352 would need to be changed, as OHA would not be maximizing federal funding for the Healthier Oregon population.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

The OHP Bridge Health Program (BHP) is administered through CCOs, with 97 percent of Healthier Oregon members receiving their care through these organizations. Without this policy package, changes to CCO contracts—including Medicaid, non-Medicaid, and BHP contracts—would be necessary to clarify which individuals receive BHP services versus those covered under Medicaid and non-Medicaid contracts. Clear communication from CCOs to members in the various languages preferred by Healthier Oregon members would be essential. Additionally, OHA worked with CMS to ensure Healthier Oregon meets Minimum Essential Coverage (MEC) requirements. If this policy package does not proceed, OHA would need to potentially forgo federal funding.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

There is no associated legislative concept for this policy package.

Staffing and fiscal impact

Implementation date(s): July 1, 2026

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

Two key assumptions primarily influence the pricing of the policy package. The most significant assumption is the caseload estimate, which predicts the number of individuals expected to enroll in the program. In this case, we used available information to estimate that about 10,000 Healthier Oregon members would transition to OHP Bridge. This estimate directly affects the overall cost projections. Additionally, the policy package assumes that any necessary IT enhancements will cost

approximately $2 million. This figure is based on prior work and system changes, providing a basis for budgeting the technological upgrades required to implement the policy.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There will be no 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.

An estimated 10,000 Healthier Oregon members are expected to become eligible and transition to the OHP Bridge. If this policy package does not move forward, the Oregon Health Authority (OHA) risks losing federal funding, which is essential to maintaining the current benefits for Healthier Oregon members and preventing any benefit reductions.

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, existing staff will need to shift their focus from planning, designing, and preparing for the program's launch to concentrating on implementation, operations, troubleshooting, and ensuring the program runs smoothly. This includes overseeing day-to-day operations, managing logistics, and addressing any issues. Their responsibilities will also involve coordinating with various stakeholders, project management, monitoring program performance, ensuring compliance with regulatory requirements, and continuously improving program processes.

16. What are the start-up and one-time costs?

Other than the IT changes, there are no startup costs associated with this policy package, as both the Healthier Oregon and OHP Bridge programs are already operational. There is a one-time $2 million startup cost for IT services.

17. What are the ongoing costs?

The ongoing costs associated with this policy package include the funds required for Healthier Oregon members to receive coverage under OHP Bridge. These costs will transition from being supported by General Funds to being covered by Federal Funds. This population will continue to be eligible for LTSS funded through Healthier Oregon.

18. What are the potential savings?

The savings from this policy package would total to an estimated $130-160 million in federal funds per biennium to cover this population, freeing up $130-160 million in Healthier Oregon costs.

19. What are the sources of funding and the funding split for each one?

Federal Funds will be from the BHP Trust Fund. LTSS funds will be from Healthier Oregon.

Oregon Health Authority
2025-27 Policy Package

Division:	Medicaid
Program:	Medicaid Children & Families Policy
Policy package title:	Child Medicaid Behavioral Health: Home & Community-Care Based Services (HCBS)
Policy package number:	418
Related legislation:	Not applicable

Summary statement:

Provides initial resources to develop and implement CMS requirements to deliver Home and Community-Based Services (HCBS) for children and youth with behavioral health needs. Provides resources and addresses CMS compliance by implementing key steps: selecting assessment tools, developing case management systems, establishing provider networks, and refining eligibility processes. Builds upon, and is contingent on, resources and structures outlined in the Adult Medicaid BH POP for HCBS. Provides access to HCBS for children and youth with behavioral health needs, ensuring equitable service delivery and compliance with federal requirements while enhancing health outcomes and reducing disparities. If not funded, Oregon risks continued non-compliance with CMS mandates, potentially losing federal funding crucial for HCBS programs, exacerbating disparities in health care access, and hindering efforts to improve health outcomes for children and youth with behavioral health needs.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$395,977**	**$0**	**$523,731**	**$919,708**	**3**	**2.25**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. **What problem is OHA trying to fix or solve?**

   Currently, children and youth with behavioral health needs do not have access to Home and Community Based Services (HCBS). This means that children experiencing and navigating behavioral health needs often cannot remain in their homes or communities because OHA does not have the structural, programmatic, policy, or funding mechanisms yet in place. The Oregon Health Authority (OHA) currently faces non-compliance issues with the Centers for Medicare & Medicaid Services (CMS) under obligations related to HCBS under the 1915(k) Community First Choice Option, or “K Plan.” Oregon’s current non-compliance results in significant health inequities experienced by children and youth in Oregon, particularly those with unmet behavioral health needs. These populations often face barriers to accessing essential HCBS due to systemic issues within the healthcare system, including inadequate service availability in appropriate settings, eligibility complexities, and underdeveloped support networks. These barriers perpetuate health disparities based on disability status and age, exacerbating inequities in health outcomes and limiting these individuals' ability to reach their full potential and well-being. Ultimately, non-compliance could result in CMS pulling funding from the HCBS program to OHA, jeopardizing crucial federal support and further exacerbating healthcare access disparities; OHA is seeking to mitigate all of these risks.

2. **What would this policy package buy and how and when would it be implemented?**

   This POP provides resources to ensure Home and Community Based Services (HCBS) are accessible to all eligible children and youth and establishes compliance with CMS under 1915(k) Community First Choice Option, aka K plan, in our Medicaid State Plan. This involves several key steps:

- Identifying, procuring, and establishing the appropriate Level of Care Assessment Tool in collaboration with the Oregon Department of Human Services (ODHS) and other key partners.
- Developing a case management system.
- Developing a contract for an Independent Qualified Agent.
- Establishing a network of providers.
- Establishing eligibility, approval and oversight process.
- Modifying the Medicaid State Plan to incorporate the chosen tools and expand the K Plan.
- Reviewing and revising regulations to facilitate interagency coordination.
- Working with providers to access the system.

The infrastructure resources in this policy package are in addition to, and contingent upon, the resources in policy package #555 Adult Medicaid Behavioral Health that expands needed infrastructure and systems for the adult BH system. Where possible, the program plans to leverage systems and processes designed for the adult system that can benefit the children's system.

To implement the above, OHA will need resources for specific child and youth related assessment tool development, case management development, contract development, training, and provider engagement support. This POP will fund three positions in the Medicaid Children & Family Policy team for the initial phase of development of this program.

OHA will need 2 years to plan, execute, and finalize a State Plan Amendment, followed with implementation of expanded 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?

Children and youth from communities of color and other populations that experience social and systemic racism and inequities are disproportionately represented in the Child Welfare and Juvenile Justice systems, are more likely to experience resource and access barriers to preventative and upstream supports and are disproportionately represented in out of home placement and behavioral health care. As a result, children and youth seeking and needing HCBS are disproportionately from communities and populations that experience health inequities and health disparities. This POP significantly benefits these children and youth by developing appropriate assessment tools, establishing a robust case management system, forming partnerships with providers, and improving eligibility and oversight processes. By implementing these measures, the policy seeks to ensure that these children and youth have access to and receive the necessary support and care, regardless of their socioeconomic status, disability, or other social determinants.

By complying with the State Plan, OHA will enhance the availability and quality of HCBS, thereby reducing disparities and advancing health equity across the state. This strategic alignment underscores OHA's commitment to providing equitable health outcomes for children and youth, promoting inclusion, and fostering a healthcare system that meets the diverse needs of Oregon's residents.

[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?

The long-term desired outcomes include improved access to HCBS for children and youth, particularly those with behavioral health needs. By streamlining eligibility processes, enhancing service availability, and reducing administrative barriers, the policy will make essential services more readily accessible and facilitate behavioral supports and services being provided to children and youth in the least restrictive setting, with the opportunity to maintain connections with family and community, when supportive. This accessibility is crucial in achieving the overarching goal of enhancing health outcomes among these populations, including better management of chronic conditions and overall improvement in quality of life. Compliance with CMS requirements ensures continued federal funding and strengthens Oregon's healthcare system by fostering interagency coordination and community engagement. Ultimately, the policy aims to empower affected individuals to lead more independent lives while promoting inclusivity and equity within Oregon's healthcare landscape.

5. How will OHA measure the impacts on health inequities of this policy package?

The long-term goal of this POP request is to expand the Community First Choice services, to more youth and families in need of BH services in home and community-based settings. However, to expand the services, the resources requested in this POP will help set up the foundation for implementation in compliance with federal requirements. This is in direct alignment with the long-term goals of SB 1557.

OHA will measure impacts on health inequities through the following metrics:

- Availability of a pathway to assess Level of Care for individuals under 21 who might be eligible for HCBS services due to behavioral health conditions.
- Number of individuals under 21 eligible for HCBS services for BH needs.
- Number of individuals receiving HCBS services.
- The types of home and community-based settings where individuals receive services and supports.
- Number of individuals who received relief care utilizing funding available through the Community First Choice Option.
- Number of individuals receiving services and supports served by child welfare programs within the department.
- The total amount of federal funds generated to serve individuals under the age of 21 years through the Community First Choice Option.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

- Reprioritized existing resources and leveraged HCBS infrastructure for the adult system when possible
- Integrated community-identified strategies, such as developing an outreach team to help with community-led policy development.
- Sought technical assistance from federal partners around flexibilities across state plan and waiver.
- Identified compliance pathways across HCBS authorities.

- Collaborated with ODHS as part of a cross-agency effort to enhance access to adults with mental health needs: the majority of identified barriers, potential solutions, and key “themes” can be leveraged to impact the needs of children and adults.

OHA's current lack of structural programmatic, policy, and funding mechanisms hinders the development of both an assessment tool to determine the level of care for behavioral health conditions and the necessary case management system for children and youth needing HCBS behavioral health services. Consequently, individuals under 21 years old requiring HCBS for behavioral health services will continue to be underserved until these mechanisms are established.

7. What alternatives were considered and what were the reasons for rejecting them?

Access to services available in the state to support individuals under 21 who need HCBS services due to BH conditions. Alternative equivalents could not be considered since an assessment tool to determine the Level of Care for BH conditions is not available yet.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

- Acute Care (behavioral and medical) and Oregon State Hospitals: Inform the impact of the lack of HCBS settings for youth on hospital systems and throughput.
- Secure Residential Treatment Facility (SRTF)/Residential (SUD/Mental Health) providers: Inform the impact of a lack of HCBS settings for complex youth within the residential system of care.
- Disabilities Rights Oregon, Oregon Law Center, and NAMI: Provide legal advice and advocacy for youth with lived experience of behavioral health needs.
- NAFY (Homeless Youth Continuum): Would be able to inform the impact of a lack of HCBS settings on houseless youth.

- ODHS: Inform the impact of a lack of HCBS settings for youth with behavioral health needs on ODDS/APD licensed settings.
- Pediatric behavioral health clinicians: Would be able to inform the behavioral health needs of youth who are currently not being served due to a lack of HCBS settings.

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, this policy package necessitates a change in the Medicaid State Plan to establish the appropriate assessment tool and the types of providers who can use it.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

ODHS is the state agency that delivers K Plan services and is, therefore, directly impacted by any changes pertaining to K Plan 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): January 2026 (positions), 2027-2028 (SPA)

End date (if applicable): Not applicable

12. What assumptions affect the pricing of this policy package?

- Policy package #555 Adult Medicaid Behavioral Health is fully funded. The infrastructure resources in this policy package are in addition to, and contingent upon, the resources in that expands needed infrastructure and systems for the adult BH system. Where possible, the program plans to leverage systems and processes designed for the adult system that can benefit the children's system.
- HCBS services costs are equal to a 10 percent increase over projected 2023-25 spending, which was calculated as 2021-23 spending levels plus 3.4 percent annual inflation.
- The requested resources are sufficient to plan and conduct the assessment and analysis to initiate and execute the State Plan Amendment.
- Additional resources for assessment tools and case management would require of $1 million General Fund. This is based on estimate of potential assessment tool related historical cost. In addition, the overall population impacted by expanded services will also add to the overall cost of service.
- Once the fiscal and population impacts have been estimated, as part of the work to initiate the State Plan Amendment, additional resources will be needed in subsequent biennia for the services.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Yes. OHA Medicaid Division staff will need to develop policies and procedures, in coordination with ODHS and OHA BH Division, to identify the appropriate tool, the appropriate providers, and the fiscal impact to initiate and execute the State Plan Amendment. Program and policy staff will need to work with community partners, contracted vendor/s, providers, and families/individuals to implement the new assessment tool. Staff will also need to work with the Office of Information Systems (OIS) and

Contracts & Procurement to administer potential procurement of an assessment tool for Level of Care assessment. Once implemented, the Medicaid division will consistently need to work with ODHS to monitor and ensure quality of services for expanded services under the Community First Choice Option.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Yes. However, since an appropriate assessment tool for the Level of Care determination does not exist yet, the caseload of eligible individuals is indeterminant.

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 POP will be used to fund the following three permanent, full-time positions in the Medicaid Children & Families Policy team:

Children HCBS Lead (Operations and Policy Analyst 3)
This position will work closely in coordination with the OPA 4 HCBS Expansion Lead on the Medicaid BH Policy team (who is responsible for establishing policy and program strategies across all ages/lifespan) to assure children and young adult have equitable HCBS access and outcomes. Duties will also include:

- Leading the development and implementation of K-Plan services for youth with severe emotional disorders.
- Consulting with CMS and ensuring all deadlines for reports, waiver applications, state plan amendments, and the rule-writing process are met.
- Participating in Tribal Consultation process as needed with assistance from Tribal Affairs.

- Continuous monitoring and improvement of expanded K Plan into Psych Under 21

Children and Youth HCBS Policy Analyst (Program Analyst 2)
Implement all EPSDT-related portions of this expansion, including assisting with rule development and contract implementation. EPSDT focuses on all individuals under 21. Duties will also include:

- Coordinating communication dissemination and support for the needs of trainers and other team members.
- Support for the enrollment of new provider types.
- Training the team to develop provider guidance, forms, and processes to deliver adequate case management services.
  - Community engagement.

Children and Youth HCBS Policy Analyst (Program Analyst 2)
Implement all Young Adults with Special Healthcare Needs (YSHCN) related portions of this expansion, including assisting with rule development and contract implementation. YSHCN focuses on individuals with high needs up to age 26. Duties will also include:

- Coordinating communication dissemination and support for the needs of trainers and other team members.
- Support for the enrollment of new provider types.
- Training the team to develop provider guidance, forms, and processes to deliver adequate case management services.
- Community engagement.

16. What are the start-up and one-time costs?

It is unknown at this time if OHA will also need to procure an assessment tool and associated case management services, which may have a start-up cost of $1 million General Fund. This potential cost is not included in this policy package.

17. What are the ongoing costs?

Payment for services and staff supporting the coordination, implementation, maintenance, and improvement of the program. Continued funds are required for the Level of Care assessment tool, Independent Qualified Agent contractor, and technical assistance and training on tools and processes.

Staff	$	581,074
Assessment Tool	$	13,000
Case Management System Development	$	26,000
Project Management Services	$	13,000
Direct Services Provided to Individuals	$	286,628
	$	**919,702**

18. What are the potential savings?

Potential savings include long-term General Fund savings for individuals under 21 who could be prevented from needing high-acuity services such as Temporary Lodging, Inpatient Care, Emergency Department visits and SRTF. Access to timely federally matched HCBS services will prevent escalation of acuity in these individuals and, therefore, less need for state funds to cover

higher levels of services. In addition, many of these individuals, if displaced from their homes and communities due to their mental health needs, may need additional Child Welfare services, thus impacting system-wide finances.

19. What are the sources of funding and the funding split for each one?

This package includes General Fund and Medicaid federal funds. The positions are priced at 50 percent state funds and 50 percent Federal Funds; this is the administrative match rate. Direct service costs are on average 72 percent Federal Funds and 28 percent state funds; this rate is based the clients' eligibility category.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$276,672	$0	$276,672	$553,344	3	2.25
Services & Supplies	$39,868	$0	$39,868	$79,736		
Capital Outlay						
Special Payments	$79,437	$	$207,191	$286,628		
Other						
Total	**$395,977**	**$0**	**$523,731**	**$919,708**	**3**	**2.25**

Oregon Health Authority: 2025-27 Policy Package

Fiscal impact by program

	Medicaid				**Total**
General Fund	$395,977				**$395,977**
Other Funds	$0				**$0**
Federal Funds	$523,731				**$523,731**
Total Funds	**$919,708**				**$919,708**
Positions	3				**3**
FTE	2.25				**2.25**

Oregon Health Authority
2025-27 Policy Package

Division:	Oregon State Hospital
Program:	Facilities – Physical Plant
Policy package title:	OSH Facility Conservation and Development
Policy package number:	419
Related legislation:	ORS 291.215, relating to Deferred Maintenance

Summary statement:

The Salem campus of the Oregon State Hospital (OSH) consists of 1.2 million sq. ft. of buildings and interior secure perimeter court yards, and 23 cottages with a current replacement value (CRV) as reported to the Capital Advisory Board of $495 million. This makes the Oregon State Hospital among the highest replacement value of any single facility owned by the state. The Junction City campus is 229,816 sq. ft. with a current CRV of $180 million. The Pendleton Cottages facility consists of several older buildings with a total of 39,390 sq. ft. and a current replacement value of $10 million.

OSH is at a crossroads where its facilities have reached an age where a robust long-term investment strategy is needed to ensure that it can effectively meet OHA's strategic plan to support all Oregonians in need of mental health treatment. This policy package provides the support OSH needs in the interim to ensure business continuity, and to reduce long-term escalation in capital outlay as building systems are added to the deferred maintenance backlog.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$1,720,156**	**$7,545,000**	**$0**	**$9,265,156**	**0**	**0**

Purpose

1. What problem is OHA trying to fix or solve?

The objective of this policy package is to support the Oregon State Hospital's (OSH) long-term strategic capital planning effort for its facilities portfolio at its Salem, Junction City, and Pendleton facilities; facilities that support the mental health care services to Oregonians by providing therapeutic, evidence-based, patient-centered treatment that focuses on recovery and community reintegration in a safe environment. Oregon State Hospital is a psychiatric hospital system that inspires hope and promotes safety and supports recovery for all. The State Hospital system served more than 1,700 patients over the last year while supporting over 2,700 budgeted positions.

OSH campuses in Salem and Junction City have a considerable volume of equipment at or near the end of their useful lifecycle that are at a point of replacement; equipment that supports the critical 24/7 level of care to patients needing intensive psychiatric treatment for severe, acute, and persistent mental illness.

Lifecycle replacement of equipment plays a crucial role in the accreditation by the Joint Commission and for Medicare reimbursement through the Centers for Medicare and Medicaid Services (CMS), which supports approximately 4 percent of OSH's biennial budget. Much of the existing equipment was procured at the time the new hospital facilities in Salem and Junction City began operations well over a decade ago; while other equipment was transferred from the old facility that was demolished. The Salem Campus began its operations in the new facility in 2011; the Junction City Campus in 2015.

The equipment has experienced heavy continuous use, typical of a hospital inpatient environment, and is requiring upkeep or replacement beyond existing budget resources. Replacement of this

equipment is critical to provide a safe and secure environment for patients and staff, as well as maintaining business continuity.

2. What would this policy package buy and how and when would it be implemented?

This policy package, minimal at best, provides a portion of the investments that support the OSH's current operations and facility infrastructure needs. The objective is to ensure that all Oregon State Hospital facilities can meet programming needs, promote a safe and healthy workplace, are functional, and are nimble to accommodate programming changes..

The specific investments are detailed below in their respective categories:

Facilities Investments	
Capital Improvement (ORS 291.215[1])	$2,675,000
Ops Equipment Investments	
Equipment Replacement	$4,788,000
TOTAL	**$7,463,000**

[1] **291.215 Governor's budget to include amount for deferred maintenance and capital improvements.** (1) Each biennium, the Governor shall propose as part of the Governor's recommended budget an amount for deferred maintenance and capital improvements on existing state-owned buildings and infrastructure that is equivalent to at least two percent of the current replacement value of the state-owned buildings and infrastructure.

(2) As used in this section, "state-owned buildings and infrastructure" does not include:

(a) Buildings and infrastructure owned by or for the use of a public university listed in ORS 352.002 or a community college as defined in ORS 341.005; or

(b) Transportation infrastructure, including roads and bridges. [2017 c.746 §9]

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?

OSH strives to achieve the highest standards and outcomes in all aspects of its work. Engaged stewardship of the public trust and public resources includes maintaining OSH's facilities portfolio to the highest standards and investing in regulatory and infrastructure improvements to meet the constantly evolving needs of patients and staff.

OSH serves one of the most marginalized populations, the mentally ill. Maintaining well-kept, safe and functional treatment environments for Oregonians in need supports OHA's strategic plan to eliminate health inequities by ensuring that all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality and affordable health care.

This policy package supports a portion of the continued investments needed to support Oregon State Hospital's mission to provide the necessary and statutorily required healthcare services to Oregonians that have historically been discriminated and oppressed; being a fundamental component of the behavioral health system; enhancing the treatment environment and providing preventive health services and acts as the foundational and core component of behavioral health in Oregon.

Without this policy package there is an elevated risk that OSH's facilities and operations will be less effective and functional, and limited in its ability to support its mandated mission.

[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?

The objective of this policy package is to support the management of OSH's facilities and site systems to ensure that they are safe, functional, resilient, and nimble to meet changing programming needs.

This investment is part of an over-arching long-term strategic facilities investment plan to ensure that OSH's strategic plan can be realized and managed in perpetuity, especially as its facilities and site systems are aging. The investments that are submitted via this policy package are one part of a multi part planning effort to ensure that all of OSH's facilities are mission ready and to ensure uninterrupted business continuity.

It's important to note that the investments requested in this policy package reflect less than the required biennial ask of an investment of at least 2% of its portfolio CRV as per ORS 291.215. OSH will be implementing a long-term capital planning effort that will provide the necessary data to support a plan that will reduce future unplanned maintenance costs, support operational sustainability, and continued compliance with regulatory requirements; all while being good stewards of state assets and to provide a safe and therapeutic environment of care to some of Oregon's most vulnerable, as well as a safe and conducive work environment where the patients and staff can thrive.

This long-term capital planning objective is to adopt a facilities portfolio management system that will provide a dynamic facilities condition index as a measuring metric to support informed decision

making as investments in minor, major, capital improvement, and capital construction projects load continuously increase, and to ensure business continuity and adaptability needs are supported.

The maintenance projections that are created by the Facilities Program are based on a tracked metric called the Facility Condition Index (FCI). The FCI is a standard facility management benchmark that is used to objectively assess the current and projected condition of a building asset and provide a means for comparisons of facility or building conditions, as well as allowing for renewal funding needs and comparisons. The FCI is the ratio of current year required renewal cost to current building replacement value, or in other words, a calculated measure of facility condition relative to its current replacement value expressed as a percentage. Based on this index, a structure's condition can be ranked as Good (0-5% FCI), Fair (5-10%), Poor (>10%) or Very Poor (>60%). An FCI of 60% or greater usually indicates that the structure should be replaced rather than renewed.

The fundamental drivers of this plan include:

- Effective long-range capital planning for maximizing the use and value of our facilities via a consistent 10-year planning vision.
- Being good stewards of our investments: this is where public investments are properly maintained to ensure occupant safety, being nimble as programming needs change or evolve, and the reduction of long-term operating costs.
- Designing for quality: good building design contributes to higher employee productivity and adaptability and enhanced public service.
- Right sizing our portfolio: sustainability and resiliency being very high priorities, and meeting programming needs.
- Conveying our identity: ensuring that our buildings have an image of accessibility and responsiveness (in-short, how adaptable are our buildings to program changes).

- Emphasizing resiliency: ensuring that buildings are prepared to withstand catastrophic events – both natural (earthquake) and man-made (climate change which could affect HVAC loads, snow loads, etc.).
- Applying best practices when maintaining and planning for new facilities: for example, utilizing Master Planning to help facilitate the long-term need when planning for larger capital improvement and capital construction projects.
- Facility investment tool: effective investment strategy that leverages matching dollars.

OSH is committed to comply with regulatory requirements and achieve good stewardship of state assets to provide a safe and therapeutic environment of care to Oregon's most vulnerable populations.

5. How will OHA measure the impacts on health inequities of this policy package?

OSH strives to achieve the highest standards and outcomes in all aspects of its work. Good stewardship of the public trust and public resources includes maintaining facilities to the highest standards and making regulatory and infrastructure improvements to meet the needs of patients and staff by upholding OHA's mission to 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 replacement of critical depreciable assets helps ensure a safe, secure, and therapeutic environment for treating some of Oregon's most vulnerable populations.

The condition of OSH's facilities and site systems has a direct effect on the service it provides to its patients, and the success of its patients being able to work and ultimately achieve agency and a meaningful life.

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 that continuously pose a challenge due to unplanned repair or replacement occurrences. The current strain on biennial operations and facilities management budgets do not provide the resources to address and resolve the large replacement load.

With close to three quarters of a billion dollars in structural assets, deferred maintenance (DM), capital improvement (CI), and capital construction (CC) investments to modernize OSH's buildings is a significant need. This is further supported by the fact that many of its newer facilities are well into their second decade of use, while the majority of its older structures are well over 50 years old.

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, 2025

End date (if applicable): Debt services for bonds end 2035-37.

12. What assumptions affect the pricing of this policy package?

Inflation and other market price escalation, and the availability of services and supplies.

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.

No positions were approved within this package.

16. What are the start-up and one-time costs?

The entirety of the package, excluding ongoing debt services related to bond-funded expenses, is one-time and requested for the 2025-27 biennium. It consists of the 8 projects that OSH both needs and has the capacity to finish within that time frame.

Description	Projects		Total
General Fund Debt Services		$	1,720,156
Total General Fund		**$**	**1,720,156**
Other Fund Projects	8	$	7,463,000
Cost of Issuance		$	82,000
Total Other Funds	**8**	**$**	**7,545,000**
Total Policy Package	**8**	**$**	**9,265,156**

17. What are the ongoing costs?

The debt services estimate for 2027-29 is expected to be $537,511 excluding principal. Principal and interest in 2027-29 is expected to total $2,697,511 for the eight bond financed projects included in the request.

18. What are the potential savings?

Savings are not directly estimable. As with any large-scale project related to operations of a facility that are deferred, expenses will continue to accrue as the projects do not receive attention and may require replacement or repair if critical failures occur. Depending on the nature of the project, this may result in greater expense than if initially addressed.

19. What are the sources of funding and the funding split for each one?

This package has components that are both General Fund (18.6 percent) and Other Funds, through bond financing (81.4 percent).

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services						
Services & Supplies	$0	$82,000	$0	**$82,000**		
Capital Outlay	$0	$7,463,000	$0	**$7,463,000**		
Special Payments						
Other: Debt Service	$0	$1,720,156	$0	**$1,720,156**		
Total	**$0**	**$9,265,156**	**$0**	**$9,265,156**	**0**	**0.00**

Oregon Health Authority: 2025-27 Policy Package

Fiscal impact by program

	OSH				Total
General Fund	$0				**$0**
Other Funds	$9,265,156				**$9,265,156**
Federal Funds	$0				**$0**
Total Funds	$9,265,156				**$9,265,156**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Medicaid
Program:	Oregon Health Plan
Policy package title:	Hospital Assessment Renewal
Policy package number:	421
Related legislation:	House Bill 2391 (2017), House Bill 2010 (2019)

Summary statement:

The hospital assessment program administered by the Oregon Health Authority is crucial to funding the Oregon Health Plan (OHP), which provides approximately one-third of its total funds when combined with federal dollars. OHP offers essential medical, behavioral, oral health, and Health-Related Social Needs services to individuals at or below 138 percent of the federal poverty level, regardless of citizenship status, ensuring equitable health outcomes for low-income Oregonians. Without authorization to continue the hospital assessment program, Medicaid stands to lose nearly $2 billion in funding. This loss would necessitate widespread cuts to benefits, services, and programs Oregonians rely on for their health needs. Extending the hospital assessment program is essential to maintaining the quality and accessibility of OHP services for all eligible individuals, stabilizing the program and ensuring meaningful health care access for Oregonians in need.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$(1,091,000,000)**	**$1,651,300,000**	**$1,424,700,000**	**$1,985,000,000**	**0**	**0.00**

Purpose

1. **What problem is OHA trying to fix or solve?**

   The hospital assessment program administered by OHA is set to expire October 1, 2025. The hospital assessment is a priority program and a foundational piece of Medicaid funding. It provides for approximately a third of total Medicaid funds. Ensuring the continuation of this critical program is a significant priority.

2. **What would this policy package buy and how and when would it be implemented?**

   The hospital assessment program would continue to fund the Oregon Health Plan (OHP), offsetting General Fund need, enhancing hospital payments and rates, and supporting the disproportionate share hospital program.

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 hospital assessment is a foundational piece of the Medicaid OHP funding package. When the collected funds are matched with federal dollars, it provides for approximately a third of the total funds for OHP. In Oregon, OHP is a medical, behavioral, oral health and health-related social needs services benefit program for persons at or below 138 percent of the federal poverty level, regardless of citizenship status. The programs and services offered by OHP are crucial to ensuring equitable health outcomes to Oregonians with low incomes. Without authorization to continue the hospital

[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.

assessment program, Medicaid would lose nearly $2 billion in funding, necessitating the widespread elimination of countless benefits, services and programs Oregonians count on for their health needs.

Quantifying results

4. What are the long-term desired outcomes?

Sustaining the quality and access of OHP services for all eligible Oregonians. Continuing the hospital assessment stabilizes OHP and ensures that Oregonians at or below 138% of the Federal Poverty Line can receive meaningful access to health services.

5. How will OHA measure the impacts on health inequities of this policy package?

Medicaid is a Federal-State partnership program, and Oregon, as an 1115 Waiver participating State, is required to maintain quality and evaluation documentation. Oregon has an overarching Medicaid Quality Strategy found at: https://www.oregon.gov/oha/HSD/OHP/Documents/Oregon%27s%202022%20Medicaid%20Quality%20Strategy.pdf.

This document outlines OHA's quality objectives, goals, benchmarks and targets for the Medicaid program.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA has prepared a current service level budget reflecting an increased need in state General Fund if the hospital assessment is not renewed.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   As part of the budget development process, OHA has priced a variety of possible program reductions that could alleviate a shortfall in resources.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   OHA leadership, the Medicaid Program and the Office of Health Policy and Analytics. External partners include the Hospital Association. All partners meet to collaborate on a bi-weekly basis to monitor the provider assessment program.

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.**

   Chapter 736 Oregon Law 2003 and OAR 410-050-0870.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    No other government agencies would be affected by this policy package.

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    This policy package is not being requested by Secretary of State or internal audit.

Staffing and fiscal impact

Implementation date(s): October 1, 2025

End date (if applicable): Unknown

12. What assumptions affect the pricing of this policy package?

The POP assumes a renewal of a 6 percent assessment rate for all hospitals currently being assessed a 6 percent rate. Projected growth rates of hospital net patient revenue are developed in conjunction with hospitals.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There will be no new responsibilities for OHA or Shared Services.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

There will be no changes to caseload or 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.

No new staff would be required to implement this policy. OHA Budget, Medicaid Unit and Health Policy Analytic teams are already in place to support the hospital provider assessment program.

16. What are the start-up and one-time costs?

There will be no additional startup costs associated with continuing this program.

17. What are the ongoing costs?

All costs in the POP are ongoing. This includes the Qualified Directed Payments (QDP) to hospitals and rate restoration.

18. What are the potential savings?

Hospital assessment is a mechanism that supports the Oregon Health Plan and reduces need for General Fund support.

19. What are the sources of funding and the funding split for each one?

This policy package reflects a reduction of General Fund using hospital assessment revenue to support OHP payments in the same manor the currently are. It includes Other Funds limitation for hospital assessment revenues and federal matching funds from leveraging state funds, see split on the following page.

Oregon Health Authority: 2025-27 Policy Package

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	$(1,091,000,000)	$1,651,300,000	$1,424,700,000	$1,985,000,000		
Other						
Total	**$(1,091,000,000)**	**$1,651,300,000**	**$1,424,700,000**	**$1,985,000,000**	**0**	**0.00**

Fiscal impact by program

	Medicaid				Total
General Fund	**$(1,091,000,000)**				**$(1,091,000,000)**
Other Funds	**$1,651,300,000**				**$1,651,300,000**
Federal Funds	**$1,424,700,000**				**$1,424,700,000**
Total Funds	**$1,985,000,000**				**$1,985,000,000**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Medicaid
Program:	Oregon Health Plan
Policy package title:	Insurers' Assessment Renewal
Policy package number:	422
Related legislation:	House Bill 2391 (2017), House Bill 2010 (2019)

Summary statement:

The Oregon Health Authority administers the Oregon Health Plan (OHP), which provides medical, behavioral, and oral health services and a health-related social needs benefit program for persons at 138 percent of the federal poverty level and below, regardless of citizenship status. The programs and services offered by OHP are crucial to ensuring equitable health outcomes for Oregonians with low incomes. The insurers' assessment is set to expire on December 31, 2026. This program provides funding for OHP and commercial reinsurance pool. Without extending the insurer assessment program, these critical health care programs risk losing funding.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$(133,891,664)**	**$170,215,962**	**$87,641,664**	**$123,965,962**	**0**	**0.00**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. **What problem is OHA trying to fix or solve?**

   The insurers' assessment is set to expire on December 31, 2026. This program provides funding for the Oregon Health Plan (OHP) and commercial reinsurance pool. Without extending the insurers' assessment program, these critical health care programs risk losing funding.

2. **What would this policy package buy and how and when would it be implemented?**

   The insurers' assessment program would continue to fund OHP, offsetting General Fund need and continuing the commercial reinsurance pool.

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 administers the Oregon Health Plan (OHP), which provides medical, behavioral, and oral health services and a Health-Related Social Needs benefit program for persons at 138 percent of the federal poverty level and below, regardless of citizenship status. The programs and services offered by OHP are crucial to ensuring equitable health outcomes for Oregonians with low incomes.

   The Department of Consumer and Business Services administers the reinsurance program. The program is designed to stabilize rates for individuals purchasing insurance on the individual market,

[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.

receiving federal funding through a waiver from the federal government. The program reimburses insurers for high-cost enrollees and spreads risk across the broader health insurance market in Oregon.

Quantifying results

4. What are the long-term desired outcomes?

Sustaining the quality and access of OHP services for all eligible Oregonians. Continuing the insurers' assessment stabilizes OHP and ensures that Oregonians at or below 138 percent of the federal poverty line can receive meaningful access to health services.

5. How will OHA measure the impacts on health inequities of this policy package?

Medicaid is a Federal-State partnership program, and Oregon, as an 1115 Waiver participating State, is required to maintain quality and evaluation documentation. The State has an overarching Medicaid Quality Strategy found at: https://www.oregon.gov/oha/HSD/OHP/Documents/Oregon%27s%202022%20Medicaid%20Quality%20Strategy.pdf.

This document outlines OHA's quality objectives, goals, benchmarks and targets.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA has prepared a current service level budget reflecting an increased need in state General Fund if this assessment is allowed to expire.

7. **What alternatives were considered and what were the reasons for rejecting them?**

   As part of the budget development process, OHA priced a variety of possible program reductions that could alleviate a shortfall in resources.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   The Medicaid budget team monitors ongoing costs associated with providing funding for OHP.

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.**

   Chapter 736 Oregon Law 2003.

10. **What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?**

    Department of Consumer and Business Services would continue to administer the program. Public Employees' Benefits Board self-insured and contracted health plans, Oregon Educators Benefits Board health plans, and coordinated care organizations would continue to pay the insurers' assessment.

11. **Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.**

    This policy package is not being requested by Secretary of State or internal audit.

Staffing and fiscal impact

Implementation date(s): January 1, 2027

End date (if applicable): Unknown

12. What assumptions affect the pricing of this policy package?

The POP assumes the assessment rates would be assessed at 2 percent to commercial insurance providers as well as CCOs. CCO's will continue receiving payments from OHA to support the ability to pay this assessment.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

There will be no new responsibilities for OHA or Shared Services.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

There will be no changes to caseload or 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.

No new staff would be required to implement this policy.

16. What are the start-up and one-time costs?

There will be no additional startup costs associated with continuing this program.

17. What are the ongoing costs?

Ongoing costs are associated with providing funding to CCOs to pay the assessment and ongoing funding of the Oregon Health Plan.

18. What are the potential savings?

Insurers' assessment is a mechanism that supports the Oregon Health Plan and reduces the need for General Fund support.

19. What are the sources of funding and the funding split for each one?

This policy package reflects a reduction of General Fund, using insurers assessment revenue to support OHP payments in the same manor the currently are. It includes Other Funds limitation for insurers' assessment revenues and federal matching funds from leveraging state funds, see split below.

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	$(133,891,664)	$170,215,962	$87,641,664	**$123,965,962**		
Other						
Total	**$(133,891,664)**	**$170,215,962**	**$87,641,664**	**$123,965,962**	**0**	**0.00**

Oregon Health Authority: 2025-27 Policy Package

Fiscal impact by program

	Medicaid				Total
General Fund	$(133,891,664)				**$(133,891,664)**
Other Funds	$170,215,962				**$170,215,962**
Federal Funds	$87,641,664				**$87,641,664**
Total Funds	**$123,965,962**				**$123,965,962**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Health Policy & Analytics
Program:	Public Employees' Benefit Board & Oregon Educators Benefit Board
Policy package title:	PEBB OEBB Program Integrity and Development
Policy package number:	423
Related legislation:	None

Summary statement:

The commercial insurance market has evolved considerably over the past decade, to the extent that we must seek new means to ensure that PEBB and OEBB members are getting the best possible deals for high quality, equity-based health care. The current budget limitation for consulting services for PEBB and OEBB has no funding for necessary Request for Proposal (RFP) support, claims audits, clinical audits, or support for the Joint Health Equity Workgroup, and is underfunded for supporting joint PEBB/OEBB work through the Innovation Workgroup and Strategies on Evidence and Outcomes Workgroup. An increased limitation for consultant services would immediately allow the boards to schedule the clinical and claims audits, which are costly and require significant resources, but are critical to ensure benefit plans and services are being administered appropriately and legally. Further, it would enable both Boards to issue RFPs as necessary to bring the strongest vendors forward to focus on eliminating health inequities for all the PEBB and OEBB members they are responsible for. RFP's cost money and take a significant amount of time, but the return-on-investment is undeniable.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$5,275,071**	**$0**	**$5,275,071**	**0**	**0.00**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. **What problem is OHA trying to fix or solve?**

   The current budget limitation for consulting services for PEBB and OEBB does not include funding for necessary Request for Proposal (RFP) support, claims audits, clinical audits and support for the Joint Health Equity Workgroup (HEW) and is underfunded for supporting joint PEBB and OEBB work through the Innovation Workgroup (IWG) and Strategies on Evidence and Outcomes Workgroup (SEOW).

   The commercial insurance market has evolved considerably over the past decade, to the extent that the Boards must seek new means to ensure that PEBB and OEBB members are getting the best possible deals for high quality, equity-based health care. Funding for Board-requested RFPs is essential to ensure we have the highest quality equity-focused carrier partners to continue to provide the best possible benefits for our members. This includes a recent RFP for Employee Assistance Program (EAP) Services and an upcoming RFP for Medical/Rx vendors. Near-term RFPs for Dental Vendors and Wellness Programs are also on the horizon. To fund the EAP RFP funds were diverted from IWG and SEOW support, placing vital initiatives on hold.

   Due to our current shortage of consulting limitation the boards have had to postpone both the conducting of claims audits and clinical audits to validate the quality of what we are purchasing, and to eliminate fraud, waste and abuse.

2. **What would this policy package buy and how and when would it be implemented?**

   An increased limitation for consultant services would immediately allow the boards to prioritize and schedule the clinical and claims audits. It would also provide support for the Medical/Rx RFP

currently under development, such that the boards would no longer need to divert needed funds from IWG and SEOW support. Furthermore, the relatively new Joint Health Equity Workgroup, which has never been funded, would be able to broaden its scope and reach without impacting other necessary initiatives, such as the Centers of Excellence workstream.

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?**

   When the Boards established the Joint Health Equity Workgroup several years ago it was with the intent to review each new benefit or benefit change with respect to correcting any negative impacts on priority populations prior to implementation. Also, as funding and bandwidth allows, a second goal of the workgroup is to review our current benefit practices and structures with a like focus. Since there is no funding in our past and current limitations, the Boards have had to postpone other vital initiatives to fund this critical equity work.

   Clinical and claims audits, which have been postponed due to lacking limitation would greatly enhance the equity work of the Boards as the clinical and claims data is paired with available REAL-D/SOGI data to identify potential areas of concern to focus on. These are expensive and require significant resources but are critical to ensure benefit plans and services are being administered appropriately and according to the law.

[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.

All RFPs issued by either Board now have equity-based questions embedded in each key focus area, allowing them to clearly evaluate vendor capabilities and implement appropriate performance guarantees with each new contract issued.

Quantifying results

4. What are the long-term desired outcomes?

The long-term outcomes of this requested limitation increase are to enable both Boards to issue RFPs as necessary to bring the strongest vendors forward to focus on eliminating health inequities for all the PEBB and OEBB members they are responsible for. RFP's cost money and take a significant amount of time, but the return-on-investment is undeniable. Further, it would help bring current the delayed initiatives focused on claims and clinical audits for the myriad reasons previously mentioned, and allow the joint workgroups focused on equity improvements to be funded properly without harming or delaying other critical work.

5. How will OHA measure the impacts on health inequities of this policy package?

Both Boards annually review all performance metrics, including health equity-based metrics and performance guarantees in our contracts, maintaining the focus on measurable outcome improvements. All new RFPs will have a health equity focus embedded throughout, rather than in a single section, providing a comprehensive and pervasive health equity focus and allowing the Boards to monitor and evaluate the success of new services or vendor relationships.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Because the Board has not had sufficient limitation to have the consultants conduct all the necessary requested work, many initiatives have been delayed to the point that they will need to be dropped or be much more expensive to complete. If no increase in limitation is made, both Boards risk not being able to ensure they are providing the best equity-based benefits at the most affordable price, and their push towards eliminating health inequities by 2030 will be severely compromised. By pushing back claims and quality audits beyond the industry-standard frequency, it impacts program integrity, cost efficiency and ultimately member health.

7. What alternatives were considered and what were the reasons for rejecting them?

The commercial insurance market has evolved considerably over the past decade, to the extent that the Boards must seek new means to ensure that PEBB and OEBB members are getting the best possible deals for high quality, equity-based health care. The alternatives to conducting what the Boards feel is this critical work, are shifting funds from other areas or eliminating workstreams. Both Boards have already shifted funds from other areas to move their equity-based work forward, resulting in delays of necessary claims and clinical audits and delays of potential RFPs.

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 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

We have assumed that between both Boards we will need to issue RFPs for services for the next several biennia, as each is a 2-to-3-year effort from development through contracting to implementation. We have further assumed that essential funding for our 3 workgroups (HEW, IWG, SEOW) is critical if we are to conduct the necessary work to do our part in eliminating health inequities by 2030.

If the policy package is not funded, the workstreams and initiatives previously mentioned will need to be eliminated or delayed indefinitely.

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?

Not applicable.

17. What are the ongoing costs?

We have assumed that between both Boards we will need to issue RFPs for services for the next several biennia, as each is a 2-to-3-year effort from development through contracting to implementation. We have further assumed that essential funding for our 3 workgroups (HEW, IWG, SEOW) is critical if we are to do our part in eliminating health inequities by 2030.

18. What are the potential savings?

The Boards have moved to conducting these critical analyses and initiatives jointly whenever possible, greatly reducing the overall spend. We expect this joint work to continue, increasing potential savings by implementing key initiatives and leveraging outcomes.

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 and OEBB Core Benefits which cannot exceed 2 percent of premiums. 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	0.00
Services & Supplies	$0	$5,275,071	$0	**$5,275,071**		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$5,275,071**	**$0**	**$5,275,071**	**0**	**0.00**

Fiscal impact by program

	HPA-PEBB/OEBB Ops				**Total**
General Fund	$0				**$0**
Other Funds	$5,275,071				**$5,275,071**
Federal Funds	$0				**$0**
Total Funds	**$5,275,071**				**$5,275,071**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Health Policy and Analytics
Program:	Oregon Health Insurance Marketplace
Policy package title:	State-Based Marketplace Eligibility and Enrollment Platform Phase II
Policy package number:	424
Related legislation:	Senate Bill 972 (2023)

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. It funds the second 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 service experience for Oregonians.
- Implements input from Oregon's various and diverse communities, including communities of focus, into technology and call centers.
- Collects, analyzes, and stores enrollment data, including REALD/SOGI data to improve access to affordable coverage for oppressed communities.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$25,000,000**	**$0**	**$25,000,000**	**15**	**10.74**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. 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 its associated call center and to fund the second 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 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 and 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. The fee is currently 1.8 percent of total premiums and is paid on a monthly basis.

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 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 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 Alabama must also work for Oregon and every other state. 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, e.g., 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 (PHE).
  - 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 due to the fact that the CAC serves many states, and not all of 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 Oregonians in the individual health insurance market in the form of increased insurance premiums. In 2024, an individual will pay an estimated $12.44 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. From 2017 to 2023, fees fluctuated from 1.5 percent to 3 percent of total premiums for plans purchased through HealthCare.gov. For 2024, federal platform fees were reduced to 1.8 percent, and in 2025, fees are slated to drop to 1.2 percent of total premiums.

- 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 has 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 six 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), far outperforming the vast majority of FFM states. The Marketplace also pays for use of a shopping tool that, among other things, allows Oregonians to compare plans based on medications taken and yields accurate provider search results. Oregon’s shopping tool provides a superior shopping experience to that of 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 has collected $6 billion in user fees, enough to pay for a state-based technology platform for a state with twice the enrollment of Oregon more than 400 times. A customizable, state-based enrollment and eligibility platform and a state-controlled call center will be a better return on investment for Oregonians than the FFM.

- **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 in which OHA must engage to be most effective. Access to more demographic data would enable OHA 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 OHA'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 raise health coverage rates in Oregon communities of focus by making health insurance more affordable and equitably obtainable. Since the marketplaces are often the mechanisms 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 Oregonians that speak languages other than English require support in additional languages (currently available only in English and Spanish) or even simply alternate verbiage on the enrollment platform, OHA cannot act because the FFM does not operationalize single state solutions. Moreover, because OHA does not own or control the data of its enrollees, there is no baseline for Oregon to know the extent of the problem faced by people of color, non-English speakers, the disabled, or people of differing sexual orientations or gender identities. Simply put, use of the FFM is a barrier to OHA's goal of ending health inequities by 2030.
  - Data collection, particularly on race/ethnicity, is widely recognized as fundamental to understanding enrollment disparities. The FFM's race/ethnicity application data is unreliable because of a low response rate, and the FFM has failed to improve data collection and does not have the ability to engage insurers in data collection and reporting like OHA's Marketplace does.
  - Without additional, more reliable data, OHA cannot refine its Marketplace outreach and communication strategies, both overall and in real-time, to better serve communities of focus and fully inform Marketplace strategies that will contribute to OHA's overall health equity goals for Oregonians.

2. What would this policy package buy and how and when would it be implemented?

The Marketplace is using a two-phase funding process. The first phase of funding (2023 to 2025) funded 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 were 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. Phase I also included the stage-gate review by Enterprise Information Services (EIS) through Gates one and two that verify the corresponding project planning artifacts and requirements.

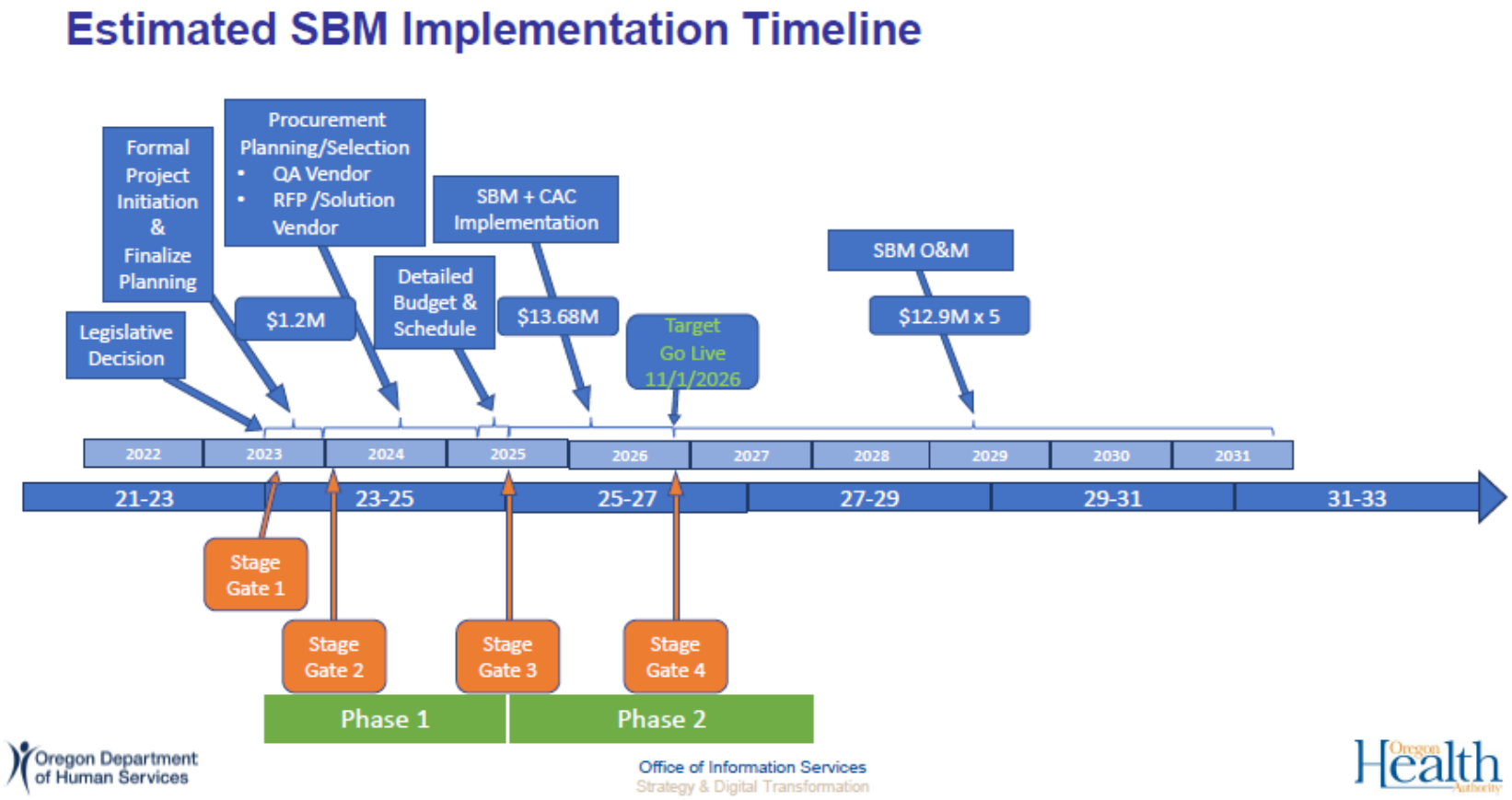
OHA released an RFP in July of 2024 for a state enrollment and eligibility platform and a call center. OHA sought bids from vendors with proven versatile, adaptable technologies capable of the following:

- 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, including communities of focus, 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 of focus while carrying out the strategies to achieve OHA's overall health equity goals.
    - Allow for real-time, micro-focused outreach and education to communities of focus to improve access to coverage and care more equitably and with greater speed and efficiency.
    - 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.
- Increasing the value and the return on investment for Marketplace technology and support for the Oregonians that fund it.

This policy package will fund the internal, external, and contracted sources for specialized expertise in the fields of project management, technology integration and implementation, procurement, quality assurance, data, legal, security, privacy, community outreach and education, training, and transition to ongoing operations. It includes funding and position authority for fifteen new permanent, full-time position and reclassifying three existing positions (see question #15 for more detail).

The implementation timeline below illustrates the estimated timing of the overall project, including Phase II.



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 second 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 disproportionately includes people across several communities of focus.
- 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, including communities of focus, 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:
    - Recognize trends and inform policy development and decision-making that affects communities of focus while carrying out the strategies to achieve OHA's overall health equity goals.

[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.

    - Allow for real-time, micro-focused outreach and education to groups who have been disproportionately affected by health inequities.
    - 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?

Failure to fund this policy package will require 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, and 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. It has fluctuated significantly over the years and cannot be predicted with any certainty.

- **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, including communities of focus, in the design and operation of the eligibility enrollment platform or call center.

5. How will OHA measure the impacts on health inequities of this policy package?

Currently, OHA does not have access to the detailed demographic data of Marketplace enrollees. The data collected on the new platform will give OHA the ability to more accurately track the demographics of Marketplace consumers, permitting OHA to establish a baseline for the populations and communities the Marketplace serves. With an established baseline and more precise demographic data, OHA can identify Marketplace populations, including communities of focus, for outreach and tailor outreach with the goal of increasing enrollment, lowering the uninsured rate, and increasing access to quality, affordable health care. The established baseline and data from subsequent plan years will provide OHA with the ability to measure the effectiveness of the Marketplace's targeted outreach to communities of focus and other communities and populations over time.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

As both a division of the Department of Consumer and Business Services and an office with OHA, 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?

While OHA has not yet directly identified additional key SBM transition partners, the procurement strategy is to contract for solutions that are highly configurable so that the solutions can modified for future partnerships and related strategies as they are needed.

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, Senate Bill 972 was signed into law in 2023.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

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.
OHA does not believe additional state, tribal, or local governments will be affected.

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, 2025

End date (if applicable):

12. What assumptions affect the pricing of this policy package?

- Estimated numbers of required resources and prices of comparable solutions in other states accurately reflect what Oregon can expect in terms of relative overall cost.
- Consumer assistance center services will be provided by a single vendor – either directly or through contract – as part of the overall solution.
- Solution vendor will agree to design, development, and implementation costs to be amortized over 48 months starting in July 2026.

- Solution vendor will agree to charge operations and maintenance costs starting in February 2027 after all 2027 Marketplace plans are officially effectuated and active.
- 80,000 to 110,000 Oregonians will remain enrolled in the Marketplace after OHP Bridge implementation, and enrollment will remain relatively stable or increase over time.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

The Marketplace will continue to 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, privacy, and rate setting. Additionally, the Marketplace will need to work with the Office of Financial Services to plan for the receipt of assessment fees for the Marketplace and the associated recordkeeping.

OIS would continue to provide specialized expertise in technology project management, technology/architecture, planning, research, and experience with large multimillion-dollar stage-gate projects. OIS expects the following new responsibilities:

- Solution planning; requirements gathering; system security plan development; disaster recovery; and, if needed, providing consulting support with the coordination of user acceptance testing;
- Web services, data analysis, application programing interface, and data interface implementation;
- Data interface planning, structured query language analysis, and Database 2 mainframe development;
- Information technology vendor management; and
- Firewall and Smart Designated Compute coordination.

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 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
- Working through project implementation tasks
- Obtaining community and partner (carrier, agent-grantee, and community partner-grantee) input
- Conducting organizational restructuring

This policy package includes funding for staff who are being considered for a reclassification to reflect the changing scope of their work, including additional employees to supervise, compliance with federal and state regulations, partnership with new vendors, increase in operational budget, increased in subject matter expertise workload, and oversight of a new capital asset for the agency:

- The Marketplace Director, to be reclassed from a Health Policy and Program Administrator 1 to a Health Policy and Program Administrator 2. This staff member is the executive leader responsible for the policy implementation and sustainable operations of the transition of the Marketplace to an SBM, including new and expanded responsibilities.
- The Marketplace Outreach and Education Manager, to be reclassed from a Health Policy and Program Manager 2 to a Health Policy and Program Manager 3. This individual will serve as the

Marketplace Deputy Director and will be responsible for two units, as well as, standing up and overseeing a contracted consumer assistance center.

- The Operations Development Specialist, to be reclassed from an Operations and Policy Analyst 3 to an Operations and Policy Analyst 4. This position will be modified to serve as the Operations and Program Liaison that will be responsible for coordinating and aligning across diverse federal and state projects and programs that the SBM will need to align with and vice versa. This individual will also serve as the lead for SBM implementation of all new policy initiatives. This staff will be the primary business liaison with OIS, EIS, and federal partners.

Staff whose areas of responsibility will be modified are the following:

- An Operations and Policy Analyst 4 to serve as the Appeals and Enrollment Advisor responsible for oversight of SBM enrollments, constituent issues, complaints, and appeals.
- An Operations and Policy Analyst 4 to serve as the Business Policy and Data Advisor tasked with ensuring business and operational policies and procedures align with federal and state regulations. This position will also be the lead in ensuring compliance with race, ethnicity, language or disability (REALD) and sexual orientation or gender identity (SOGI) requirements. This analyst will be responsible for all ensuring all reporting and audit deliverables are complete and on time.
- An Operations and Policy Analyst 4 to serve as the Tribal and Provider Liaison. This individual will be responsible for supporting providers who will need additional outreach and direct services from staff during and after the SBM transition.
- An Operations and Policy Analyst 4, who is the Agent and Employer Liaison, will be responsible for offering Marketplace certification training to agents and brokers. This position will help create training, host and present virtual and in-person training sessions, and collect data on agents/brokers who are certified and trained. This staff will provide collected data to DFR to

identify which agents/brokers have completed certification training and will cross reference additional data to ensure agents/brokers have completed all other training and licensing required by the State of Oregon. This staff will provide subject-matter expertise to insurance companies with respect to questions from agents about commission payments related to Marketplace enrollments.

- A Public Service Representative 4 will handle calls from Oregon's new CAC and will provide subject matter expertise and tier two call center support to the CAC leadership. This position will continue to provide public/consumer education on the Oregon Health Insurance Marketplace and corresponding Affordable Care Act provisions via email and respond to related health insurance inquiries, ranging from general information and referral to detailed problem solving and resolution. This position will take calls from CAC leads, community partners, agents, and representatives from other state agencies who call the Marketplace service line.

The following fifteen new permanent, full-time employees will be needed for implementation (priced at 24 months for the 2025-27 biennium):

- One (1) Business Operations Manager 2 to serve as lead for implementation and improvement of Marketplace eligibility, enrollments, business policy, data quality, quality assurance, and appeals. This individual will also provide supervisory services for the new Marketplace unit.
- Two (2) Program Analyst 2 staff to provide subject matter expertise and use diverse and comprehensive insurance knowledge to analyze complex case eligibility and enrollment issues, identity verification issues and technology platform issues, facilitate escalations, and process complaints and appeals. These staff will be a direct line of contact for contract leads at the CAC and will create program operational guidelines and procedures for use by state agencies; insurance carriers; health insurance agents; and community organizations, including certified application assisters. They will also support training and development, compliance and quality

assurance for both the technology platform and consumer assistance center, and tier two level calls.

- One (1) Operations and Policy Analyst 3 to oversee Marketplace data and quality assurance and support data and processing regarding individuals who have applied for or are determined eligible for Marketplace coverage. This analyst will develop new information about the Marketplace, establish criteria to identify and measure program effectiveness, and develop methods to improve operations or develop new approaches to program evaluation that serve as precedents for others. This position will design and oversee the collection of data for organizational surveys, as well as analyze data, evaluate findings, and recommend policy and operational changes.
- One (1) Learning and Development Specialist 2 to design, deliver, and evaluate complex training and development projects that facilitate group processes and instruct and inform transitioning and implementing a fully operational SBM. The specialist will be responsible for training a contracted consumer assistance center that will support eligibility and enrollment year-round, training community-based organizations to become Marketplace certified application assisters, and certifying health insurance agents to enroll consumers into a Marketplace plan. The specialist will also conduct quality assurance of all Marketplace trainings.
- One (1) Public Affairs Specialist 2 to develop and implement strategies to inform potential and current enrollees and partners, manage challenges, communicate internally, and promote the Marketplace mission. The position assesses communications needs, evaluates processes, designs and directs information or education, and enhances customers' abilities to understand Marketplace products and programs through the design, readability, and digital accessibility of publications and other communication materials.
- One (1) Program Analyst 3 to serve as a subject matter expert on plan management and coordinate the plan management program and the Small Business Health insurance Options

Program (SHOP). This position will review, evaluate, and approve/deny applications for participation submitted by insurance carriers wishing to sell QHPs or Stand Alone Dental Plan (SADPs) through the Marketplace, set Marketplace-specific certification requirements for QHPs and SADPs and work with the Division of Financial Regulation (DFR) to set filing requirements and coordinate review of plans, review QHPs and SADPs for compliance with state and federal certification requirements and certify plans for sale, provides outreach and education to insurance carriers, and work collaboratively with contacts at CMS and insurance carriers to solve operational issues.

- One (1) Project Manager 2 to manage medium to large operations projects. The person in this position will be responsible for supporting the successful implementation of technology solutions and operation initiatives through facilitation and coordination with interested parties, project staff, other agency staff, and contractors to define project activities, solve problems, redefine project scope, and sequence project activities. This position will lead and collaborate with internal and external partners to achieve project objectives.

OIS will continue providing its expertise in technology project management, vendor management, solutions planning, systems security, user acceptance testing management and interface systems development, and data analysis. OIS will need the following new permanent, full-time positions for Phase II:

- Three (3) Information Systems Specialist 8 staff (24 months)
- One (1) Information Technology Manager 2 (8 months)
- Two (2) Information Systems Specialist 8 staff (24 months)

The Health Policy and Analytics Business Operations office will expand its current responsibilities with existing staff providing support for recruitment, contract management, payment processing, and

budget analysis. In addition, Business Operations will need one new ongoing position for revenue analysis and fee rate setting. The person in this position will be responsible for tracking and forecasting enrollment and revenue trends, calculating revenue receivables from carriers, and annual fee rate setting recommendations to OHA leadership and the Health Insurance Marketplace Advisory Committee.

- One (1) Economist 3 (18 months)

16. What are the start-up and one-time costs?

- Vendor implementation costs through the first open enrollment on the new platform (Nov. 1, 2026 – Jan. 15, 2027) before final project acceptance (estimated $25.8 million+)
- Independent Quality Management Services (IQMS) vendor to perform Quality Assurance (QA) services for the project. The estimated cost is $881,500.
- OIS Resources:
    - One (1) Project Manager 2
    - One (1) Information Systems Specialist 8

17. What are the ongoing costs?

- Ongoing costs consist primarily of Operations and Maintenance costs for the contracted solutions, (estimated at $17.2 million annually) and the additional requested ongoing positions.
- The staffing resources listed in the response to question 15 are required for Phase II and are ongoing.
- The ongoing OIS resources are:
    - One (1) Information Technology Manager 2
    - One (1) Operations Policy Analyst 4

- Five (5) Information Systems Specialist 8 staff

18. What are the potential savings?

Potential savings are yet to be determined and dependent on contract negotiations that are estimated to be completed by Spring 2025.

Participating insurers currently pay a fee to CMS for use of the FFM. They will stop paying that fee when the SBM technology and call center services are implemented. A Marketplace carrier assessment increase will be timed to pay for the new solution after implementation.

- Potential savings are assumed to be the difference between what carriers currently pay for the FFM and what carriers will pay after SBM implementation.
- The FFM fee is a percentage of the aggregated premiums of all Marketplace enrollees. The federal government can, and often does, change the percentage each year. Because the federal government does not explain its methodology for making changes or provide more than a cursory explanation of the reasons underlying a change, specific savings estimates in the short and long term are difficult to predict. At the FFM's and Marketplace's current assessment rates, an SBM enrollment technology and call center in the short term is expected to cost about the same, or possibly slightly less, than the FFM if current price estimates hold.
- In the longer term, an overall savings is more likely to occur since the FFM fee is tied to increases in insurance premiums while the Marketplace currently plans to continue assessments based on projected cost to operate. However, this will depend largely on the changes to the FFM fee based on the hidden and unobtainable criteria that determines those changes year over year.
- Regardless of savings realized, transitioning to a full SBM will provide a better overall value to Oregonians through the following time savings for partners and consumers, including quicker complex-issue-turnaround times; improved customer service; access to data for analysis to better inform equity strategies and allocate resources to those most in need of them; and the ability to

implement state initiatives with speed and efficiency that would otherwise be difficult or impossible through the FFM.

19. What are the sources of funding and the funding split for each one?

Other Funds – Fees, including reserves, collected from participating insurers based on operating expenses. Implementation and operation of a state-based platform and call center will increase operating costs and necessitate an increase in the fees collected from participating insurers.

General Fund may be required if, and only if, excess moneys are not sufficient to fund Phase II. Phase II will require the Marketplace to raise its annual assessment and may require the receipt of General Fund if the timing of the assessment adjustment does not align with the implementation costs through calendar year 2026.

As noted in the response to question 18 above, participating insurers currently pay a fee to CMS for use of the FFM. They will stop paying this fee in 2027 when the SBM technology and call center services are implemented. Instead, participating insurers will pay the state an increased Marketplace assessment to pay for the new solution after implementation.

The Marketplace assessment rate is established on an annual basis. The goal is to keep the increased Marketplace assessment at or below the total amount participating insurers are currently charged by the FFM and the Marketplace. The 2027 Marketplace assessment will be established in early 2026, allowing for the completion of DDI vendor negotiations and for the review of additional data related to the impact of OHP Bridge on Marketplace enrollment and resulting revenue.

Oregon Health Authority: 2025-27 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$0	$5,797,664	$0	**$5,797,664**	15	10.74
Services & Supplies	$0	$18,602,336	$0	**$18,602,336**		
Capital Outlay						
Special Payments	$0	$600,000	$0	**$600,000**		
Other						
Total	**$0**	**$25,000,000**	**$0**	**$25,000,000**	**15**	**10.74**

Fiscal impact by program

	Shared Services	SAEC	HPA		Total
General Fund	$0	$0	$0		**$0**
Other Funds	$1,379,635	$30,234	$23,590,131		**$25,000,000**
Federal Funds	$0	$0	$0		**$0**
Total Funds	**$1,379,635**	**$30,234**	**$23,590,131**		**$0**
Positions	6	0	9		**15**
FTE	3.99	0.00	6.75		**10.74**

Oregon Health Authority
2025-27 Policy Package

Division:	Health Policy and Analytics
Program:	Public Employees' Benefit Board and Oregon Educators Benefit Board
Policy package title:	Benefits Management System (OEBB-PEBB BMS) Replacement
Policy package number:	425
Related legislation:	None

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 member experience and customer care. The new BMS would facilitate the potential collection of REALD & SOGI data and provide a mobile app experience for members, including those in underserved communities, easier access to enroll in benefits, utilize benefit tools and wellness programs, and make informed benefit choices. The new system will also include a Financial Module, improving carrier management and invoicing. 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 this replacement system is not complete prior to the expiration of existing vendor support in 2026.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$6,188,956**	**$0**	**$6,188,956**	**3**	**1.62**

Purpose

1. 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 have 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; however, we are working to extend it to account for any potential delays to the BMS system.

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 final stages of the replacement BMS implementation. 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. The implementation plan outlined by the selected vendor, Telus Health, has a go live date in the first quarter of 2026.

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 READL & 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 OEBB-PEBB replacement Benefits Management System (BMS) would facilitate the potential collection of REALD & SOGI data.
- As part of HB 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:

<u>Business Automation</u>

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.

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.

5. How will OHA measure the impacts on health inequities of this policy package?

Surveys and the availability of demographic, including REALD/SOGI, data would allow the opportunity to evaluate access and usage of benefit enrollment tools available in the new BMS. Such information would lead to more targeted improvements in the application and better-informed choices by the members.

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 2025

End date (if applicable): March 2026 (project completion date)

12. What assumptions affect the pricing of this policy package?

- Response. 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 (Telus Health)
- Forty percent contingency to account for movement of Deliverables and potential gaps.

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 three new limited duration positions for the implementation of the project. One of these positions will be to coordinate OEBB and PEBB User Acceptance Testing. Two 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. The request includes the implementation of the new BMS and the operations & maintenance of the current BMS system through June 2026.

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 (Telus Health) contract and the current O&M costs for the legacy system. The O&M costs for Telus Health 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	$0	$329,235	$0	**$329,235**	3	1.62
Services & Supplies	$0	$5,859,721	$0	**$5,859,721**		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$6,188,956**	**$0**	**$6,188,956**	**3**	**1.62**

Fiscal impact by program

	HPA – PEBB/OEBB Ops				**Total**
General Fund	$0				**$0**
Other Funds	$6,188,956				**$6,188,956**
Federal Funds	$0				**$0**
Total Funds	**$6,188,956**				**$6,188,956**
Positions	3				**3**
FTE	1.62				**1.62**

Oregon Health Authority
2025-27 Policy Package

Division:	Public Health Division
Program:	Health Care Regulation and Quality Improvement
Policy package title:	Ensuring High-Quality Care in Oregon Hospitals
Policy package number:	426
Related legislation:	Ensuring High-Quality Care in Oregon Hospitals

Summary statement:

The purpose of hospital licensing regulation is to ensure safe, high-quality hospital care for people in Oregon. This is especially important for chronically ill individuals and individuals with disabilities, who proportionally use more hospital services, and for many historically underserved populations. In recent years the volume and severity of hospital complaints have increased. From 2017 to 2023, the number of complaints received about hospitals jumped over 130 percent, from 177 per year to 414. In 2023, OHA received and investigated 14 complaints, covering 12 different hospitals, alleging hospital noncompliance that put patients at risk of death or serious harm. The scope and complexity of hospital licensing has also increased with new state laws required for hospital licensing, and the opening of new services and new service types. The hospital licensing fee program has limited resources available to provide outreach, timely investigations, and assistance to individuals who speak a language other than English. Limited resources also hinder the program's efforts to assist in equitable emergency planning and disaster response, answer frequent queries from the public, and consult on regulatory solutions for hospital that best serve community needs.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$1,025,426**	**$(25,429)**	**$999,997**	**6**	**6.00**

Purpose

1. **What problem is OHA trying to fix or solve?**

   This POP seeks to ensure that OHA has sufficient resources for hospital oversight. Funding for hospital licensing program has remained unchanged for 15 years and no longer covers costs of the program and the full scope of regulatory work required to regulate and support the hospital licensees including rule implementation and community outreach, complaint triage and intake and frequent regulatory interpretation guidance and data queries. There is also a need for more detailed and accessible licensing information about hospitals and other health care facilities during an emergency or natural disaster not supported by existing fees.

2. **What would this policy package buy and how and when would it be implemented?**

   This POP allows Health Care Regulation and Quality Improvement (HCRQI) to increase hospital licensing fees to ensure adequate funding to support all resources needed for hospital oversight.

   HCRQI is proposing to implement a fee increase to the current hospital licensing fees that are based on number of beds and satellite location(s). The fee increase allows for a $999,000 Other Funds limitation that will support unfunded program costs and six new positions.

   Funds will be used to maintain current service levels (timely onsite complaint investigations, initial licensure surveys, routine onsite licensure surveys, technical support services for licensees, complainants and other interested parties), improve capacity to implement and enforce increasing regulatory requirements added to the statute since 2009, maintenance costs for an online licensing system that will be easier to use, and provide needed information for emergency preparedness. In addition to existing positions, funds will also cover new permanent, full-time positions to operate and

lead the licensing and complaint intake process and meet the increasingly complex and acute complaint work in hospitals: one Operations and Policy Analyst 3, four Client Care Surveyors, and one Administrative Specialist 1. Fees generated from this POP will also cover inflation that has not been accounted for since 2009. The new positions will be in place starting October 1, 2025, and the new fee structure will go into effect October 1, 2025, for the 2026 annual license renewal.

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 hospital licensing regulation is to ensure safe, high-quality hospital care for people in Oregon. This is especially important for chronically ill individuals and individuals with disabilities, who proportionally use more hospital services, and for many historically and increasingly geographically rural underserved populations. The fee that supports hospital licensing was last increased in 2009. Since then, state law added many new hospital licensing requirements for OHA to enforce and OHA licensing programs face increasing complex closure of hospitals and services that reduce access for vulnerable populations such as the reduction of maternity services. These included safe discharge and transition requirements for patients after a behavioral health crisis or suicide attempt, ensuring patients with disabilities can have a support person with them in the hospital, and ensuring patients with opioid use disorder leave the emergency department with two doses of overdose reversal medication.

[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.

Limited resources for the licensing program led to less community outreach, less timely investigations, and less assistance for individuals who speak a language other than English or experience other communication barriers. This limitation also hinders the program's efforts to assist in equitable emergency planning and disaster response, answer frequent queries from the public, and consult on regulatory solutions for hospital that best serve community needs.

Quantifying results

4. What are the long-term desired outcomes?

Adequate capacity to conduct timely initial licensing surveys and investigate patient safety incidents in hospitals. Enforce new equity focused laws and increase outreach to the public and hospitals about these new patient protections. Modernize the licensing system to allow online license verification, electronic payment, reporting functions and increased transparency of hospital services and public posting of regulatory findings. To offer support and coordination to hospital leadership on regulatory matters. Improve communication with patient populations and health care consumers, including through community-based and advocacy organizations.

5. How will OHA measure the impacts on health inequities of this policy package?

OHA will measure process outcomes including outreach presentations to community-based organizations and volume of non-English-language complaints received following increased availability of complaint intake in multiple languages. OHA will measure the impacts of this policy package by scope and scale of complaint investigations.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA – HCRQI has conducted many process improvements over the years to use existing hospital licensing resources most efficiently, engaged with the Hospital Association of Oregon and their members related to regulatory matters to improve hospitals' ability to comply with requirements and provided FAQs and other materials for the public to clarify implementation of new rules like the Support Person legislation for individuals with disabilities. In addition, OHA proposed a hospital fee increase for the 2023, which was not moved forward.

HCRQI has also responded to the dwindling fee revenue by reducing spending whenever possible in this program and applying fee funding from other facility types to indirectly support the work of the hospital licensing and certification program.

To the greatest extent possible, management and staff have also reprioritized time and resources to meet expanded program implementation needs including drafting communications for the public and conducting webinars with Q&A for partners and organizations representing special populations impacted by new laws and rules.

7. What alternatives were considered and what were the reasons for rejecting them?

The program considered several alternatives in lieu of the proposed fee increase, including:

- Imposing a limit on the type of regulatory requirements reviewed during required re-licensure and/or initial licensure surveys.
- Setting new higher acuity criteria to limit the types of complaint investigations that the program would triage for investigation.

- Reducing the scope of regulatory activities performed for other types of health care facilities regulated by the program.

These were rejected because they do not meet the minimum expectations for current service level in OHA statutes and rules, would result in longer wait times for initial survey for needed new services and create a gap in accountability for hospitals.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

None at this time.

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. ORS 441.020, 441.021, 441.044, and 441.062.

- ORS 441.020 Changes to fee structure and increase amounts.
- ORS 441.021 Delete the separate fee collection for complaint investigations is administratively burdensome and no longer in alignment with federal survey process.
- ORS 441.044 There is a gap in confidentiality protections for complainants that submit information to OHA as part of the complaint intake and triage process, leaving them potentially exposed to the release of their intake narrative. This could indirectly result in the risk of retaliation against a patient.
- ORS 441.062 There is an administrative weakness in current statutes regarding licensing surveys completed by accrediting organizations. Current statute only requires licensed health care facilities to submit documentation confirming outcomes of the accreditation survey upon

request to OHA. This is additional administrative burden for OHA and leaves the regulatory program without proof of successful licensing survey and represents a gap in public accountability.

OHA is also considering adding a provision to license Hospital At Home programs and Rural Emergency Hospitals. While these two new programs are available federally, Oregon would need a statutory change to allow them to operate in Oregon.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

This fee increase will affect the Oregon State Hospital, which pays annual licensing fees.

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, 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

The pricing of this policy package was established by projecting expenditures vs. revenues needed to support current service levels, new positions and estimated increase in services and supplies.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

New responsibilities include conducting outreach to impacted people and community-based organizations that represent them, providing assistance for individuals who speak a language other than English or experience other communication barriers, providing data and expertise related to equitable emergency planning and disaster response, answering frequent queries from the public, and consulting on regulatory solutions for hospital that best serve community needs.

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.

New positions to operate and lead the licensing and complaint intake process and meet the increasingly complex and acute complaint work in hospitals include the following six permanent, full-time positions:

- One Operations and Policy Analyst 3
- Four Client Care Surveyors
- One Administrative Specialist 1

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

Staffing, DOJ, other services and supplies, cost allocation and data base maintenance.

18. What are the potential savings?

While there is an upfront financial impact on hospitals, improved oversight is expected to reduce costs throughout the hospital system, by preventing or mitigating hospital closures, streamlining the licensing system, reducing cases of improper care that lead to complaints and complications, and supporting innovative approaches to improving hospital care.

19. What are the sources of funding and the funding split for each one?

Other Funds from hospital licensing fees and Federal Funds for surveyor positions only.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$0	$1,443,058	($30,637)	**$1,412,421**	6	6.00
Services & Supplies	$0	($417,632)	$5,208	**($412,424)**		
Capital Outlay						
Special Payments						
Other						
Total	**$0**	**$1,025,426**	**($25,429)**	**$999,997**	**6**	**6.00**

Fiscal impact by program

	Public Health				Total
General Fund	$0				**$0**
Other Funds	$1,025,426				**$1,025,426**
Federal Funds	($25,429)				**($25,429)**
Total Funds	$999,997				**$999,997**
Positions	6				**6**
FTE	6.00				**6.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Public Health Division
Program:	Health Promotion and Chronic Disease Prevention
Policy package title:	Protecting Youth by Closing Tobacco Loopholes
Policy package number:	427
Related legislation:	LC 44300-012 (2025); LC 455 (2023); LC 1731 (2023); 2021 SB 587; HB 2261 (2021)

Summary statement:

Tobacco is the leading preventable cause of death and disease in Oregon, costing the state $5.7 billion and over 8,000 lives every year. Moreover, the burden of tobacco use is not distributed evenly, falling heavily on Oregonians with low incomes, African Americans, Native Americans and Alaska Natives, and those who identify as LGBTQ+. This policy package would reduce youth access to harmful emerging oral nicotine products by ensuring all nicotine products are covered by the minimum legal sales age and other tobacco sales regulations. The policy package removes criminal penalties and eliminates loopholes for tobacco product home delivery and giveaway change machines. Department of Revenue estimates that the bill would generate $9.3 million for the Oregon Health Authority, of which an estimated $8.4 million would go to the Oregon Health Plan and $900,000 would go to the Public Health Division.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$0**	**$9,300,000**	**$0**	**$9,300,000**	**0**	**0.00**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. What problem is OHA trying to fix or solve?

Tobacco is the leading preventable cause of death and disease in Oregon, costing $5.7 billion in medical expenses and lost productivity and over 8,000 lives every year.

- Tobacco products, regardless of the source of nicotine, pose a significant risk to public health and obstacle to health equity due to their role in nicotine addiction. Regulation of emerging oral nicotine products, such as oral synthetic nicotine products and tobacco derived products, is not consistent or comprehensive. Oregon law has not been updated to cover these new products.
  - A growing number of e-cigarette and e-liquid manufacturers have switched to using synthetic nicotine or nicotine derived from tobacco (sometimes marketed as “tobacco-free”) to evade regulation and continue marketing their products to kids. Nicotine pouches, gums, tablets, gummies and other oral, smokeless products (e.g. Zyn, Velo, On!, Fre, NIC-S) contain nicotine and are gaining popularity among youth with flavors such as mint, fruit, coffee and cinnamon.
  - Oral nicotine pouches have become the second most commonly used tobacco product in the United States, with approximately 890,000 students reporting having used them in 2024.
  - Furthermore, tobacco companies have increased marketing for a wide range of oral nicotine products in youth-appealing flavors. These products are often sold with marketing claims that suggest they are safer than tobacco products. The truth is that nicotine is highly addictive, regardless of nicotine source.
  - There is no evidence suggesting that oral nicotine products are less addictive or harmful for long-term users than other oral tobacco products, and these products are increasingly popular among youth and young adults.

  - Smokeless oral nicotine products containing synthetic or tobacco derived nicotine are not regulated by state law in Oregon, including the state's Minimum Legal Sales Age (MLSA) restrictions. This means there are no state penalties for retailers who sell these products to people under 21 years of age. The federal government and many states include oral nicotine products in their tobacco product definitions and enforcement, but Oregon does not have a comparable state law.

- Commercial tobacco sales laws and policies must be equitably enforced and focus on retailers, distributors, and manufacturers. To improve compliance, penalties should not focus on individuals such as retail clerks and people who use tobacco products. Civil enforcement is a best practice for equitable enforcement of tobacco laws.
  - OHA does not have independent civil authority to issue penalties for selling tobacco to people under 21. Currently, prohibiting the sale of tobacco products and inhalant delivery systems (IDS) to people under 21 years of age lives in ORS 167.755, which is criminal statute. Prior statute gave OHA independent authority, but it shifted when the age to purchase tobacco increased from 18 to 21.
  - The Oregon Tobacco Retail License (TRL) Program refers to criminal statute for enforcement; however, the penalty process would be cleaner if MLSA prohibitions were clarified under OHA's civil authority and criminal penalties language was repealed altogether. This is also a request from OHA's partners to ensure the commercial tobacco industry is held accountable for nicotine addiction, not the individuals addicted to these products.

- Oregon prohibits most remote sales of tobacco products and IDS. However, current statute has a loophole that allows for home deliveries by tobacco retail employees.

  - There are Oregon businesses that sell cigarettes, smokeless tobacco, and IDS online and offer delivery service provided by company employees. Existing statute that prohibits the online sale and delivery of tobacco products only prohibits delivery services that rely on independent contractors to fulfill deliveries (e.g. DoorDash, Instacart, Uber Eats). By employing their own staff to deliver the tobacco products, businesses evade regulation on the products they sell online and deliver.

- Commercial tobacco prevention partners in Oregon have observed tobacco products and IDS in giveaway prize machines. This violates federal law, but Oregon currently lacks a comparable state law – and the United States Food and Drug Administration does not prioritize enforcement for these violations.

2. What would this policy package buy and how and when would it be implemented?

The Oregon TRL Program administers and enforces tobacco retail sales laws statewide. The program has the necessary staff and procedures in place to enforce policy changes in this policy package. If these changes are passed, OHA will revise the program's inspection protocols to include oral nicotine products in the state's minimum legal sales age inspections to ensure all nicotine products are held to the same standard across Oregon.

Including oral nicotine products may be revenue raising as it expands the definition of tobacco products. Some of these products are currently exempt from taxation, which makes them cheap and accessible for youth. Based on the US market share date from the Federal Trade Commission, The Oregon Department of Revenue (DOR) estimates a total biennial revenue increase of $20,220,000 to the state. Of this, an estimated $8.4 million would go to the Oregon Health Plan, and $900,000 would go to the Tobacco Use Reduction Account in the Public Health Division. Increased revenue for

the Public Health Division in the first biennium would go to implement the policy change, including updating training and communications materials for retailers, translating and distributing retailer materials, and updating the TRL Program retailer database to include oral nicotine products. Any revenue not needed for policy implementation in the first biennium and future revenues to the Public Health Division would be used for tobacco prevention and cessation services.

DOR administers Oregon's cigarette and tobacco taxes. If the Legislative Concept accompanying this policy package changes Oregon tax statute, DOR would need to update their data system, education for retailers, and protocols to include these products.

The policy package clarifies that tobacco sales violations are civil penalties instead of criminal violations as a best practice for equitable tobacco enforcement. Civil penalties for the sale of tobacco products to customers under the age of 21 would apply to retailers, distributors or manufacturers, not individual store clerks or people who use the tobacco products. To implement this change, OHA would update its procedures and civil penalty processes and documents. No revenue is needed to implement this component of the policy package.

The Department of Justice (DOJ) is the enforcing agency for the delivery sales ban of cigarettes, IDS, and smokeless tobacco products. If the policy package eliminates loopholes that allow for tobacco product access through home delivery, DOJ would need to update their protocols and education for retailers.

All parts of policy package could be implemented by the January 1 of the following year.

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?

Tobacco products, regardless of the source of nicotine, pose a significant risk to public health and obstacle to health equity due to their role in nicotine addiction. The burden of tobacco use is not distributed evenly, falling most heavily on Oregonians with low incomes, African Americans, Native Americans and Alaska Natives, and those who identify as LGBTQ+. For decades, the tobacco industry has marketed tobacco products to youth, people who are stressed or struggling, and the African American community. Nicotine addiction also contributes to poor mental health, creating and exacerbating stress and forming neural pathways that make young people more vulnerable to other addictions. Ensuring that all nicotine products are regulated, regardless of the nicotine's source, will get addictive products out of the hands of youth and reduce tobacco-caused addiction and disease.

Policies that put equity first, like equitably enforcing the sale of commercial tobacco products and regulating the sale of synthetic nicotine products, can reduce the influence of tobacco companies marketing tactics that drive health inequities.

Enforcing commercial tobacco sales laws and policies should focus on retailers, distributors and manufacturers, instead of placing the burden on individuals, such as retail clerks and people who use tobacco products. Criminal penalties can inequitably impact communities of color and low-wage workers, unintentionally harming the very communities the policy is seeking to protect. By enforcing

[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.

civil penalties, OHA can reduce access and availability of harmful commercial tobacco products, while diminishing unjust racial disparities in criminal enforcement and related health outcomes.

This policy package supports OHA's mission by preventing youth tobacco addiction and helping create healthier communities throughout Oregon. It provides a foundational expectation that sales to youth will not be tolerated throughout Oregon. Additionally, this policy package ensures the equitable enforcement of tobacco laws by holding tobacco retailers responsible if they choose to offer addictive nicotine products for sale.

Quantifying results

4. What are the long-term desired outcomes?

Consistent and comprehensive regulation of tobacco and nicotine products and IDS can reduce the number of Oregon children and young adults that become addicted to tobacco, help current tobacco users quit, and reduce health care costs for the State of Oregon.

In 2021, with passing Senate Bill 587, the Oregon Legislature established an effective tool – the Oregon TRL Program – to protect Oregon children and young adults from nicotine addiction. A strong retail license system creates a straightforward way to track businesses that sell tobacco products and IDS and manage enforcement of tobacco laws, such as the minimum legal sales age of 21. Regulating tobacco and nicotine products manufactured with nicotine from any source is an important step to ensure integrity and consistency of tobacco sales regulations. Comprehensive and equitable enforcement can decrease illegal sales to youth.

Tightening regulation of the remote sales of tobacco products and IDS will decrease accessibility of these harmful products without proper age verification. This change would close a loophole that allows businesses to evade regulation.

Prohibiting the distribution of commercial tobacco products via prize machines will stop the tobacco industry from using coin machines as another channel to get their harmful products into the hands of youth and young adults without any form of age verification.

5. How will OHA measure the impacts on health inequities of this policy package?

Key indicators of success for this policy package include decreased rate of illegal tobacco sales to underage persons, fewer youth starting to use tobacco, fewer youth reporting that tobacco and e-cigarettes are easy to get in Oregon, and, ultimately, lower rates of youth tobacco and nicotine product use.

While the impact of this policy package will decrease access to youth overall, it may increase retailer violation rates in the short-term.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Related policy concepts were considered by the Oregon Legislature in prior sessions, obtained support, but never fully cleared the legislative process. Most recently, House Bill 3090 in the 2023 legislative session gained significant momentum but stalled with other legislation at the end of the session. The bill introduced prohibition of flavored tobacco products and IDS and included updating tobacco product definitions to include nicotine products.

In 2021, Senate Bill 587, the TRL bill, partially removed purchase, use, and possession criminal penalties, but inadvertently left some criminal statute in place. Identifying small changes is an expected part of implementing a new program, and partners have requested this change to avoid inadvertent targeting of communities of color with criminal penalties.

7. What alternatives were considered and what were the reasons for rejecting them?

The Tobacco Prevention and Education Program funds every local public health authority in Oregon to decrease youth tobacco initiation and support individuals who are attempting to quit. Local momentum has also built in recent years for this policy package.

In the last five years, some communities have passed local policies to regulate flavored tobacco products with nicotine from any source in their local jurisdictions. In 2021, Washington County passed a ban on flavored products that included synthetic nicotine products and IDS such as e-cigarettes, e-cigars, vape pens and e-hookahs. In 2022, Multnomah County commissioners unanimously voted to approve a flavor ban that also included the regulation of products containing, made or derived from tobacco or nicotine, natural or synthetic. The United States Food and Drug Administration also considers oral synthetic nicotine products to be tobacco products, but the Oregon TRL Program can’t hold retailers to this standard without a comparable state law.

This fragmentation in local policy results in protections for only a portion of Oregon youth while other youth live in communities with limited regulation of tobacco products. Discrepancy with federal policy creates confusion for retailers trying to comply with multiple regulatory frameworks.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

The DOR and DOJ have been consulted and provided feedback on the synthetic nicotine policy package. Both agencies would continue to play a collaborative role in the enforcement and administration of a statewide TRL. OHA has also been discussing these changes with the American Heart Association, American Cancer Society, Oregon Partners for Tobacco Prevention, Local Public Health Authorities, and other tobacco prevention partners. These non-governmental partners are supportive of these changes and seek to introduce a flavored tobacco prohibition in the upcoming session that would include many changes suggested in this POP.

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. The policy amends current statutes: ORS 431A.175, ORS 180.441, and ORS 167.750.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

ORS 431A.218(2) allows for local jurisdictions to administer and enforce standards established by the state laws or rules regarding regulating the retail sale of tobacco products and IDS. To date, six local public health authorities have opted into this responsibility and would help implement enforcement if the bill passes. In addition, the four Oregon counties that maintain their own TRL programs (Benton, Clatsop, Klamath, and Multnomah) will need to adjust their enforcement protocols and procedures to include all tobacco products.

Tribal lands and sales are sovereign and not affected by this Oregon state legislation. If the Legislative Concept accompanying this policy package changes Oregon tax statute, the DOR may need to collaborate with tribes on updating tax compacts to include these products. The department maintains cigarette tax refund agreements with eight of the nine federally recognized tribal governments in Oregon. OHA defers to DOR and DOJ on these changes.

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): Based on final Legislative Concept

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

Including oral nicotine products may be revenue raising as it expands the definition of tobacco products. Overall revenue for the state if these products are taxed is estimated to be $20,220,000 for the 2025-27 biennium, depending on the bill's effective date. For a full biennium, this would include $8.4 million to the Oregon Health Plan and $900,000 to the Tobacco Use Reduction Fund in the Public Health Division.

The DOR's estimates are based on the 2002 report from The Federal Trade Commission on US market share of oral nicotine products and historical estimates of the proportion of national sales that occurs in Oregon.

Since these products are currently exempt from taxation, there is not an expected loss of revenue from other oral tobacco products.

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.

No new positions would be needed to implement the policy. Existing staff time would be adequate to revise program protocols, procedures and educational resources, complaints and, if appropriate, to issue citations may also increase costs. No existing positions would need to be modified as these tasks would fall under existing job duties.

16. What are the start-up and one-time costs?

OHA may have increased costs associated with educational outreach to retailers to help businesses comply with the revised requirements. There would also be one-time startup costs to update the TRL Program retailer data system. These one-time costs could be covered by the additional $900,000 in

revenue to Tobacco Use Reduction Account in the 2025-27 biennium, with additional Tobacco Use Reduction Account revenue going to tobacco prevention and cessation.

17. What are the ongoing costs?

Ongoing costs would be assessed annually as part of the Oregon TRL fee calculation. Ongoing revenue to Tobacco Use Reduction Account would be used for tobacco prevention and cessation programming, in line with other revenue in that fund. This would require a small increase to the budget limitation for these programs starting in the 2025-27 biennium.

18. What are the potential savings?

In the short-term, this would create staff time efficiencies as nicotine products would be held to a consistent standard at the federal, state, and local levels. In the long term, there may be savings in health care costs and other tobacco-related costs to the state through reductions in tobacco use.

19. What are the sources of funding and the funding split for each one?

This policy package includes Other Funds from new revenues in the Tobacco Use Reduction Account. It also includes funding for the Oregon Health Plan for the 2025-2027 biennium and future biennia.

Oregon Health Authority: 2025-27 Policy Package

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services					0	0.00
Services & Supplies	$0	$900,000	$0	**$900,000**		
Capital Outlay						
Special Payments	($8,400,000)	$8,400,000	$0	**$0**		
Other						
Total	**($8,400,000)**	**$9,300,000**	**$0**	**$900,000**	**0**	**0.00**

Fiscal impact by program

	Public Health	Medicaid			Total
General Fund	$0	($8,400,000)			**($8,400,000)**
Other Funds	$900,000	$8,400,000			**$9,300,000**
Federal Funds	$0	$0			**$0**
Total Funds	$900,000	$0			**$900,000**
Positions	0	0			**0**
FTE	0.00	0.00			**0.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Behavioral Health Division
Program:	Behavioral Health Workforce Incentives, Office of Recovery and Resiliency, Behavioral Health Equity and Community Partnerships
Policy package title:	Behavioral Health Workforce Investments
Policy package number:	550
Related legislation:	Senate Bill 2 (2013), House Bill 2086 (2021), House Bill 2949 (2021), House Bill 2235 (2023), Senate Bill 1592 (2024)

Summary statement:

OHA aims to tackle the shortage of behavioral health professionals, especially in rural areas and SUD services, by attracting, retaining, and supporting a diverse, culturally competent workforce. This proposal offers financial incentives, reduces educational and certification barriers, and expands training access. It also invests in peer delivered services and a central resource hub for providers. Failure to fund this proposal would perpetuate workforce shortages, particularly in underserved and marginalized communities, leading to decreased access to essential behavioral health services, increased burnout among existing providers, and continued health inequities across Oregon.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$ 24,838,542**	**$(1,427,215)**	**$ 838,673**	**$ 24,250,000**	**4**	**3.00**

Purpose

1. What problem is OHA trying to fix or solve?

Oregon is facing a critical shortage in its behavioral health workforce, particularly among Substance Use Disorder (SUD) service providers. The most severe gaps are evident in the supply of Certified Prevention Specialists and Qualified Mental Health Associates, with 94 percent and 86 percent deficits, respectively. This shortage is more pronounced in rural areas, where the provider-to-population ratios are significantly lower than in urban centers like Multnomah County.

The pandemic has intensified these gaps by disrupting educational and training pathways, leading to a workforce that is both insufficient in number and unevenly distributed across the state. Additionally, the workforce's demographic makeup does not reflect the diversity of Oregon’s population, particularly among Hispanic or Latine communities.

Despite recent initiatives aimed at addressing these shortages and various funding programs for education, loan repayment, and recruitment bonuses, the demand for behavioral health services continues to outstrip supply. To bridge these gaps, sustained and targeted investments are crucial. Programs that focus on reducing financial barriers for trainees, increasing geographic and demographic representation, and enhancing recruitment and retention strategies are essential. Continuing successful initiatives like the Workforce Bonus and Housing Stipend Grant, which has been effective in rural and culturally specific contexts, will be vital in creating a more robust and equitable behavioral health workforce in Oregon.

Addressing the behavioral health workforce gaps in Oregon requires a multi-faceted approach that includes continuous funding, targeted incentives, and strategic investments in education and training.

Only through these sustained efforts can Oregon hope to meet the growing demand for behavioral health services and improve health outcomes for its residents.

Oregon's Behavioral Health Workforce

The behavioral health workforce in Oregon includes a variety of professionals who provide mental health and substance use disorder services. These professions include:

- Psychiatrists
- Psychologists
- Nurse Practitioners (especially those specializing in psychiatric care)
- Physician Assistants (specializing in psychiatric care)
- Clinical Social Workers
- Marriage and Family Therapists
- Licensed Professional Counselors
- Substance Abuse Counselors
- Peer Support Specialists
- Case Managers
- Psychiatric Nurses
- Behavioral Health Technicians
- Rehabilitation Counselors
- Occupational Therapists (with a focus on mental health)
- School Psychologists
- Art, Music, and Recreation Therapists (specializing in mental health and substance use disorders)

These professionals work in various settings, including hospitals, clinics, schools, residential treatment facilities, and community-based organizations, to provide comprehensive behavioral health

care. According to the 2022 Healthcare Workforce Reporting Program Supply Report,[1] behavioral health professionals as a group have the largest difference in ratio of professionals between the most covered county to the least covered county, as compared to primary and oral care professionals. Other key insights from this informative report include:

- **Licensed Professionals**: Between 2020 and 2022, Oregon had nearly 192,000 licensed health care professionals, with 13,919 actively practicing in behavioral health, making it the largest specialty group.
- **Direct Patient Care FTE**: The direct patient care Full-Time Equivalent (FTE) had increased for some occupations between 2020 and 2022, particularly for counselors, therapists, clinical social work associates, nurse practitioners, and physician assistants. Conversely, clinical nurse specialists, licensed massage therapists, certified registered nurse anesthetists, and pharmacists saw a decline.
- **Geographic Distribution**: Behavioral health professionals are primarily concentrated in Multnomah County and are underrepresented in most other counties. Health care professionals, in general, are well represented in Deschutes, Hood River, Multnomah, Wallowa, and Washington counties but are lacking in Columbia, Crook, Gilliam, Jefferson, Morrow, Sherman, and Wheeler counties.
- **Provider-to-Population Ratios**: Statewide, there are 17.1 behavioral health professionals per 10,000 Oregonians. This ratio varies significantly by county, with Multnomah having 31.9 per 10,000 and Grant County only 2.3 per 10,000.
- **COVID-19 Impact**: The pandemic has significantly strained the health care workforce, disrupting educational and training pathways and impacting the mental and physical health of current professionals.

[1] Healthcare Workforce Reporting Program Supply Report

According to the 2023 ECONorthwest survey of Oregon health care providers, over 60 percent of respondents reported their organizations needed more behavioral health providers, and 76 percent of respondents stated it is very important to expand Oregon's capacity to educate, train, and develop more behavioral health professionals.[2] Furthermore, behavioral health providers have highlighted a variety of challenges affecting the training and educational trajectories for behavioral health workers, including the absence of clear pathways for many behavioral health occupations and inadequate training opportunities.

According to the 2023 Substance Use Disorder Services Inventory & Gap Analysis,[3] a study conducted by Oregon Health & Science University, the following table illustrates the current gaps in SUD service providers:

Provider Type	Role	Current Gap	# Needed
Qualified Mental Health Professionals (QMHPs)	Provide direct mental health services including assessment, diagnosis, and treatment.	93%	11,740
Qualified Mental Health Associates (QMHAs)	Assist QMHPs in delivering mental health services, often working directly with clients.	86%	17,717
Certified Alcohol and Drug Counselors (CADCs)	Specialize in treating substance use disorders through counseling and support.	41%	2,018
Certified Recovery Mentors (CRMs)	Offer mentorship and support for individuals in recovery from SUD.	28%	612
Provider Type	**Role**	**Current Gap**	**# Needed**

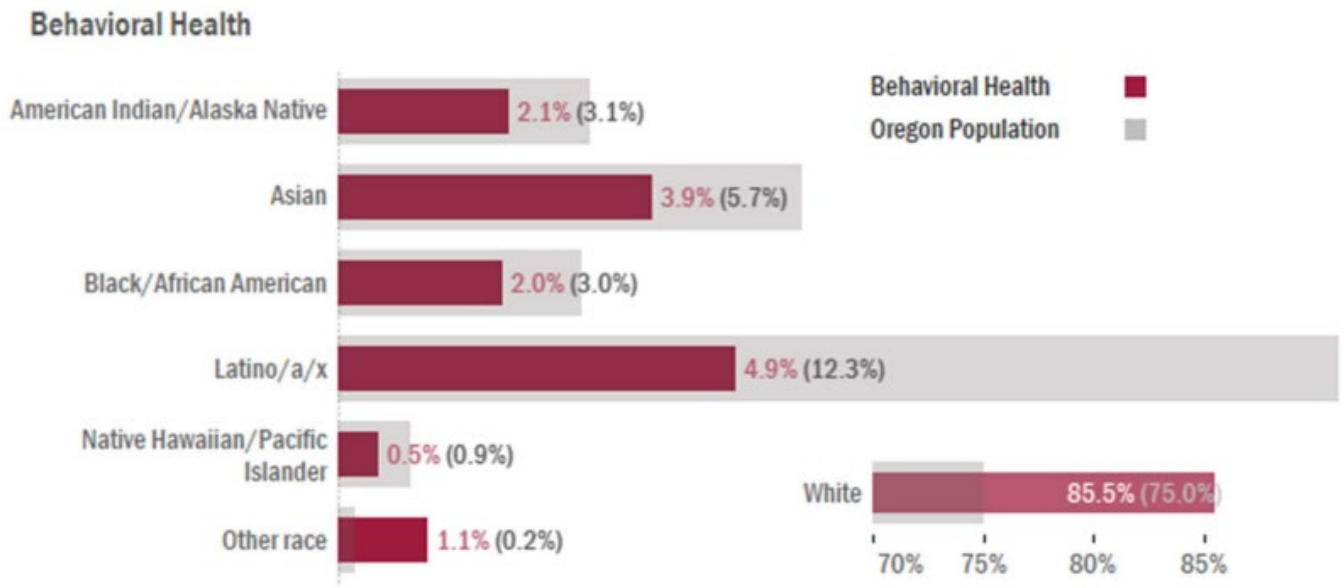
[2] 2023 OHA healthcare workforce needs assessment
[3] 2023 Substance Use Disorder Services Inventory & Gap Analysis

Certified Prevention Specialists	Develop and implement prevention programs to reduce substance abuse.	94%	906
Prescribers with Buprenorphine Waiver	Prescribe medication-assisted treatment (MAT) for opioid use disorder.	51%	1,955
Nurse Practitioners (NPs) specializing in Psychiatric Care	Provide psychiatric evaluation, diagnosis, and medication management.	Significant shortage, exact numbers not specified.	
Medical Doctors (MDs) specializing in Psychiatry	Comprehensive psychiatric care including complex diagnosis and treatment planning.	Significant shortage, exact numbers not specified.	
Peer Support Specialists	Provide support and advocacy based on lived experience with mental health or SUD.	High demand with shortages noted, exact numbers not specified.	

Disparities in the substance use disorder workforce were also compared to the demographics of the state. The largest disparities were among people who are Hispanic or Latine, with only 6.3 percent of non-prescribers and 0.4 percent of prescribers in the workforce compared to 13.2 percent of population in Oregon.

Additionally, the 2023 Healthcare Workforce Reporting Program Diversity Report[4] states, “Greater diversity in the health care workforce advances cultural competency and increases access to high-quality health care... Among behavioral health professionals, health care providers of color are underrepresented. White providers are overrepresented in all groups, but this is especially pronounced among behavioral health providers...” The chart below illustrates the racial and ethnic distribution of Oregon’s behavioral health workforce in 2022 compared to Oregon’s population:

[4] 2023 Healthcare Workforce Reporting Program Diversity Report



Peer Delivered Services

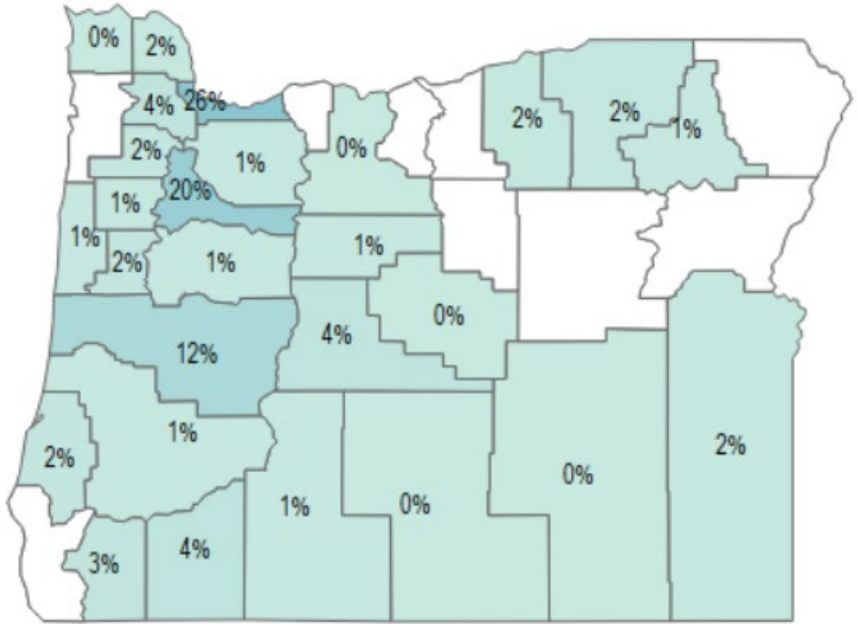
Peer Support Specialists (Peers) play a transformative role in the behavioral health care workforce by providing support and advocacy based on lived experience with mental health or substance use disorders. Peers provide supportive services to current and former consumers of mental health or addiction treatment, and their contributions are based on principles of respect, shared responsibility, and mutual support, offering empathy, encouragement, and assistance through shared experiences. Peers enhance the behavioral health care workforce by promoting mutual support and recovery and their integration into health systems represents a significant advancement in providing holistic and empathetic care.

Many behavioral health providers in Oregon rely on Peers for on the ground implementation. Harm reduction, opioid overdose response, court deflection programs, community supports and housing programs, transition programs, all rely heavily on peer delivered service workers.

To become a Peer Support Specialist, an individual must self-identify with having lived experience, attend a state certified 40-hour core curriculum training, and successfully complete a certification process and background check with the OHA Background Check Unit to be placed on the Traditional Health Worker Registry. According to OHA's Traditional Health Worker Program, Oregon has 5,704 certified peer delivered service workers actively working in communities across Oregon as of February 2024. Since 2022, 4,247 peer delivered service workers have become certified, and 1,300 have been trained and are awaiting certification this year.

Peers are not distributed equally geographically throughout Oregon. According to a 2021 survey of Traditional Health Workers, which included responses from 365 Peers, the majority of Peers reported working for organizations located in Multnomah, Marion, and Lane Counties, with very few reporting working for organizations in rural or coastal counties[5]:

[5] Pilot Survey of OHA Registered Traditional Health Workers



Culturally & Linguistically Specific Providers

Disparities in behavioral health are stark, reflecting systemic inequities and social injustices that disproportionately affect people and communities of color. Despite having similar rates of mental health disorders as the white population, people of color experience longer lasting and more disabling conditions. This issue is compounded by significant treatment gaps: in 2020, only 37.1 percent of Black people and 35 percent of Latine people with any mental illness received mental health services, compared to 52 percent of white people.[6] Cost and lack of insurance are common barriers across all racial groups, but systemic inequities exacerbate these challenges for communities of color. For instance, the COVID-19 pandemic intensified mental health issues, with higher rates of depression and substance use among the Latinx population compared to the white population.

[6] National Institute of Mental Health

Adults from racially minoritized groups face similar disparities, with lower treatment rates and higher prevalence of serious mental health problems. Factors like mistrust in health care systems, rooted in historical and ongoing discrimination, further hinder access to necessary care. Addressing these disparities requires a commitment to racial equity and culturally specific health care to ensure that all individuals can achieve their full health potential.

Oregon has made significant strides toward health equity by developing culturally and linguistically specific delivery systems. These efforts integrate national Culturally and Linguistically Appropriate Services (CLAS) Standards into state policies and benchmarks, guiding various initiatives such as OHA's Behavioral Health Strategic Plan and mandatory cultural competency training for health professionals. Coordinated Care Organizations (CCOs) provide integrated care across physical, mental, behavioral, and dental health for Medicaid recipients. Additionally, the establishment of Regional Health Equity Coalitions (RHEC) supports community-driven activities to reduce health disparities, and the collection of disaggregated data on race, ethnicity, language, and disability during the COVID-19 pandemic has been essential for advancing health equity.

Despite these advances, Oregon faces challenges in providing culturally and linguistically specific behavioral health care. While CLAS Standards offer a framework for improving services, they often do not reflect the everyday lives and insights of communities of color. There are common issues such as the lack of multilingual and multicultural providers, particularly in rural areas, and difficulties accessing culturally specific services. Various reports highlight the mental and behavioral health challenges faced by communities of color in Oregon, emphasizing the need for better data collection, increased support for multilingual/multicultural practitioners, and more culturally relevant care approaches. To advance health equity, it is crucial for health systems to incorporate the insights of marginalized communities and support their existing networks of care.

2. What would this policy package buy and how and when would it be implemented?

The Behavioral Health Workforce Investments policy package includes various grants and programs that aim to enhance behavioral health services and support successful workforce growth. OHA's Health Services Division established a Behavioral Health Workforce Incentives (BHWI) unit to implement recent investments efficiently and effectively in Oregon's behavioral health workforce. BHWI has launched ten programs to bolster recruitment, reduce barriers, and enhance retention, and despite significant achievements, sustained investments are needed to address ongoing workforce gaps.

This policy package proposes funding to continue and improve existing BHWI programs that aim to increase behavioral health workforce retention, bolster recruitment efforts, and decrease barriers through workforce development and career pathway opportunities. The policy package also proposes funding for initiatives aimed at supporting peer support services and culturally and linguistically specific providers.

- $1.25 million to continue the Bonus and Housing Stipend Grant program.
- $8,911,458 to continue awards under the Behavioral Health Workforce Initiative Loan Repayment program.
- $10 million to continue the Tuition Assistance and Graduate Stipend program
- $1.5 million to continue low-barrier entry to the behavioral health workforce as well as supporting the success of those entering the behavioral health workforce through the Mental Health and Addiction Counselor Board of Oregon Agreement.
- $1 million for Peer Delivered Services Workforce Capacity Grants
- $1 million to establish a Behavioral Health Workforce Center of Excellence

Bonus and Housing Stipend Grant ($1.25 million)

BHWI established the Bonus and Housing Stipend Grant for behavioral health organizations to provide recruitment and retention bonuses as well as housing stipends as recruitments strategies. The program prioritizes peer run, rural, and culturally/ linguistically specific provider organizations. The Bonus and Housing Stipend Grant awarded just over $2m in grants to 20 culturally responsive, peer run, culturally specific, and rural behavioral health organizations to provide housing stipends (rural providers and out of state recruits), recruitment bonuses, and retention bonuses. However, the demand outweighed the allocation, as the sum of all eligible applicants totaled nearly $21.5m (86 organizations applied).

Quarterly reporting and participant feedback indicate the grant program has been particularly effective in supporting Peer Support Specialists (including Certified Recovery Mentors) and Certified Alcohol and Drug Counselors. During the first year of this program, 20 organizations hired approximately 130 new behavioral health providers, paid out retention bonuses to approximately 138 employees, and disbursed approximately 31 housing stipends to assist with relocation expenses of newly hired employees. In total, the program has resulted in approximately 299 bonuses and stipends to behavioral health workers as of December 31, 2023. The program's housing stipends are designated for providers moving to rural areas or providers moving from out of state. They can pay up to $10,000, which comprises 23 types of credentialed behavioral health providers including buprenorphine prescribers.

The current proposal seeks $1.25 million to continue to provide incentives to increase retention of behavioral health providers in Oregon by continuing the Bonus and Housing Stipend Grant for the grant to additional behavioral health organizations and prioritizing the SUD/Co-occurring disorder segments of the behavioral health workforce. Additionally, the grant program will focus further on filling hard to fill or underutilized positions, such as those in post-acute care facilities where SUD

needs often cause denial of access.[7] It is estimated that 625 bonuses and stipends will be paid out with this request.

Behavioral Health Workforce Initiative Loan Repayment Program ($8,911,458)

BHWI established the Behavioral Health Workforce Initiative Loan Repayment Program (LR) to boost behavioral health workforce retention as well as to increase community access to behavioral health providers for people of color, Tribal members, and residents of rural areas, by supporting behavioral health care workers who represent and/or serve underserved communities in Oregon, as well as those who serve people regardless of their health care coverage (e.g., Medicaid, Medicare, or private insurance) or ability to pay.[8]

Licensed Behavioral Health Providers, Certified Behavioral Health Providers, and Registered Traditional Health Workers who work at least 16 hours a week are eligible to apply for the LR program. In exchange for two years of service, LR program participants receive a tax-free award of funds to repay qualifying undergraduate and post-graduate loan debt. OHA may also consider other educational loan debt. OHA calculates awards based on the participant's balance owed on qualifying loans. Participants who do not meet the two-year service obligation must repay the full or partial balance of their award for time not served during each obligation year.

Just over $202 million (2,323 applicants) in student debt was requested to be repaid, but only $15.8 million was awarded to 265 applicants. An average of 64 percent of awardees are licensed behavioral health providers, and an average of 36 percent of awardees are certified behavioral health providers. Out of all who were awarded, 94 percent have been retained within the state's behavioral health workforce and 77 percent remain at their original job upon application. The awards

[7] Issue Brief: Oregon's Post-Acute Workforce
[8] Oregon Behavioral Health Loan Repayment Program

were distributed equitably among applicants, as 70 percent identify as Black, Indigenous, or a person of color and 25 percent provide services in rural areas.

The current proposal seeks $8,911,458 million to continue to support behavioral health care workers who represent and/or serve underserved communities in Oregon, as well as those who serve people regardless of their health care coverage (e.g., Medicaid, Medicare, or private insurance) or ability to pay. BHWI intends to initiate a yearly award cycle to boost retention and evolve into a recruitment tool as students transition into their first provider position after graduation. It is estimated that 165 individual behavioral health workers will benefit from this current request.

Further, the LR program will prioritize the hardest to fill positions (mobile crisis, CMHP roles, inpatient roles, etc.) located within the publicly financed behavioral health system while also continuing to prioritize providers from historically underserved communities.

Tuition Assistance, Graduate Stipends, and Scholarships ($10 million)

BHWI established the Tuition Assistance and Graduate Stipend program for graduate level behavioral health training programs to equitably increase the recruitment and retention of culturally and linguistically responsive providers in behavioral health. BHWI made just over $10m awards in tuition assistance and graduate stipends to eight graduate programs in Oregon (ranging from $378k to the Oregon Health and Sciences University to $1.8 million each to Lewis & Clark College, Pacific University, Portland State University, and Southern Oregon University), but the total amount requested was $12.2 million.

Portland State University recently announced using their award to support about 100 behavioral health graduate students,[9] and grant reporting indicates that 101 tuition assistance/stipends have

[9] PSU awarded $1.8 million towards behavioral health programs

been awarded from other grant recipients. It should be noted that awardees have just started distributing tuition assistance and stipends, and three out of eight award recipients have not begun distributing funds to students. Therefore, it is difficult to estimate the outcomes at this time, but the impact is expected to be substantial for those with the intent to enter the behavioral health workforce, as participating graduate programs are required to distribute funds equitably by prioritizing funds to students who represent historically underserved communities. After graduating, students are able to become certified as QMHPs, which increases capacity of the hardest to fill positions and bridges one of the most severe service gaps.

An additional factor to consider is the demand for lowering the barrier for entry into the behavioral health workforce by supporting community college programs that offer training in behavioral health and include a practicum. This demand was made apparent from testimonies (including the Oregon Community College Association) for Senate Bill 1592 (2024), which appropriates moneys to the Higher Education Coordinating Commission for distribution to certain institutions of higher education to expand the behavioral health workforce in Oregon.

In response to the rising costs of tuition for students pursuing higher education in health care, the Oregon Legislature enacted Senate Bill 2 (2013), which established the Scholars for a Healthy Oregon Initiative within the Oregon Health and Sciences University to provide free tuition and fees for certain students in health care disciplines in exchange for student commitment to work in underrepresented locations after graduation. In 2024, OHA was able to secure $2 million in one-time funding for awards to behavioral health education programs to provide scholarships modeled after the Scholars for a Healthy Oregon Initiative. These awards were distributed to Pacific University, Lewis and Clark College, Umpqua Community College, Chemeketa Community College, and the Mental Health & Addiction Association of Oregon to encourage and support students seeking higher education in behavioral health. The program is ongoing but has provided 126 scholarships.

The current proposal seeks $10 million over the 2025-27 biennium to expand the Tuition Assistance and Graduate Stipend program to majority publicly financed behavioral health organizations to offer as a retention tool. It is tentatively estimated that this request will yield 300 students being awarded tuition assistance/stipends.

Mental Health and Addiction Counselor Board of Oregon Agreement ($1.5 million)

BHWI established an agreement with the Mental Health and Addiction Counselor Board of Oregon (MHACBO) to reduce the barriers to enter the behavioral health workforce with $3.7 million in obligated funding. The MHACBO agreement provides no cost registrations, applications, renewals, exams, exam prep, and basic diagnostic training to Peer Support Specialists (including Certified Recovery Mentors), Certified Drug and Alcohol Counselors, Qualified Mental Health Associates, and Qualified Mental Health Providers. According to the quarterly report ending on December 31, 2023, MHACBO is exceeding expectations for registrations:

- 2,133 Qualified Mental Health Associates
- 1,131 Qualified Mental Health Providers
- 1,386 Certified Drug and Alcohol Counselors
- 1,420 Certified Recovery Mentors

The current proposal seeks $1.5 million to continue low-barrier entry to the behavioral health workforce as well as supporting the success of those entering the behavioral health workforce through the MHACBO agreement. It is estimated that approximately 2,500 initial registration/ application fees will be paid for with the current request.

Peer Delivered Services Workforce Capacity Grants ($1 million)

OHA's Health Services Division created the Office of Recovery and Resilience (ORR) in 2022 to elevate the voices of individuals with lived experience to policy and behavioral health systems and ensure a vibrant and resilient peer delivered services workforce. The current proposal seeks $1M for Peer Delivered Services Workforce Capacity Grants to enhance the peer delivered services workforce.

This proposal seeks $1 million for direct investment into curriculum development, provision of trainings, peer delivered service supervision structures, development of best practice guides, educational toolkits for CCOs and other organizations to properly invest and develop peer programs and work with peers, as well as process improvement for certification processes. It is estimated that this program will provide support for 25 organizations.

Behavioral Health Workforce Center of Excellence ($1 million)

The ORR focuses on amplifying the voices of individuals with lived experience and supporting a resilient peer-delivered services workforce. Since 2014, Regional Facilitation Center Grants have been provided to counties like Multnomah, Yamhill, and Coos, where local peer-run organizations offer consultation, training, and policy development for the peer-delivered service workforce. As of 2024, these centers have supported over 5,000 individuals entering the workforce, enhancing peer service sustainability and accessibility across Oregon. The current proposal seeks funding to maintain support for these centers. Furthermore, it aims to establish a statewide Behavioral Health Workforce Center for Excellence, which would act as a hub for counties receiving Regional Facilitation Center Grants and offer consultation, training, supervision, and support for both culturally specific and peer-delivered service providers. This initiative includes the administration of Peer Delivered Services Workforce Capacity Grants in addition to the expansion of culturally and linguistically specific services and providers, thereby strengthening Oregon's behavioral health workforce.

Culturally Responsive Workforce Technical Assistance in Behavioral Health (new staffing request only-see below section)

House Bill 2086 (2021) tasked OHA with creating peer and community-driven programs to ensure access to culturally specific and responsive behavioral health services for communities of color, tribal communities, and individuals with lived experience. In response, OHA's Health Services Division established the Behavioral Health Equity and Community Partnerships (BHECP) unit in 2022. The BHECP aims to elevate the voices of communities most affected by health inequities and build partnerships that support behavioral health and wellness. A key component of their workforce development strategy is to cultivate a behavioral health workforce that is skilled in providing healing-centered, trauma-informed, and culturally responsive care to diverse communities. However, BHECP's ability to offer technical assistance to over 30 culturally specific organizations and individuals aspiring to become behavioral health providers has been limited by high demand. There is a significant need for technical assistance to develop and expand culturally specific services.

To address these challenges, the proposal seeks funding for BHECP staff to implement culturally specific training grants, identify avenues for technical assistance for grant writing, and to consult and train larger non-culturally specific organizations to improve cultural responsiveness. Additionally, staff members will gather feedback from marginalized communities through active engagement. By enhancing the capacity of culturally specific organizations and improving the cultural responsivity of non-culturally specific organizations, the proposal aims to better meet the needs of diverse populations within Oregon’s behavioral health continuum of care.

Behavioral Health Division Staffing ($588,542)

To effectively implement and continue existing supports for enhancing Oregon's behavioral health workforce, the proposal seeks positions to support this work. The proposed funding for staffing the Behavioral Health Division includes:

- One OPA1 to coordinate planning and provide staff support to BHWI programs
- One Research Analyst 2 responsible for ensuring accurate organization and interpretation of data to measure the impact of BHWI programs.
- One PA2 to support culturally specific training grants, data collection and technical assistance to culturally specific providers.
- One OPA3 to support partnership with community experts in the development of needed culturally specific services within the behavioral health continuum of care.

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?

This POP will fund programs that highly prioritize behavioral health providers from historically marginalized communities and rural areas. This method has proven results that increased career opportunities and maintained job retention for culturally and linguistically specific service providers, rural providers, and peers from previous rounds of funding. This policy package will further refine these programs to increase effectiveness and equity of awarding and outcomes. Therefore, this policy package fully aligns with OHA's goal to eliminate health inequities by 2030 as well strategies of OHA's behavioral health strategic plan to bolster the behavioral health workforce.

[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.

Bonus and Housing Stipend Grant

Grants for bonuses and housing stipends help attract health professionals to regions where behavioral health services are limited for historically marginalized communities. Prioritizing grant funding for behavioral health professionals from diverse backgrounds can provide financial stability, access to safe housing, and improved job performance and satisfaction.

Behavioral Health Workforce Initiative Loan Repayment Program

Loan repayment incentives are highly sought after programs that can be used to help promote workforce diversity by recruiting and retaining talented and diverse behavioral health professionals serving Oregon's communities affected most by health inequities. Student loan debt reduces job satisfaction and impedes providers ability to attain financial freedom, and discourages providers from attaining higher levels of education. Reducing financial strain on behavioral health providers helps keep providers in high-need areas across the state, along with helping enhance community health to communities that have limited access to behavioral health services.

Tuition Assistance, Graduate Stipends, and Scholarships

Financial assistance through tuition assistance, graduate stipends and scholarships helps increase access to behavioral health education for individuals from low-income or marginalized backgrounds. These programs help strengthen career pathways in behavioral health, especially for diverse groups of individuals, increasing the representation and improvement of behavioral health services to communities most impacted by health inequities.

Mental Health and Addiction Counselor Board of Oregon Agreement (MHACBO)

Oregon's certified workforce is the backbone for many community health facilities that work with our most vulnerable populations across the state, especially those who are uninsured or are on Medicare and Medicaid plans. Contracting with Oregon's primary certification board for certified professionals

has helped MHACBO cover and waive licensing and testing fees for certified providers registering and renewing their certifications, which in turn have helped maintain and reduce financial barriers for providers seeking mental health and addiction certifications.

Peer Delivered Services Workforce Capacity Grants

Investments in the peer delivered workforce provides essential and uniquely relatable care to individuals with mental health and substance use disorders. Bolstering the peer delivered services help with improving services centered around empathetic and relatable support and help reduce stigma many individuals face when seeking out mental health and substance use treatment. Peer delivered services are instrumental in improving recovery outcomes, especially when those services work in unison with clinical treatment services for a more holistic approach to recovery.

Direct Investment into the peer workforce will elevate the voice of lived experience in the behavioral health workforce for communities and providers historically harmed by health inequities and excluded from services based on racism and dominant culture practices. Often, when consumers of behavioral health services are excluded or find services inaccessible, they will still maintain connection to a Peer throughout their journey to health and wellness. Direct engagement with peer support leads to higher rates of accessibility and retention in services and leads to a level of advocacy, supporting person-directed treatment and guidance on trauma informed and culturally responsive service delivery.

Culturally Responsive Workforce Technical Assistance in Behavioral Health

There is no one-size-fits-all approach to behavioral health and substance use treatment, as specific populations, and communities across Oregon face unique challenges in achieving their desired health outcomes. To address this, Oregon needs a workforce that reflects and responds to the

diverse needs of its cultures and communities. Expanding culturally and linguistically specific services helps equip the workforce to tackle health inequities by removing barriers, promoting engagement, tailoring treatment approaches, and fostering trust and understanding between providers and individuals from diverse backgrounds.

Culturally and linguistically specific behavioral health services are designed based on the languages and cultural values of distinct minoritized communities, aiming to elevate their voices and experiences. However, these programs are often small businesses that lack dedicated staff to apply for grants and can struggle with writing grants in general to continue funding. Therefore, it is crucial for OHA to have dedicated staff to assist these provider organizations with identifying avenues to gain technical assistance with grant opportunities and to create dialogue between these organizations to create larger communities of practice.

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence

The creation of a Behavioral Health Workforce Center for Excellence would significantly improve access to high-quality behavioral health services by serving as a central hub for training, support, and resource development for providers. This center would provide comprehensive training programs for behavioral health providers, including peer-delivered and culturally and linguistically specific providers, ensuring they have the necessary skills and knowledge to deliver effective and culturally specific care. It would also establish robust structures to support providers in navigating complex systems and enhancing their professional development, ensuring consistent delivery of high-quality care.

Additionally, the center would develop and disseminate best practice guides and educational toolkits, equipping providers with the latest evidence-based practices and culturally sensitive approaches. It would offer technical assistance and consultation services to both culturally specific and non-

culturally specific organizations, helping them implement and sustain practices congruent with the minoritized communities they serve. Streamlining processes would expedite the entry of qualified professionals into the workforce, addressing provider shortages and improving access to care, especially in underserved areas. By actively engaging marginalized and minoritized communities to gather their input and recommendations, the center would ensure that services are aligned with the actual needs and preferences of the communities served, leading to more effective and accepted behavioral health interventions.

Quantifying results

4. What are the long-term desired outcomes?

Bonus and Housing Stipend Grant

- To increase the number and retention of culturally and linguistically specific behavioral health providers in Oregon.
- To increase the number and retention of rural behavioral health providers in Oregon.
- To increase the number and retention of behavioral health providers who provide services to underserved communities.
- To increase the number and retention of licensed or certified behavioral health providers in historically hard-to-fill positions

Behavioral Health Workforce Initiative Loan Repayment Program

- To increase retention of culturally and linguistically specific behavioral health providers, rural behavioral health providers, and providers of behavioral health services in underserved communities.
- To increase retention of hard-to-fill positions within the behavioral health workforce.

- To increase retention of providers who work for publicly financed health and behavioral health organizations.

Tuition Assistance, Graduate Stipends, and Scholarships

To increase the number of students from underserved communities completing behavioral health provider training programs in Oregon.

Mental Health and Addiction Counselor Board of Oregon Agreement

- To reduce barriers for individuals from underserved communities to entering the behavioral health workforce.
- To provide a career pathway and advancement for certified behavioral health providers.
- To increase the number of Medicaid providers in Oregon.

Peer Delivered Services Workforce Capacity Grants

- To increase the number of certified peers active in Oregon.
- To increase the availability and access of Peer Delivered Services and overall access to care.
- To increase the available trainings, including trainings for culturally specific peers and rural peers.
- Overall practice development including best practice guides and policy and procedure statewide.
- To increase the retention of peers in the workforce.

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence

- To increase the number of certified peers active in Oregon.
- To increase competencies and quality of peer services in Oregon.
- To increase the availability and access of Peer Delivered Services and overall access to care.

- To increase the available trainings, including trainings for culturally specific peers and rural peers.

Culturally Responsive Workforce Technical Assistance in Behavioral Health

To build and sustain a behavioral health workforce that reflects the diversity of Oregon's communities and to reverse trends of inequity. This will ensure that all individuals achieve optimal health and that gaps in health outcomes between dominant culture groups and minoritized communities are reduced and ultimately eliminated.

- To create a sustainable and equitable behavioral health care system in Oregon.
- To develop a well-trained and culturally competent behavioral health workforce capable of addressing the diverse needs of all communities, particularly marginalized and minoritized groups.
- To ensure that providers are equipped with the latest knowledge and skills to deliver high-quality, culturally responsive care.
- To enhance the overall quality and accessibility of behavioral health services.
- To reduce provider shortages and ensure that individuals have easier access to care.
- To ensure that services are tailored to meet the specific needs of those most impacted by health inequities, ultimately leading to improved health outcomes and reduced disparities.
- To build towards a resilient and inclusive behavioral health system where all individuals, regardless of background, can achieve optimal behavioral health and wellness.

5. How will OHA measure the impacts on health inequities of this policy package?

OHA will employ a comprehensive approach to measure the impacts of these initiatives on health inequities. This will include the establishment of quarterly reporting metrics, final reporting or 'exit surveys,' and annual Race, Ethnicity, Language, and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) surveys administered to all program participants. Additionally, regular

feedback sessions will be conducted with grant recipients and community partners to gather qualitative insights. Furthermore, specific incentive programs will be tailored to collect data pertinent to their respective objectives. This approach ensures that data collection aligns closely with the desired outcomes outlined in contractual agreements and the development of incentives. By structuring data collection methods in this manner, OHA aims to obtain a nuanced understanding of how these initiatives impact health inequities across diverse communities.

Bonus and Housing Stipend Grant

- Tracking geographic distribution of grant recipients.
- Tracking populations served by grant recipients through grant application process and reporting.
- Annual REALD and SOGI data surveys for each beneficiary.
- Assessing changes in employment and income before and after awarded funding.
- Qualitative feedback of participants experiences after receiving funding.

Behavioral Health Workforce Initiative Loan Repayment Program

- Assessing the duration and retention rates of individuals working in behavioral health before and after receiving awards.
- Collecting employment data and the services awardees provide to their communities.
- Collecting demographic data to determine the effectiveness of prioritizing awards to diverse behavioral health professionals.
- Tracking qualitative data through application essays, oral and written communication and exit surveys.

Tuition Assistance and Graduate Stipends

- Analyzing graduation rates, retention rates, academic performance, and the amount of time it takes awarded students to complete their degree.
- Tracking student curriculum, practicum and internship opportunities, employment outcomes, and the financial impacts of awarded students.
- Assessing the diversity of awardees through demographic data (i.e., REALD and SOGI), socioeconomic status, and first-generation college status.
- Tracking qualitative data through application essays, oral and written communication and exit surveys.

Mental Health and Addiction Counselor Board of Oregon Agreement

- Monitoring testing certification, renewal rates, and attrition rates of certified providers during grant funding to compare rates before and after grant funding period.
- Assessing financial benefits for individuals who received fee waivers through surveys and qualitative data.
- Tracking geographic distribution of incentive beneficiaries.
- Assessing REALD data from incentive beneficiaries.
- Monitoring and analyzing exam pass rates with demographics and historic pass rates.
- Tracking credential advancements.
- Tracking and analyzing number of ethical grievances with historic data and demographics (geographic and REALD).

Peer Delivered Services Workforce Capacity Grants

- Tracking numbers of certified peers, curriculums/ best practice guides, and provision of trainings.
- Tracking retention rates of peers employed in various sectors across the state.
- Surveying the workforce for sustainability and resilience of peers.

- Monitoring the adoption of best practice guides and the effectiveness of technical assistance in improving cultural responsiveness and service delivery processes.

Culturally Responsive Workforce Technical Assistance in Behavioral Health

- Analyzing baseline data on current health inequities and the availability of culturally and linguistically specific services in Oregon.
- Gathering qualitative and quantitative data from training grant recipients, non-culturally specific organizations, and community members through surveys, interviews, focus groups, and community forums.
- Tracking the number and demographics of training grant recipients and credentialed providers,
- Assessing changes in organizational cultural responsiveness via pre- and post-training assessments.

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence

- Monitoring key health outcomes such as patient satisfaction, service utilization rates, and specific health indicators.
- Evaluating implementation of community recommendations and their impact on health services.
- Tracking training completion rates, certification rates, and provider retention rates.
- Assessing service quality through provider feedback, patient satisfaction surveys, and cultural competency assessments.
- Evaluating service utilization rates and geographic coverage to determine if more individuals, especially in underserved areas, are accessing behavioral health services.
- Analyzing changes in health disparities among different demographic groups and collecting community engagement feedback.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In 2021, the Oregon Legislature invested over $200 million to increase and diversify Oregon's behavioral health workforce. House Bill 2949 (2021) directed OHA to provide incentives to increase recruitment and retention of behavioral health providers with associate, bachelor's, master's, or doctoral degrees, or other credentials who are people of color, tribal members, or residents of rural areas in the state, and appropriated $80 million for these efforts. House Bill 4071 (2022) expanded the number of behavioral health providers who may be eligible for programs and incentives created under House Bill 2949 (2021) by replacing the requirement that providers be tribal members, or people of color, or residents in rural areas, with a requirement that providers increase access to culturally specific, community and peer-driven services. These investments, along with House Bill 4004 (2022), represent a significant shift towards addressing decades of underinvestment in Oregon's behavioral health workforce. They provide a strong foundation for growth by investing in diversity, equity, and accessibility, thereby improving the state's capacity to deliver comprehensive and culturally responsive behavioral health services across the state.

OHA's Health Services Division established a Behavioral Health Workforce Incentives (BHWI) unit to implement these investments efficiently and effectively. The BHWI unit established ten programs aimed at bolstering recruitment, decreasing barriers, and increasing retention of the behavioral health workforce in Oregon:

<u>BHWI programs that aim to bolster recruitment efforts:</u>

- Workforce Bonus and Housing Stipend Grant

- Mental Health and Addiction Counselor Board of Oregon Agreement
- Peer Support Services
- Tribal set-aside for every BHWI program

<u>BHWI programs that aim to decrease barriers through workforce development and career pathway opportunities:</u>

- Mental Health and Addiction Counselor Board of Oregon Agreement
- Peer Support Services
- Tuition Assistance, Graduate Stipends, Scholarships
- Social Work exam fee vouchers and licensing fee waivers
- Tribal set-aside for every BHWI program

<u>BHWI programs that aim to increase workforce retention:</u>

- Behavioral Health Workforce Loan Repayment Program
- Workforce Bonus and Housing Stipend Grant
- Mental Health and Addiction Counselor Board of Oregon Agreement
- Peer Support Services
- Tribal set-aside for every BHWI program

OHA has seen significant achievements in recruitment and retention efforts of behavioral health workers in Oregon, but additional investments are needed to continue building a workforce that meets the current demand. Therefore, one-time investments are not sufficient to meet the need. Sustained investments are needed to make the greatest impact, as education, training, credentialing, supervision, and licensure take years to produce outcomes (i.e., minimum of 4 years for licensure when including graduate level education).

Peer Delivered Services

House Bill 2949 (2021) supported the successful fourfold increase of certified Peer Support Specialists between 2021 and 2024. ORR conducted a Request for Grant Application process with an applied equity lens for Peer Delivered Services and Peer Run Organizations and allocated $5 million to 58 organizations in one-time lump sum projects across Oregon. These projects included development of curriculums, provision of trainings, professional development for peers, retention/sign-on bonuses, and wellness initiatives for peer support workers. The overall solicitation received $16m in project proposals, leaving a deficit of $11 million unfunded.

ORR also provided grant funds to Peer Run Organizations and Peer Programs that identified as culturally and linguistically specific and that have historically underfunded. These organizations used the funds to develop curriculums and provide trainings for underserved and underrepresented communities who have been most harmed by health inequities, resulting in two culturally specific best practice guides and several culturally specific, peer delivered service workforce associations and initiatives for peer support workers.

Culturally Responsive Workforce Technical Assistance in Behavioral Health

Oregon has made significant strides towards health equity by developing culturally and linguistically responsive health delivery systems. Key policy and programmatic efforts in the state have integrated national Culturally and Linguistically Appropriate Services (CLAS) Standards, which provide strategies to address and eliminate health disparities. These standards have been pivotal for initiatives such as the OHA's Statewide Behavioral Health Strategic Plan, the Cultural Competence Continuing Education Committee, the Senate Bill 21 (2013) Service Equity Subcommittee, and House Bill 2011 (2019). Consequently, Oregon is one of only ten states that mandates cultural competency training for health professionals regulated by any Oregon State Health Profession Board.

Oregon has also led in establishing a continuum of care model through its CCOs, which provide integrated care for Medicaid recipients across physical, mental, behavioral, and dental health. Additionally, the state formed six Regional Health Equity Coalitions (RHEC) in 2011 to support community-driven activities aimed at reducing health inequities. The RHECs potentially impact 60 percent of Oregon's population. In response to the COVID-19 pandemic, the state legislature mandated healthcare providers to collect and share disaggregated data on race, ethnicity, language, and disability, ensuring services adhere to CLAS standards, including telemedicine. This data collection is crucial for advancing health equity and addressing social determinants of health in Oregon.

There has been promising growth of Community Based Organizations (CBOs) in Oregon working in the behavioral health sector to reach and create access to behavioral health care for communities historically harmed by health inequities. This growth was accelerated during the pandemic, with federal funding and additional resources directed toward efforts to support culturally specific CBOs. OHA has cultivated and established strong relationships with these providers, which have identified a need for a level of technical assistance and support beyond a state agencies scope to remain sustainable and supportive in their communities. These community-based organizations have been consistent partners with OHA in working towards eliminating health inequities by 2030.

7. What alternatives were considered and what were the reasons for rejecting them?

No alternatives have been considered.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Bonus and Housing Stipend Grant

Office of Recovery and Resilience (OHA), Equity and Community Partnerships (OHA), Health Policy and Analytics (OHA), Addiction Treatment Recovery and Prevention (OHA), Culturally and Linguistically Specific Behavioral Health Providers, and Rural Providers.

Behavioral Health Workforce Initiative Loan Repayment Program
Health Policy and Analytics (OHA), Association of Community Mental Health Programs, Culturally and Linguistically Specific Behavioral Health Providers, and Rural Providers.

Tuition Assistance, Graduate Stipends, and Scholarships
Public and private universities and colleges, Health Policy and Analytics (OHA), and Equity and Inclusion (OHA).

Mental Health and Addiction Counselor Board of Oregon Agreement
Addiction Treatment Recovery and Prevention (OHA), Office of Recovery and Resilience (OHA), and the Mental Health and Addiction Counselor Board of Oregon (MHACBO).

Peer Delivered Services Workforce Capacity Grants
Peer Run Organizations, County Behavioral Health Divisions, Oregon Tribes, Equity and Inclusion Division (OHA), Public Health Division (OHA), CBOs, CCOs, Consumer Advocacy Groups, Certification Boards.

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence
Peer Run Organizations, County Behavioral Health Divisions, Oregon Tribes, Equity and Inclusion Division (OHA), Public Health Division (OHA), CBOs, CCOs, Consumer Advocacy Groups, Certification Boards.

Culturally Responsive Workforce Technical Assistance in Behavioral Health
Alliance of Culturally Specific Providers, the Oregon Black Brown and Indigenous Advisory Coalition and the Oregon Latino Emotional Health Collaborative. Peer Run Organizations, County Behavioral Health Divisions, Oregon Tribes, Equity and Inclusion (OHA), Public Health Division (OHA), CBOs, CCOs, Consumer Advocacy Groups, Certification Boards, Alliance of Culturally Specific Providers, the Oregon Black Brown and Indigenous Advisory Coalition and the Oregon Latino Emotional Health Collaborative.

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?**

    Bonus and Housing Stipend Grant
    The grant recipients are expected to be positively affected by this grant opportunity. Grant recipients can include counties (Community Mental Health Programs), School Districts, or other entities that employ behavioral health care workers which may be a part of local governments or public universities. OHA has developed an application process to minimize grant writing and management burden that the recipients may otherwise experience. Recipients will be required to provide regular reporting to track outcomes and demographics of final beneficiaries (REAL D and SOGI data).

    Behavioral Health Workforce Initiative Loan Repayment Program
    None

Tuition Assistance, Graduate Stipends, and Scholarships
Public universities and community colleges will need to provide reporting data on awards to students including (but not limited to) award amounts, as well as REAL D and SOGI data.

Mental Health and Addiction Counselor Board of Oregon Agreement
None

Peer Delivered Services Workforce Capacity Grants
The grant recipients are expected to be positively affected by this grant opportunity. Grant recipients can include counties (Community Mental Health Programs), School Districts, or other entities that employ certified behavioral health peers which may be a part of local governments or public universities. OHA has developed an application process to minimize grant writing and management burden that the recipients may otherwise experience. Recipients will be required to provide regular reporting to track outcomes and demographics of final beneficiaries (REAL D and SOGI data).

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence
All behavioral health peers registered as traditional health workers who participate with the program who work for or with counties (Community Mental Health Programs), School Districts, Tribes, or other entities that employ certified behavioral health peers which may be a part of local governments.

Culturally Responsive Workforce Technical Assistance in Behavioral Health
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, 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

- The progress which has already been made from existing BHWI and ORR programs will continue if those programs are funded from this POP.
- With sustainable investments that progress will continue.
- By prioritizing publicly financed and hard to fill positions within BHWI programs that access to specialized, and emergency behavioral health services (MH and SUD) will increase.
- Continuing to prioritize funding to Culturally and Linguistically Specific Service (CLSS) providers and rural providers within BHWI and ORR programs will increase workforce diversity and increase equitable access to services.
- Investing in long-term and sustainable interventions that support career pathways while supporting programs that focus on retention (that is, Loan Repayment and bonuses) will increase Oregon's behavioral health workforce capacity and access to services.
- Lowering barriers to entering the behavioral health workforce by funding initiatives like the incentives from MHACBO will increase the number of behavioral health professionals and paraprofessionals with lived experience.
- Providing long-term/permanent funding of graduate level scholarships and stipends will lower up-front costs and reduce student loan debt for students seeking to become licensed behavioral health providers in Oregon.
- Using BHWI and ORR programs to lower barriers at each stage (i.e., entry-level, mid-level, advanced-level) of behavioral health career pathways will increase the number of professionals

and paraprofessionals from underserved communities and with lived experience. Thus, equitably (geographically, racially/ethnically, gender identity, sexual orientation, and etc.) increasing the capacity of Oregon's behavioral health workforce and equitable access to services.

- The need for culturally specific services will continue to grow as the population of Oregon grows and changes.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Yes, for OHA there will be new responsibilities. OHA will increase its research, collaboration, and scope when refining existing programs. OHA will need operational support to provide responsive technical assistance, reporting, communication, and customer service to incentive/grant recipients. Further, outcomes and data tracking tools will also need to be developed and maintained to ensure program effectiveness.

Bonus and Housing Stipend Grant

New responsibilities will include the development of improved outcome metrics and methods to track progress.

Behavioral Health Workforce Initiative Loan Repayment Program

New responsibilities will include the development of improved outcome metrics and methods to track progress (RA 2). The program is also expected to triple the amount of loan repayment recipients which will significantly increase the operational support needed to administer funds and track compliance (OPA 1).

Tuition Assistance, Graduate Stipends, and Scholarships
New responsibilities will include re-developing the program to be more focused on providing funding to publicly financed provider organizations (CMHPs, COAs, CCBHCs, etc.) and developing outcome metrics/reporting for this new development.

Mental Health and Addiction Counselor Board of Oregon Agreement
New responsibilities will include the development of improved outcome metrics and methods to track progress.

Peer Delivered Services Workforce Capacity Grants
No new responsibilities.

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence
New responsibilities will include developing partnerships, contracts, and outcomes tracking mechanisms.

Culturally Responsive Workforce Technical Assistance in Behavioral Health
New responsibilities will include supporting culturally specific training grants, data collection and technical assistance to culturally specific providers (PA 2), as well as supporting partnership with community experts in the development of needed culturally specific services within the behavioral health continuum of care (OPA 3).

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

The expectation is for initiatives funded in this policy package to equitably increase capacity of Oregon's behavioral health workforce which will lead to a higher degree of access to behavioral health services. OHA expects there to be an increase in the following behavioral health services because of the expanded workforce:

- SUD services
- Child and family behavioral health services
- Medication Assisted Treatment services
- Peer Delivered Services
- Mobile crisis services
- Inpatient services
- Co-occurring disorder behavioral health services
- Rural based behavioral health services
- Culturally and linguistically specific services
- Behavioral health prevention 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.

New positions included in this policy package:

- Operations and Policy Analyst 1
- Operations and Policy Analyst 3
- Program Analyst 2
- Research Analyst 2

Please see below for a breakdown by program. Some positions appear more than once because they support separate programs or more than one program.

Bonus and Housing Stipend Grant

- Research Analyst 2 to develop new outcome metrics and new methods to track progress in collaboration with program lead and the BHWI manager. This work will assist program leads and the BHWI manager to ensure that the program's progress maintains alignment with OHA strategic goals.
- Operations and Policy Analyst 1 to meet the need of increased operation support administrating funds, providing recipient technical assistance, and track grant compliance. This program is expected to double the amount of grant recipients if this POP is approved.

Behavioral Health Workforce Initiative Loan Repayment Program

- Research Analyst 2 to develop new outcome metrics and new methods to track progress in collaboration with program lead and the BHWI manager. This work will assist program leads and the BHWI manager to ensure that the program's progress maintains alignment with OHA strategic goals.
- Operations and Policy Analyst 1 to meet the need of increased operation support administrating funds, providing recipient technical assistance, and track grant compliance. This program is expected to triple the amount of loan repayment recipients if this POP is approved.

Tuition Assistance, Graduate Stipends, and Scholarships

- Research Analyst 2 to develop new outcome metrics and new methods to track progress in collaboration with program lead and the BHWI manager. This work will assist program leads and the BHWI manager to ensure that the program's progress maintains alignment with OHA strategic goals.

- Operations and Policy Analyst 1 to meet the need of increased operation support administrating funds, providing recipient technical assistance, and track grant compliance. This program is expected to increase 50 percent the amount of grant recipients within the 2025-2027 biennium if this POP is approved.

Mental Health and Addiction Counselor Board of Oregon Agreement

- Research Analyst 2 to develop new outcome metrics and new methods to track progress in collaboration with program lead and the BHWI manager. This work will assist program leads and the BHWI manager to ensure that the program's progress maintains alignment with OHA strategic goals.
- Operations and Policy Analyst 1 to meet the need of increased operation support administrating funds, providing recipient technical assistance, and track grant compliance.

Peer Delivered Services Workforce Capacity Grants

No new staff or modified positions.

Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence

No new staff or modified positions.

Culturally Responsive Workforce Technical Assistance in Behavioral Health

The following positions will work closely with the BHWI team and will be recruited, hired and onboarded within the BHECP team beginning July 1, 2025:

- Culturally Specific Training and Services Specialist PA2 to support culturally specific training grants, data collection and technical assistance to culturally specific providers.

- Community Engagement Specialist OPA3 to support partnership with community experts in the development of needed culturally specific services within the behavioral health continuum of care.

16. What are the start-up and one-time costs?

There are no start-up costs expected.

17. What are the ongoing costs?

- OHA staffing ($588,542)
- Incentive/Grant program funding:
  - BHWI Loan Repayment Program ($8,911,458)
  - Bonus and Housing Stipend Program ($1.25 million)
  - Tuition Assistance, and Graduate Student Stipends ($10 million)
  - Mental Health and Addiction Counselor Board of Oregon Agreement ($1.5 million)
  - Peer Delivered Services Workforce Capacity Grants ($1 million)
  - Facilitation Centers and establish a Behavioral Health Workforce Center of Excellence ($1 million)

18. What are the potential savings?

There is both qualitative and quantitative data which shows the cost effectiveness and reduction of expenses related to hospitalization and inpatient care with the utilization of behavioral health services. Investing in the behavioral health workforce through this POP has several long-term economic advantages. This includes:

- Decrease in overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services, increasing the use of outpatient services.
- Decrease in financial/staffing burden on emergency health services.
- Decrease in financial/staffing burden on law enforcement and carceral systems.

19. What are the sources of funding and the funding split for each one?

This policy package includes approximately 96.6 percent General Fund and approximately 3.4 percent Federal Funds and a reduction in Other Funds. The reduction is created by the removal of limitation for positions previously funded by the American Rescue Plan Act (ARPA), replacing them with funding from the statewide allocation now that ARPA funds have been exhausted.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$588,542	$(1,427,215)	$838,673	**$0**	4	3.00
Services & Supplies						
Capital Outlay						
Special Payments	$24,250,000	$0	$0	**$24,250,000**	0	0
Other						
Total	**$24,838,542**	**$(1,427,215)**	**$838,673**	**$24,250,000**	**4**	**3.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Behavioral Health Division
Program:	Adult Behavioral Health
Policy package title:	Save Lives Oregon Harm Reduction Clearinghouse & Opioid Treatment Innovation Listening Sessions
Policy package number:	551
Related legislation:	None

Summary statement:

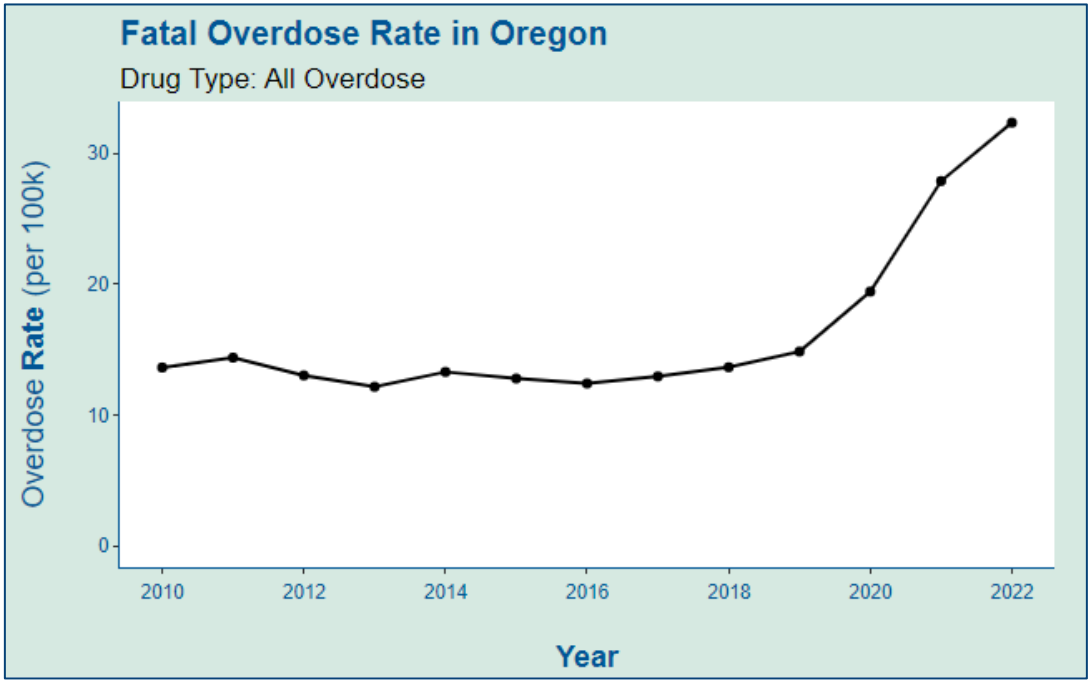
To address the state's substance use, addiction, and overdose crisis, OHA proposes the Save Lives Oregon Initiative's Harm Reduction Clearinghouse. The Harm Reduction Clearinghouse provides essential harm reduction supplies to community organizations, community and Tribal health clinics and programs, uniformed first responders and jails, substance use disorder facilities, and Special District entities, such as rural EMS, hospitals, transportation, libraries and more. The work of the Save Lives Oregon's Harm Reduction Clearinghouse expands community access to lifesaving medications like naloxone and supports organizations to integrate harm reduction strategies into their work that help prevent overdose, infections, and injuries. The Save Lives Oregon Harm Reduction Clearinghouse also provides opioid overdose response kits to schools, colleges, universities, and school-based health centers.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$10,394,821**	**$0**	**$0**	**$10,394,821**	**2**	**1.5**

Purpose

1. What problem is OHA trying to fix or solve?

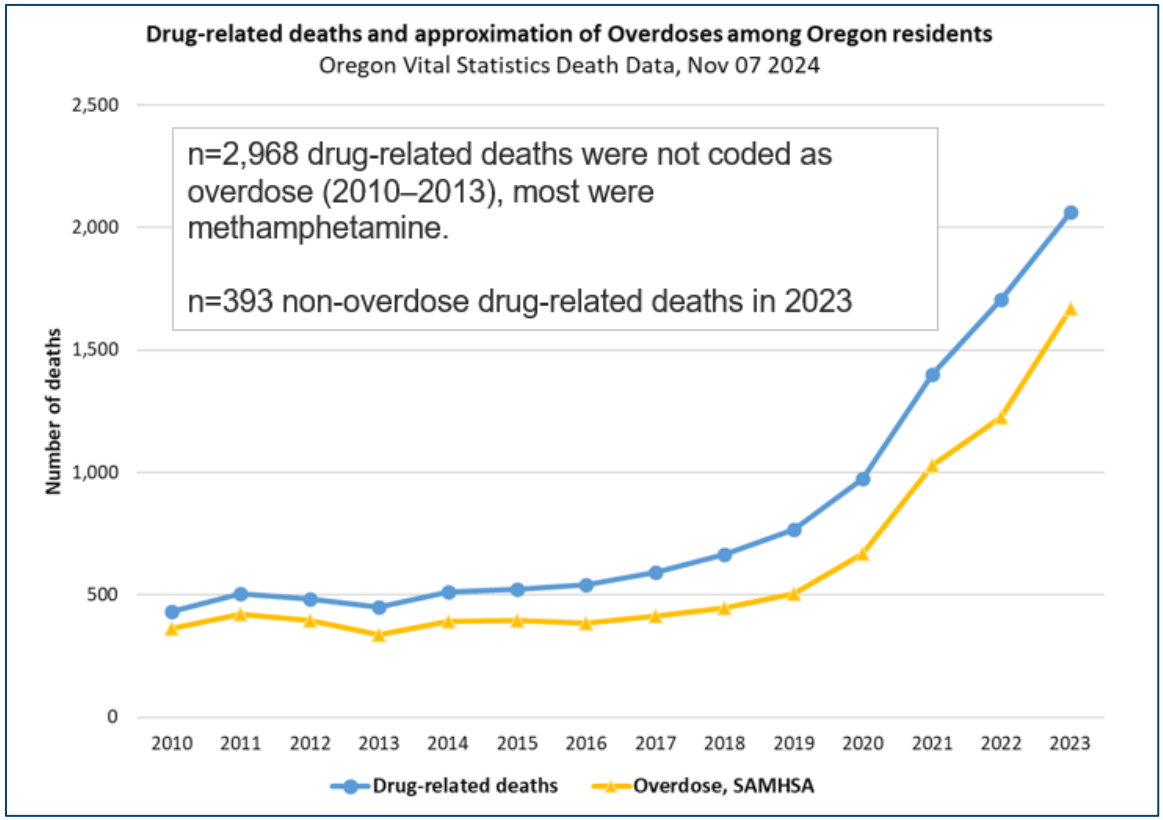
At this point in the ongoing substance use, addiction and overdose crisis facing the United States and Oregon, nearly every family has been affected by substance use or addiction. Too many families know someone who has experienced an opioid or stimulant overdose, an infection or an injury related to substance use. Fatal drug overdose rates have nearly tripled in Oregon from 12 per 100,000 residents in 2016 to 32 per 100,000 residents in 2022.[1] While nationally in the U.S. overdose deaths decreased for the first time in 2023, this was not the case in western states. Oregon was among the states that experienced the greatest rate increase in opioid overdose fatalities in 2023. And, while initial 2024 Oregon data is suggesting a decrease in opioid overdose deaths, drug related deaths in Oregon remains unacceptable.



[1] Oregon Center for Health Statistics Oregon Overdose Prevention Dashboard

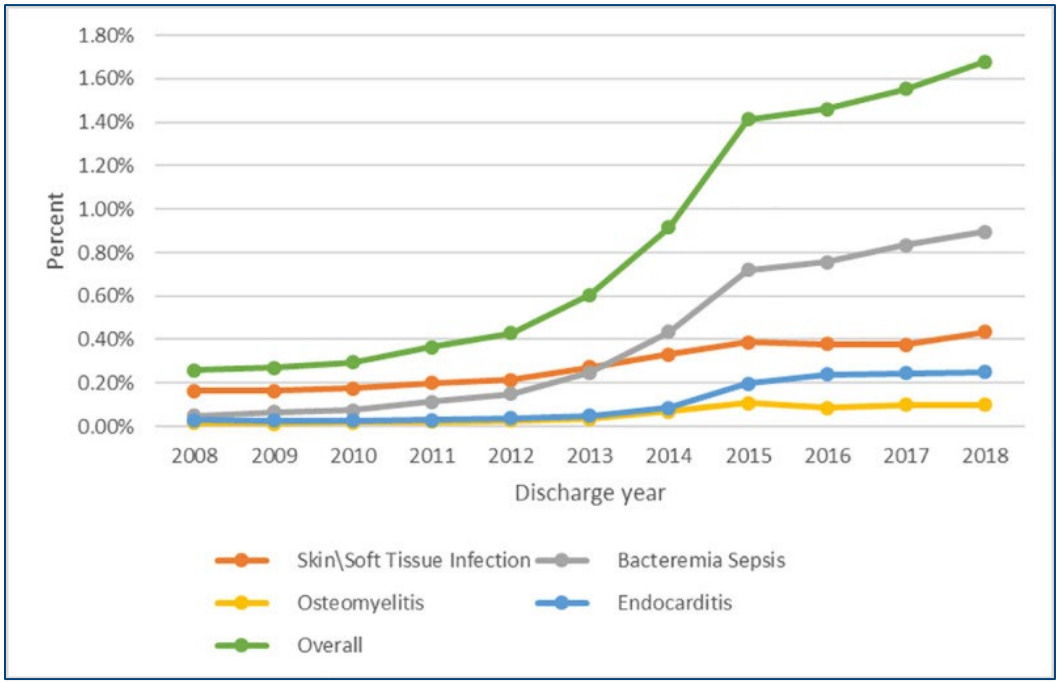
Oregon Health Authority: 2025-27 Policy Package

In Oregon, drug related deaths continued to increase through 2023. Drug-related death in the below graphic[2] include deaths with any illicit drug contributing as a cause of death on the death certificate: fentanyl, methamphetamine, cocaine, heroin, methadone, opium, barbiturates, benzodiazepine, and other opioids.



[2] 12/6/2024 *Substance Use, HIV and Syphilis* presentation at the Oregon Viral Hepatitis Collective Meeting in Portland, OR
Consensus recommendations for national and state poisoning surveillance:
https://cdn.ymaws.com/www.safestates.org/resource/resmgr/imported/ISW7%20Full%20Report_3.pdf

Overdose is one of many serious health outcomes related to substance use. Other life-threatening consequence of the substance use centered syndemic include blood-borne infections, such as viral hepatitis, HIV, and serious skin and soft tissue infections caused by bacterial and fungal infections. Prior to the COVID-19 pandemic and the inflection point of fentanyl saturation in Oregon's illicit drug market, OHA published a study on injection drug use (IDU) related infections in the state.[3] Between 2008 and 2018, IDU-related serious bacterial infections (SBIs) hospitalizations increased over six-fold, from 980 to 6,265 hospitalizations. Opioid use diagnoses accounted for the largest percentage of hospitalizations for injection drug use-related SBIs, but hospitalizations for amphetamine-type stimulant-related serious bacterial infections rose most rapidly with a 15-fold increase.



The same study found that people living with HIV and HCV experienced increases in hospitalizations for injection drug use-related serious bacterial infection. Overall, the total cost of hospitalizations for injection drug

[3] Population-based trends in hospitalizations due to injection drug use-related serious bacterial infections, Oregon, 2008 to 2018.

use related SBIs increased from over $16.3 million in 2008 to over $150.9 million in 2018 (P<0.001). Stimulant and opioid use disorder related deaths have increased since 2018 and accelerated since illicit fentanyl entered and saturated Oregon's illicit drug supply.[4]

Furthermore, people who use drugs in Oregon have limited options when seeking treatment. According to the recently released Behavioral Health Residential + Facility Study, the state needs an additional 2,357 SUD residential treatment facilities and 571 withdrawal management beds to meet current needs.[5] The study also highlights the lack of access to facility-based care, which leads to long wait-times as well as a mismatch between the level of care needed and the level of care received. Moreover, the study emphasizes the critical need to expand availability of SUD services, culturally specific services, care to meet complex and overlapping needs, services in rural areas, and peer-based services.

To address the rising overdose rates in Oregon, Community Based Organizations (CBOs) and local governments have distributed harm reduction supplies to people who use drugs. Many CBOs access naloxone and harm reduction supplies from Direct Relief, a nonprofit humanitarian organization that sends donated harm reduction supplies, including naloxone, to areas in need across the nation as well as internationally. Direct Relief is no longer sending out donated supplies, leaving a gap in access to harm reduction supplies available to CBOs to distribute in their communities. Although harm reduction efforts across the state have had success in reducing overdoses and infections among people who use substances, the rapid increase of drug use in Oregon necessitates more resources dedicated to harm reduction efforts and increasing treatment services.

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4 *"It wasn't here, and now it is. It's everywhere"*: Fentanyl's Rising Presence in Oregon's Drug Supply.

5 Behavioral Health Residential + Facility Study

Medication for opioid use disorder and harm reduction strategies have decades of proven results in reducing overdose and death from illicit drug use, preventing the spread of infectious diseases, and reducing criminal activity related to drug use. This policy package includes two initiatives requiring resources:

Save Lives Oregon's Harm Reduction Clearinghouse

Save Lives Oregon is a collaborative initiative founded by the Oregon Health Authority (OHA**)** in partnership with leading harm reduction organizations and Tribal communities across the state. Launched in 2020 during the COVID-19 pandemic, the initiative responded to the heightened overdose crisis by launching the Harm Reduction Clearinghouse to provide life-saving supplies like naloxone to organizations working directly with people who use drugs. Co-led by OHA and a Leadership Team of 10 partner organizations — including HIV Alliance, Miracles Club, El Jardín, Max's Mission, 4D Recovery and others— Save Lives Oregon is committed to expanding harm reduction strategies across the state and supporting equitable access to harm reduction supplies through the Harm Reduction Clearinghouse.

As of December 2024, the Save Lives Oregon Initiative has more than 375 community agency partners across the state and Tribal communities. These partners access state-funded harm reduction supplies through the Harm Reduction Clearinghouse and distribute those supplies to community members who are at risk of overdose or substance-use-related harm. Many partners also participate in other Save Lives Oregon initiative offerings such as monthly Learning Collaboratives and utilize the initiative's informational tools and materials.

Through annual partner surveys and ongoing engagement with partners, we know that the Harm Reduction Clearinghouse serves as the sole source of harm reduction supplies for most partners. As of November 2024, Save Lives Oregon has distributed more than 675,000 doses of naloxone to

more than 375 community partners across the state and Tribal communities, as well as equipped more than 665 schools with opioid overdose reversal kits. According to the 2024 Save Lives Oregon Partner Survey: 96% of respondents reported that Save Lives Oregon has positively impacted their organization's ability to support the communities they serve.

2. What would this policy package buy and how and when would it be implemented?

Save Lives Oregon Harm Reduction Clearinghouse

The Save Lives Oregon Harm Reduction Clearinghouse project supports CBOs in actively implementing harm reduction in communities by distributing supplies that prevent overdoses, infections, and injuries related to substance use. The Clearinghouse supports this effort by providing access to over 300 harm reduction products. Although naloxone purchases have historically dominated the budget, the recent decrease in naloxone prices has encouraged the use of more cost-effective options like injectable naloxone. Despite these efforts, many CBOs struggle to purchase and distribute necessary supplies due to limited resources.

The Save Lives Oregon Harm Reduction Clearinghouse provides access to over 300 state-funded harm reduction supplies, including naloxone, to more than 375 community agencies across the state and Tribal communities. These community agencies utilize these lifesaving and harm-reducing supplies in their existing programs to prevent overdose deaths, infections and injuries related to substance use. Other elements of the Save Lives Oregon Initiative include communication resources and materials to help community partners explain and share about harm reduction strategies for example videos and written information about how to give naloxone. The Save Lives Oregon Initiative also provides individualized technical assistance and hosts monthly Learning Collaboratives to support organizations to learn about, integrate and implement harm reduction strategies into their work. Many CBO partners have expressed that they struggle to purchase and distribute necessary

supplies due to limited resources and have found the monthly learning collaboratives very informative and have used the information in their work.

This policy proposal seeks to address the resource limitations by increasing spending allocations for organizations and securing additional funding to allow more entities to partner with Save Lives Oregon and enroll in the Harm Reduction Clearinghouse. Currently, over 375 community partners participate, but funding restrictions hinder the organizations' ability to meet the ongoing demand for harm reduction supplies. Moreover, the proposal includes provisions to continue to support schools and colleges to maintaining their opioid overdose reversal kits, addressing feedback from educational institutions about their difficulties in replacing naloxone in kits due to funding constraints.

The policy package also addresses the need for additional staffing, proposing the funding of two positions (1.5 FTE) to manage organization enrollment, support and process supply ordering, provide technical support, develop materials and implement learning activities. By enhancing support for organizations and educational institutions, this proposal aims to stabilize and expand the Save Lives Oregon Initiative, ensuring that communities can access the specific supplies they need to effectively reduce harm associated with substance use.

3. **How does this policy package help, or potentially hinder, populations impacted by health inequities from achieving health equity[6] or equitable health outcomes? How does this policy package further OHA's mission and align with its strategic plan?**

   Save Lives Oregon Harm Reduction Clearinghouse

[6] 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.

This proposal would help with improving health equity and health outcomes by providing lifesaving medication (naloxone) and other supplies to decrease overdose deaths and infectious disease across the state. The Save Lives Oregon Harm Reduction Clearinghouse specifically gets harm reduction supplies and naloxone into the hands of people who are using substances. We know that people who are using substances in Oregon are less likely to access medical and other health services, and when they do, they receive less than equitable care. This policy package gets lifesaving supplies into the hands of a wide variety of partner organizations who are invested in serving people who are using substances, provide naloxone, guide safer use strategies, and support positive substance use and other life changes the person identifies and wants for themselves. Further, OHA has worked diligently with community partners to ensure that communities who have and are currently addressing high rates of opioid use are prioritized for additional funding and support.

Quantifying results

4. What are the long-term desired outcomes?

Save Lives Oregon Harm Reduction Clearinghouse

The Save Lives Oregon Harm Reduction Clearinghouse provides lifesaving naloxone and other harm reduction supplies that are needed to decrease the number of overdose deaths and reduce infections and other substance use-related harm across the state of Oregon. There have been over 19,000 community overdose reversals voluntarily reported to the Harm Reduction Clearinghouse by Save Lives Oregon community agency partners since the project began in 2021. The long-term desired outcome of this proposal is to increase reversals of community overdoses as well as decrease acute care needs among people who use substances in Oregon.

In addition to lowering the number of opioid overdose deaths, Save Lives Oregon works to increase equitable health outcomes for people who use substances through increased and equitable access to wound care, hygiene, and other types of supplies that help lower rates of infectious disease related to substance use within communities. Another key goal is to improve access to harm reduction resources, such as naloxone, particularly in underserved and high-risk communities. By increasing the availability of these resources, the initiative aims to prevent overdoses and reduce the harm associated with substance use.

5. How will OHA measure the impacts on health inequities of this policy package?

Save Lives Oregon Harm Reduction Clearinghouse
Save Lives Oregon conducts an annual survey and conducts in-depth interviews with initiative partners and includes questions about the primary communities that organizations serve. Organizations enrolled in the Harm Reduction Clearinghouse also voluntarily report on community overdose reversals achieved from the use of harm reduction supplies. OHA will measure the impacts of this proposal by monitoring the number of newly enrolled Clearinghouse participants, documenting and analyzing the percent increase of funding allocations for ordering supplies, analyzing responses to the annual survey to monitor the increase of harm reduction supplies in communities, and analyzing the number of deaths caused by overdose and monitoring this number to see if there is a reduction over time.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

Save Lives Oregon Harm Reduction Clearinghouse

The Harm Reduction Clearinghouse has utilized COVID-19 funding, State Opioid Response funding, and has recently received Opioid Settlement Board funding. Each of these funding sources are one-time funding that allow the Clearinghouse to offer a limited number of supplies and naloxone to CBOs enrolled in the Clearinghouse. OHA continuously looks for funding sources to keep the Clearinghouse a viable option to ensure that naloxone and other needed supplies are available in each community. At this time, the Harm Reduction Clearinghouse is currently is funded with an Oregon Opioid Settlement Prevention, Treatment and Recovery Board one-time funding allocation. No other funding sources have been identified.

7. What alternatives were considered and what were the reasons for rejecting them?

Save Lives Oregon Harm Reduction Clearinghouse
Prior to the initiation of the Harm Reduction Clearinghouse Project, the responsibility to purchase supplies was solely the responsibility of community organizations. In a 2022 survey of Harm Reduction Clearinghouse enrolled organizations, 65% of respondents said their organization did not order naloxone or other harm reduction supplies prior to ordering through the Clearinghouse because they did not have the funding to do so or did not have a licensed prescriber to sign to order naloxone. No other alternatives were considered.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

Save Lives Oregon Harm Reduction Clearinghouse
Save Lives Oregon is a collaborative initiative founded by OHA with leading organizations active in harm reduction from across the state and Tribal communities. It is led by OHA and a Leadership Team including HIV Alliance, Miracles Club, Max's Mission, Outside In, Painted Horse Recovery, El Jardín (formally Northwest Instituto Latino), Multnomah County Health Department, 4D Recovery,

Siletz Tribal Health, and Clatsop County Public Health. There are currently over 375 community agencies receiving state-funded harm reduction supplies through the Harm Reduction Clearinghouse, including 164 community-based organizations, 54 Uniformed First Responder Agencies, 33 Substance Use Disorder Facilities, 49 Syringe Service and Harm Reduction Programs, 21 Health Centers and Emergency Departments, 54 Special District entities.

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.

Save Lives Oregon Harm Reduction Clearinghouse
This policy package does not require changes to existing statute, although legalizing drug checking would streamline Clearinghouse project efforts so that people who use substances could test their drugs at a drug testing site to avoid unintentional drug overdose deaths. Additionally, allowing individuals who obtain naloxone to legally distribute it was repealed but could reinstated to reduce the interruptions to providing harm reduction supplies to people who use substances.

Opioid Treatment Innovation Listening Sessions and Community Response
No

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Save Lives Oregon Harm Reduction Clearinghouse
Each of the 375+ community agencies that currently receive state-funded supplies through the Harm Reduction Clearinghouse will be positively affected by this policy package as they would have increased access to harm reduction supplies to distribute in their communities.

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, 2025 Save Lives Oregon – ongoing Opioid Treatment Innovation Listening
End date (if applicable):	Sessions – December 2027

12. What assumptions affect the pricing of this policy package?

Save Lives Oregon Harm Reduction Clearinghouse

OHA assumes that overdose rates will continue at the current or higher rates. According to the recently published SUD financial analysis, there is a minimum need of 56 full service harm reduction programs in Oregon. The annual cost estimate for needed harm reduction supplies is $1,575,775 per program. To fund a minimum of 56 programs for only their harm reductions supplies is $88,243,400.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Save Lives Oregon Harm Reduction Clearinghouse

This proposal will increase the workload in processing Clearinghouse enrollees and ordering, requiring additional staff.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Save Lives Oregon Harm Reduction Clearinghouse
OHA expects an increase of organizations and schools to enroll in the Clearinghouse with the expanded funding through this POP.

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.

Save Lives Oregon Harm Reduction Clearinghouse
The Clearinghouse Project is currently staffed by two Operations and Policy Analyst (OPA) 3 positions who support enrolled CBOs through one-to-one technical assistance meetings, monthly learning collaboratives about topics such as “All About Naloxone”, and information resources that include posters, Good Samaritan cards, factsheets, and educational videos. These positions would not need to be modified. The policy package would buy two additional permanent, full-time staff to manage the Clearinghouse efforts:

- The OPA2 will read, answer or forward to appropriate staff daily emails sent to the info@savelivesoregon.org email inbox. This is very active inbox that receives up to 50 and sometimes more emails each day. Emails range from general questions about the Clearinghouse Project, entities applying to be in the Clearinghouse, and issues experienced by participating CBOs. The OPA2 will answer and direct all emails, as well as enroll new CBOs into the Clearinghouse. Enrollment activities include gathering the legal documents, ensuring CBOs meet eligibility criteria, and enrolling CBOs into the Cardinal Health online site where participating CBOs order supplies.

The OPA2 will also conduct weekly orientation meetings with newly enrolled CBOs and provide technical support for placing and receiving orders. The OPA2 will also attend and reach out to potentially eligible CBOs throughout the state through virtual and in-person community events and meetings. The OPA 2 will attend weekly team meetings with the project's main distributor, Cardinal Health, to address orders and participating agency issues. They will also attend weekly meetings with communications contractor, as well as assist the OPA3 (described below) with individual participant agency order tracking.

- The OPA3 coordinates with the OPA2 (described above) to address participating CBO staff questions, issues and technical assistance needs. The OPA3 also answers emails and supports participating CBO enrollment and training. The OPA3 approves and tracks supply orders for each enrolled CBO to ensure compliance with the project's formulary and each CBOs allotted spend cap amount. The OPA3 works with Cardinal Health to ensure orders and invoices are accurate and paid. The OPA3 also interacts with OHA's Office of Financial Services and budget teams to ensure the project's budget and spending are aligned and tracking with the overall initiative budget.

  The OPA3 will also work with the project's communications contractor to ensure all marketing and communication strategies align with the goals and current evidence-based harm reduction practices and strategies. The OPA3 will coordinate and lead monthly learning collaboratives with the Save Lives Oregon community partners. The OPA3 will develop materials to engage and educate internal OHA programs about the Clearinghouse and coordinate with internal OHA programs to educate community partners. The OPA3 provides guidance and subject matter expertise to programming and leadership about the Clearinghouse and the harm reduction strategies the project supports. The OPA3 will also engage with community groups and

organizations at outreach events throughout Oregon in-person and virtually to promote the Save Lives Oregon Harm Reduction Clearinghouse Project. Additionally, the OPA3 will work closely with teams in the Behavioral Health Division, including the Substance Use, Prevention, Treatment, and Recovery Supports federal block grant team, State Opioid Response federal grant team, Substance Use Disorder programs, and Ballot Measure 110 program, to ensure that the harm reduction information, messaging and knowledge, funding supported strategies align.

16. What are the start-up and one-time costs?

Save Lives Oregon Harm Reduction Clearinghouse
No start-up or one-time costs

17. What are the ongoing costs?

Save Lives Oregon Harm Reduction Clearinghouse
Ongoing cost will be the cost of two additional staff and the continued cost of the harm reduction supplies and naloxone.

18. What are the potential savings?

OHA anticipates savings in acute care for people who use substances as harm reduction and innovative treatment projects will be expanded with this POP, thus reducing overdoses and needs for hospital services among people who use substances in Oregon.

19. What are the sources of funding and the funding split for each one?

This package is entirely General Fund.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$376,333	$0	$0	**$376,333**	2	1.50
Services & Supplies	$18,488	$0	$0	**$18,488**		
Capital Outlay						
Special Payments	$10,000,000	$0	$0	**$0**		
Other						
Total	**$10,394,821**	**$0**	**$0**	**$10,394,821**	**2**	**1.50**

Fiscal impact by program

	BHD				Total
General Fund	$10,394,821				**$10,394,821**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$10,394,721				**$10,394,821**
Positions	2				**2**
FTE	1.50				**1.50**

Oregon Health Authority
2025-27 Policy Package

Division:	Behavioral Health Division
Program:	Behavioral Health Investments, Child and Family Behavioral Health
Policy package title:	Residential+ Study
Policy package number:	552
Related legislation:	House Bill 5024 (2021), Senate Bill 606 (2023)

Summary statement:

OHA proposes expanding behavioral health residential treatment and support services to address insufficient infrastructure for substance use disorders, psychiatric treatment, and co-occurring needs across the state. The proposal aims to increase the capacity of residential programs for youth, young adults, and adults by adding new psychiatric residential treatment facilities and SUD treatment beds, focusing on mandated populations as well as regional and cultural diversity. The plan includes purchasing, constructing, or renovating facilities, stabilizing current providers, and supporting culturally and linguistically diverse services. For youth, the initiative will reduce long wait times for treatment and reliance on emergency departments. For adults, it will improve access to developmentally responsive licensed residential and SUD treatment and housing, emphasizing equitable distribution of funds to smaller, culturally specific providers, and those that serve the Aid and Assist population.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$100,000,000**	**$0**	**$0**	**$100,000,000**	**0**	**0**

Purpose

1. **What problem is OHA trying to fix or solve?**

   Oregon's behavioral health residential treatment and supports are essential services for some of our most vulnerable residents. For the full lifespan from children to older adults, we continue to hear from communities, providers, and funders that the current infrastructure is insufficient to meet the needs of our state for substance use disorders (SUD), psychiatric treatment, and co-occurring needs. OHA is recommending expansion of our residential programs for youth, young adults, and adults through several initiatives.

   For youth and young adults, the number of residential treatment beds for substance use disorder and psychiatric treatment was assessed to be inadequate to meet the needs of Oregon's youth and families, and an ODHS study in 2018 recommended a significant increase in residential capacity. Efforts to expand program availability for youth and young adults were significantly impacted by the COVID-19 pandemic, and while Oregon's system has added multiple youth and family providers and increased residential bed availability over recent years, the need for residential treatment has grown and remains woefully inadequate. Communities continue to tell us that family members have only hospital emergency departments to look to when their children are experiencing substance use or behavioral health crises, when psychiatric hospital beds for youth are full, and when youth and young adults' needs worsen as they experience lengthy wait lists for the essential care they need.

   Current wait time for youth psychiatric residential treatment facilities (PRTF) is 6-10 weeks, and providers are not accepting young adults ages 18-21, who often have no placement options within the adult system either. System estimates report a need for an increase of approximately 70 psychiatric, substance use or integrated beds to meet Oregon's needs, in addition to the existing 200 PRTF beds and 65 SUD beds for youth. Existing programs are primarily located along the I-5

corridor between Portland and Eugene, meaning that families from outside that region often struggle to get their children into care and have long drive times for admissions or visits.

Within the adult behavioral health system, the highest priority needs for Oregon are ensuring equitable access to culturally and linguistically diverse services, residential treatment services and supports for the mandated population, and developmentally responsive licensed residential and SUD treatment and housing. The current system for disbursing funding to community organizations is informed by bureaucratic processes tailored for large organizations with the resources to effectively compete for funding, thus reducing funding access for culturally and linguistically diverse providers and smaller organizations. This approach has led to broken trust with communities and inadequate services for individuals needing culturally and linguistically diverse services and supports.

Per the key findings from the adult system's Behavioral Health Residential+ Facility Study,[1] there is a significant need to expand availability of services across the behavioral health continuum, specifically SUD services, culturally diverse services, care to meet complex and overlapping needs, services in rural areas, and peer-based services. In order to meet the complex behavioral health care needs of communities, the Residential+ Study recommended further developing the SUD continuum of care, specifically highlighting a necessary expansion of residential SUD facilities and withdrawal management services throughout the identified Trauma System Areas.

The current system for disbursing funding to community organizations is informed by bureaucratic processes that are tailored for larger organizations with the resources to effectively compete for funding, thus reducing funding access for culturally and linguistically diverse providers and smaller organizations. Additionally, this approach has led to broken trust with communities and inadequate

[1] Oregon Heath Authority Behavioral Health Residential+ Facility Study: June 2024 Final Report

services for individuals needing culturally and linguistically diverse services and supports. The recommendations of the Residential+ Facility Study considered feedback from focus group sessions completed with informants of a diverse range of prospective and experiences across Oregon, and who consistently identified a need for support for small organizations and culturally specific providers.

This policy package aims to address the above needs for Oregon by enhancing intensive behavioral health services using three overall strategies:

- Expand capacity for residential psychiatric and SUD treatment services for youth and families, particularly in smaller home-like settings where possible, and with greater regional diversity, and a focus on serving mandated individuals.
- In addition to expanding capacity of licensed residential and SUD treatment and housing for adults, an intentional approach to improving upon the current method to disbursing funding across the adult behavioral health system by providing community coordination and technical support to culturally and linguistically diverse and smaller organizations serving marginalized communities.
- Increasing access to residential treatment facilities and community-based SUD treatment, including community-based supports for court mandated populations as they transition into the community. Increasing access to community-based services will help ensure that individuals under court orders are served in the least restrictive setting possible.

2. What would this policy package buy and how and when would it be implemented?

Beginning with the 2025-27 biennium, this policy package aims to expand capacity in both the youth and adult behavioral health systems by addressing the need for additional community coordination and support, and specific gaps in much-needed services.

This package will fund the purchase, construction, or renovation, and start-up costs for approximately 26 children's residential psychiatric beds, with a focus on regional equity and expanding access to treatment. This funding would also pilot capacity payments to stabilize current PRTF providers' abilities to address hiring and retention barriers, meet 24/7 staffing challenges, and enhance post-pandemic resources to maintain clinical and organizational best practices. Additional staffing resources for OHA will support the oversight of cross-system expansion, focusing on collaboration and quality. OHA has strong relationships with well-qualified providers and has begun preliminary discussions with those interested in partnering with the state to meet this need.

For the adult behavioral health system, this package will provide funding for multiple capital development projects to purchase, build, or renovate existing licensed residential and SUD treatment and housing for adults, prioritizing culturally and linguistically diverse services and supports as well as services for the mandated population. Funding disbursements will be aligned with the 5-year plan for increasing statewide capacity as outlined in the Residential+ Facility Study. Historical data from House Bill 5024 (2021) project development costs has shown the average cost per bed is approximately $230,428. Based on this data, we anticipate a total increase in capacity of approximately 642 beds/units from the funding through this policy package. Considering the restricted number of data points and the substantial ranges, these figures are subject to change as more data on facility costs becomes available.

Additionally, this package includes funding for the development of a local treatment facility that provides culturally and linguistically diverse residential treatment and service for the Latine and Spanish speaking community within proximity to the Tri-county area. This facility would be staffed with qualified behavioral health providers who are bilingual, bicultural, and connected to other behavioral health ancillary services to meet the needs of a growing Spanish speaking population in the Tri-county area.

The policy package also includes funding for five permanent, full-time positions to support implementation and maintenance of the new and expanded treatment facilities and services.

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?**

   Increasing statewide capacity of licensed residential psychiatric and SUD treatment for children and youth is essential to meet the urgent and critical needs of Oregon families today. Statistics show youth of color are among those most negatively impacted by inadequate social determinants of health supports, thus experiencing poverty, racism, institutionalized discrimination, educational disruption, and other barriers to health care access. Children who qualify for PRTF and SUD services are struggling with the most acute and complex behavioral health conditions. Those in state custody also experience the absence of safe parents and a familiar, stable home. This combination of factors results in a disproportionate number of children and adolescents from minoritized groups placed in residential treatment programs or in need of multi-system services to ensure access for an equitable opportunity to thrive.

   Initial Planning Grant investments for adult residential providers of $5 million from House Bill 5024 (2021) funded $50,000 per awardee and were disbursed to 104 Community Mental Health Programs (CMHPs), Regional Health Equity Coalitions, Tribes, and other community organizations for conducting research to identify community needs, gaps, and barriers to services. The second iteration of this effort was to execute a contract for continued community engagement with the

[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.

Planning Grant partners, and this approach has yielded rich and actionable information for improving OHA's community engagement efforts aimed at increasing licensed residential and SUD treatment and housing for adults.

Consistent feedback received from the original Planning Grant partner network has been their recommendation to develop a funding distribution plan in collaboration within each Trauma System Area (TSA)[3] or county, to effectively meet their respective local needs, and to empower communities to work alongside OHA in planning efforts for disbursing funds for capital development. Redistribution of funding is a symbolic redistribution of power achieved by investing funds back to the community for the community to best meet the needs of their unique population.

Quantifying results

4. What are the long-term desired outcomes?

OHA is working toward the statewide expansion of residential bed capacity and timely access to SUD and psychiatric treatment across the lifespan, including housing for adults, with a focus on youth and families needing regionally, culturally, and linguistically diverse and responsive services and supports. Specific, measurable enhancements will include shorter wait times to receive care, reduced use of hospital emergency departments for significant mental health concerns, and access to facilities close to their home community.

[3] Trauma system areas are based on patient referral patterns, resources, and geography and are defined by administrative rule (OAR 333-200-0040). Each TSA has an Area Trauma Advisory Board which is responsible for acting as a liaison between providers and the public as well as participating in trauma system area planning.

For the adult system, OHA has a goal of increased system capacity and improved trust with community organizations; shared leadership with communities working alongside us in our planning efforts and allowing them to inform the specific service needs and gaps within their respective TSAs/counties. Demonstrating our sincere respect and value of community voice will make it easier for community organizations to work with their government in providing the services needed throughout the state.

The long-term goals for Oregon's mandated population focus on ensuring equitable access to diverse and responsive community-based services, particularly in residential treatment and substance use disorder services. This involves expanding the capacity of residential and SUD treatment facilities, especially in smaller, home-like settings with regional diversity, to better serve court-mandated individuals. By expanding residential services in particular OHA will be able to increase the flow of individuals through levels of care, such as Aid and Assist clients needing discharge from the Oregon State Hospital. Another objective is to reform the funding disbursement process to support culturally and linguistically diverse providers and smaller organizations, thereby rebuilding trust with communities and improving access to essential services. Additionally, the policy package emphasizes increasing access to community-based residential treatment and supports for court-mandated populations, facilitating their transition into the community and ensuring they receive care in the least restrictive settings possible. These efforts aim to address the complex needs of Oregon's mandated population and promote a more inclusive and effective behavioral health care system.

One of the challenges that OHA has in the funding of culturally and linguistically diverse, and developmentally responsive licensed residential and SUD treatment and housing for adults, and PRTF for youth are the inefficiencies and inequities in the grant funding cycle. Previous efforts have not been successful and community partners point to missed opportunities for community collaboration throughout the process. This policy package will expedite the process for disbursing

funding to communities for behavioral health investments, improve relationships, and increase coordination at the local level.

OHA's goal is for community-based organizations (CBOs) and service providers to increase their in-region coordination and collaboratively plan and solicit funding opportunities together, instead of competing with one another for funding opportunities. Another goal is to improve the efficiency and reduce waste in the funding cycle by modernizing grants and contracts in alignment with both state-level modernization efforts and the change opportunities identified through ongoing partner engagement. The activities in this policy package will improve the efficiency of fund distribution by leveraging and expanding collaborative community relationships and adding partner engagement/technical supports to the funding cycle.

This policy package aligns well with Senate Bill 606 (2023), which established a task force to examine how the state's granting and public procurement practices limit the wages of nonprofit organizations. A community-informed, collective impact approach models the work of SB 606 Modernizing Contracts and Grants Taskforce with a shared focus on:

- Providing structure for CBOs to coordinate with each other on shared project development and investment planning.
- Focusing their asks on culturally and linguistically diverse services for their Trauma Service Area.
- Reducing funding competition between organizations.
- Improving efficiency in the funding process and reducing administrative burden.
- Provide regionally targeted technical support for investment monitoring requirements.

5. How will OHA measure the impacts on health inequities of this policy package?

For the youth system, measurements of success include:

- Increased number of beds/units available and accessible in licensed residential and SUD treatment and housing access for adults, and PRTF for youth throughout the state
- Reduction in the number of days on a waitlist for referrals to be admitted into residential SUD and PRTF treatment
- Reduced boarding of youth (stays longer than 24 hours) in hospital emergency rooms for significant mental health concerns
- Decreased travel distances for families to attend therapy and make in-person visits

For the adult system, the following data points will be utilized:

- The number of culturally, linguistically, developmentally responsive, smaller organizations that are awarded funding.
- The level and type of technical support provided to culturally and linguistically diverse, developmentally responsive, smaller organizations.
- The number of successful project completions – fewer project withdrawals.
- Conducting satisfaction surveys with community organizations about their experience in working with us with this new collaborative planning approach to disbursing funding and technical support.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

OHA has devoted extensive focus over the last few years to designing and building an online tool for tracking referrals and bed capacity for the youth SUD and psychiatric residential services across the state. This tracking effort consistently demonstrates that existing facilities are operating at maximum capacity, and since the workforce impacts of the COVID pandemic, they are even further stretched. In addition, OHA holds the role of supporting the coordination of care for Oregon's highest-acuity,

most complex child and youth cases. Through our day-to-day involvement in this work, our staff have extensive and detailed insight into the various circumstances that result in the four- to six-week (average) waitlist and the scarcity of needed residential beds.

Relative to the adult-system strategies, the proposed concept was developed as a result of analyzing the progress reports provided by the Planning Grant Partners, and through the ongoing community engagement efforts with the Planning Grant Partner network that has been facilitated through a contract.

For the youth and family behavioral health continuum of care in Oregon, recent accomplishments have begun the momentum toward expansion. A policy option package of $7 million was funded in 2021 and dispersed to three different projects that have grown the available bed capacity, but only by a fraction of the need. In any discussion of residential services, it is key to note that residential SUD and psychiatric care are but one of many types of intervention and exists at the far end of a well-functioning continuum of care. OHA is dedicated to strengthening the entire continuum, with the awareness that a robust system of community-based and in-home services can be effective in preventing the need for a residential admission in many cases. As such, OHA is simultaneously striving to grow these lower levels of care for families in Oregon.

OHA is engaged in extensive collaborative efforts to address the need for additional youth and young adult residential beds through inter-agency agreements, active workgroups, and data collection partnerships. Our close partnership with ODHS/Child Welfare will improve access and responsiveness for children in their custody as well as careful collaboration with community-based services for stepdown and service continuity while ensuring culturally and linguistically appropriate services are available. Collectively, we have begun establishing a “priority allocation” of beds at cooperating PRTFs for youth in state custody and hope to expand this model to additional facilities.

OHA is actively seeking, reviewing, and consulting with PRTF providers from other states who are interested in opening new facilities in highest-need regions of Oregon.

OHA and Child Welfare's vision is to increase capacity through the development of smaller psychiatric residential facilities across the state. This approach ensures youth/young adults can be closer to their families and natural supports and creates equitable access for youth from communities of color and rural communities. OHA has begun creating state-level best practices to support and oversee this growth it essential to have strong networks of communication, collaboration, and oversight among PRTFs statewide.

Within the adult system, the initial Planning Grants investment of $5M from House Bill 5024 (2021) was disbursed to 104 CMHPs, Regional Health Equity Coalitions, Tribes, and other community organizations for conducting research to identify community needs, gaps, and barriers to services. The second iteration of this effort was to execute a contract for continued community engagement with the Planning Grant partners, and this effort has yielded rich and actionable information for improving OHA’s community engagement efforts aimed at increasing licensed residential and SUD treatment and housing for adults with the focus of prioritizing equitable access for adults needing culturally and linguistically diverse and responsive services and supports.

7. What alternatives were considered and what were the reasons for rejecting them?

The current system for disbursing funding to community organizations is informed by bureaucratic processes that are tailored for large organizations with the resources to effectively compete for funding, thus reducing funding access for culturally and linguistically diverse and smaller organizations. This approach has led to broken trust in communities and inadequate services for individuals needing culturally and linguistically diverse services and supports.

Additionally, oftentimes funding alone will not adequately meet the community need when it comes to capital development projects, in general, and especially for culturally and linguistically diverse, and developmentally responsive licensed residential and SUD treatment and housing for adults. Intentional community coordination and support will improve project completion success rates.

8. What other agencies, programs, community partners or stakeholders are collaborating on this policy package?

The Planning Grant Partner network, and the community at large are collaborating on this policy package. Additionally, OHA has been collaborating with external partners and people with lived experience to inform the development of this policy package.[4]

Moreover, OHA works closely and often with ODHS Child Welfare-Treatment Services in monitoring and striving to improve access to residential services for children with medical necessity. ODHS strongly supports this proposal for its potential to bring much-needed additional capacity to the continuum of care for youth and young adults in their custody.

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.

Not at this time.

[4] OHA and ODHS are no longer using the term “stakeholders” when referring to community partners, external partners, and people with lived experience, as this term has negative connotations for tribal communities and other historically marginalized populations.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Consultation with the nine federally recognized tribes of Oregon to determine a set aside amount of funding appropriated for capital development projects would be initiated. Proactive engagement with local government agencies would happen in an intentional way with invitations to contribute to the TSA/county level planning efforts.

11. Is this policy package being requested because of an Oregon Secretary of State or internal audit? If so, provide further information.

No, neither of the proposed expansion strategies are resulting from an audit.

Staffing and fiscal impact

Implementation date(s): July 1, 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

- Funding amounts to be designated for disbursement to community organizations for projects to increase capacity of culturally and linguistically diverse, and developmentally responsive licensed residential and SUD treatment and housing for adults, and PRTF for children. Funding disbursement will be aligned with the 5-year plan for increasing statewide capacity as outlined in the Residential+ Facility Study.
- Funding needs for youth residential expansion projects are based on recent project costs for new buildings or renovation of existing spaces, as well as program start-up. As construction costs

increase, capital projects continue to cost millions of dollars, in addition to staffing and soft costs for program expansion.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

This expansion of youth psychiatric facilities will substantively expand the responsibilities of the Child and Family Behavioral Health unit at OHA. These include significant additional coordination across multiple OHA units including Housing and Licensing as well as contract management and cross-agency liaising with ODHS-Child Welfare.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

By focusing on and prioritizing the increase of culturally and linguistically diverse capacity, diverse populations will have more equitable access to licensed residential and SUD treatment and housing for adults.

By expanding into new, additional PRTS facilities and supporting the start-up costs for those much-needed services to youth with high-level behavioral health care needs, we would be positively impacting current caseloads and services provided to this population. Additional services will relieve current pressure on existing providers to maximize and exceed their optimal milieu census, thus reducing wait times and creating quicker access for youth at risk of temporary lodging, and others. Furthermore, this expansion will extend access regionally to areas of our state where families are not currently able to get PRTF treatment locally, nearer to their home communities.

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.

N/A

16. What are the startup and one-time costs?

For the 2025-27 biennium, $10 million would allow for the purchase, renovation, and/or new construction of facilities to create new, expanded bed capacity for approximately 26 children's residential psychiatric service beds across Oregon. It would encompass one-time start-up costs to providers and added staff and dollars at OHA to ensure needed coordination with licensing, regional coordinated care organizations, and industry best practice oversight by OHA. This work includes oversight of the Secure Inpatient Programs for children and adolescents (alternative to State Hospital level of care).

For the 2025-27 biennium, $148 million would allow for the purchase, renovation, and/or new construction of capital development projects to create new, expanded licensed residential and SUD treatment and housing capacity for adults, along with two-months of startup costs.
Including the development of a local treatment facility that provides culturally and linguistically appropriate residential treatment and service for the Latine and Spanish speaking community within proximity to the Tri-county area. This facility would be staffed with qualified behavioral health providers who are bilingual, bicultural, and connected to other behavioral health ancillary services to meet the needs of a growing Spanish speaking population in the Tri-county area.

17. What are the ongoing costs?

Beginning in the 2027–29 biennium, $2 million in ongoing funding for subsequent building renovations needs, continued workforce development and supporting an active community of

practice among these residential providers throughout the state. These funds would be dedicated to bolstering the existing PRTF providers' ongoing abilities to maintain high quality care and protecting the state's investment in these programs.

The new OHA staff listed above.

18. What are the potential savings?

Fewer project withdrawals from community organizations would create significant savings in OHA staff time on multiple levels, as well as community organizations' staff time and planning. Assuming licensed residential and SUD residential treatment and housing beds cost less than beds at Oregon State Hospital and/or other hospital settings, increased capacity could generate savings overall in the long run. Furthermore, an increase in accessible residential and housing would correspond with a decrease in emergency department visits and need for acute care, thus reducing costs of such care.

19. What are the sources of funding and the funding split for each one?

All funding to expand capacity in both the youth and adult behavioral health systems is 100 percent General Fund.

The four positions in the Behavioral Health Division are priced at 85 percent General Fund and 15 percent Federal Funds, which is based on Oregon's approved CMS Statewide Allocation for Medicaid and CHIP.

The Government Relations Manager 2 position is in Central Services, which works on behalf of the entire agency and is priced using an agency-wide cost allocation plan to distribute costs to all

agency-wide available 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						
Services & Supplies						
Capital Outlay						
Special Payments	$100,000,000			$100,000,000		
Other						
Total	**$100,000,000**	**$0**	**$0**	**$100,000,000**	**0**	**0.00**

Fiscal impact by program

	BHD				Total
General Fund	$100,000,000				**$100,000,000**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	$100,000,000				**$100,000,000**
Positions	0				**0**
FTE	0.00				**0.00**

Oregon Health Authority
2025-27 Policy Package

Division:	Medicaid; Behavioral Health Division
Program:	Medicaid Behavioral Health: Medicaid Safety Net Policy
Policy package title:	CCBHC Expansion
Policy package number:	556
Related legislation:	House Bill 4002 (2024), House Bill 5204 (2024)

Summary statement:

This policy package implements House Bill 4002, which mandates OHA to secure federal approval via a State Plan Amendment (SPA) for CCBHC program funding before the current demonstration expires, ensuring strategic leveraging of federal financial support for statewide expansion. OHA plans to integrate fifteen additional clinics in 2026, expanding beyond the existing twelve to meet the statewide requirement. Funding for this POP is needed to provide services at these 15 new clinics and to establish two crucial staff positions essential for supporting statewide expansion by ensuring Medicaid compliance, optimizing payment models, developing policies, coordinating programs and fostering collaboration. Without the funding in this POP, OHA cannot fulfill its statutory obligations, ensure compliance with federal regulations, and expand access to vital behavioral health services statewide, which is critical for Oregon's comprehensive mental health care delivery.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$14,096,922**	**$0**	**$33,708,295**	**$47,805,217**	**2**	**1.50**

Purpose

1. What problem is OHA trying to fix or solve?

House Bill 4002 (2024) requires that prior to the expiration of the demonstration, OHA must seek federal approval through a State Plan Amendment (SPA) to receive federal financial participation in the cost of the Certified Community Behavioral Health Clinic (CCBHC) program. The SPA will require the CCBHC program to be statewide.

Oregonians experience multiple barriers to behavioral health services, due to a workforce shortage, a bifurcated system, and limited access to low-barrier treatment services within their community. In the evaluation of Oregon's CCBHC program, evaluators found that Oregon CCBHCs demonstrated a 4.9 percent increase in the number of individuals served and increases in the number of services per person. Clinic leaders attributed these increases to their ability to hire and retain more staff, greater flexibility in providing services "outside of the four walls," and greater flexibility in community outreach. These flexibilities are primarily the result of the prospective payment system (PPS) model that pays for the CCBHCs. The PPS model is a cost-based, clinic-specific rate paid per member per day, regardless of the number or type of services provided. The rate allows clinics to include both the direct and indirect costs of services, giving them greater flexibility in how services are provided. Because the rate is the same regardless of the number or type of services, it creates parity between mental health and substance use services and greater flexibility within backend billing practices to offer integrated care. It also allows clinics to cover transportation and liability costs more sustainably when providing services within the community, thereby increasing their ability to provide services where people are as opposed to solely within the physical location of the clinic. Lastly, the PPS model allows clinics to be creative in how they conduct community outreach. Clinics have been able to host community events and free services to community members as a result of the financial sustainability the PPS model creates.

Currently, Oregon has 12 CCBHCs covering 14 of 36 counties. Expanding the CCBHC model will allow more clinics to shift away from a fee-for-service payment model to the more flexible PPS model. This will allow more equitable distribution of resources to clinics in counties that currently do not have CCBHCs and increase services to Oregonians within those communities.

OHA anticipates integrating fifteen clinics across the state into the program (in addition to the twelve clinics currently part of the demonstration), eight clinics beginning in April 2026, and seven more in October 2026.

OHA has funds in its base budget to pay for services at established CCBHCs but lacks funding to pay for services provided by new clinics that come online in 2026. This POP would secure funding for CCBHC services at 15 new clinics. In addition, this POP would add two new staff positions that were not funded through House Bill 5204 (2024), both of which are needed to effectively implement House Bill 4002 and support statewide expansion.

Without this funding, the CCBHC program would be unable to grow and reach statewide status, as there is no alternative funding source for new clinics. This would render OHA incapable of meeting its statutory obligation to pursue a SPA and deny broader access to high-quality, integrated, holistic behavioral health care.

2. What would this policy package buy and how and when would it be implemented?

The policy package would fund services at future CCBHCs for the 2025-27 biennium and would be required on an ongoing basis. This package would also fund two new staff positions to provide crucial technical assistance for clinics to achieve CCBHC status successfully and support the

effective development and implementation of infrastructure necessary to sustain the program and ensure compliance with federal standards and reporting requirements.

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 address health inequities by significantly enhancing access to integrated behavioral health services. The addition of fifteen new clinics will enable the delivery of more comprehensive care, encompassing mental health, substance use, and primary care services. This expansion is particularly beneficial for groups experiencing disproportionate impact that often encounter barriers to health care access. The commitment of CCBHCs to serve individuals regardless of payment type or ability to pay supports broader efforts to diminish disparities in health care access. Specifically, CCBHCs bolster community-based services through provision of diverse services, including street outreach, school-based programs, home-based care, services within shelters, and therapists integrated into primary care and other community settings. Moreover, the program has demonstrated significant reductions in inpatient and emergency department visits among American Indian/Alaska Native and Black/African American service users, reflecting improved treatment outcomes for these groups as well as for Black adults and children and Latina and American Indian/Alaska Native children.

   Specifically, the 2023 Evaluation of the Oregon CCBHC program conducted by Oregon Health Sciences University-Portland State University (OHSU-PSU) School of Public Health found,

[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.

"Analysis of the Mental Health Statistics Improvement Program (MHSIP) data provides compelling evidence of improvements in access to behavioral health care across various perspectives. Specifically, rural adults and urban children and youth reported higher satisfaction levels with access to care, indicating that the service expansion has been successful in enhancing access for these groups. The data also revealed that Black/African American adult respondents reported the most significant improvements in their perception of access to care. This finding is especially noteworthy as this group has historically experienced, and continues to encounter, significant barriers in accessing health care due to systemic racism present in both the health care system and society at large."

Quantifying results

4. What are the long-term desired outcomes?

The long-term desired outcome is to transform health care delivery through integrating mental health, substance use, and primary care services and to improve health outcomes by providing timely and comprehensive care that prevents the worsening of behavioral health conditions and reduces reliance on emergency services and hospitalizations. In addition, expanding geographic coverage of CCBHCs across Oregon will reduce health care disparities among communities with insufficient resources and infrastructure and promote equitable access to critical services. In addition, because the CCBHC model allows providers to meet people where they are, outside of the four walls of the clinic, and requires care coordination with a broad range of providers and organizations serving the individual, they typically have greater reach within their communities compared to provider organizations operating under non-CCBHC models.

The expansion also focuses on systemic improvements in health care delivery through collaborative care models. By strengthening connections between CCBHCs, coordinated care organizations

(CCOs), primary care providers, and community services, the desired outcome is to deliver more coordinated and patient-centered care and achieve cost savings by reducing the burden on emergency care resources. This approach improves health outcomes and enhances patient satisfaction and overall efficiency in health care delivery statewide.

5. How will OHA measure the impacts on health inequities of this policy package?

To measure impacts on health inequities, OHA will track several key metrics related to Certified Community Behavioral Health Clinics (CCBHCs):

- **Number of clinics certified as CCBHCs statewide**: This metric provides an overview of the availability of CCBHCs across the state.
- **Number of CCBHCs in compliance with federal and state standards**: Monitoring compliance ensures that CCBHCs meet required quality and operational standards.
- **Hospitalization and ED Utilization:** Analyzing utilization data helps assess the impact CCBHCs have on utilization of higher levels of care.
- **Increased enrollment of individuals in CCBHCs**: Tracking enrollment numbers indicates the accessibility and utilization of CCBHC services by the community.
- **Demographic diversity of individuals enrolled in CCBHCs compared to the community**: Analyzing demographic data helps evaluate whether CCBHCs are effectively reaching and serving diverse populations within their communities.

Regarding data collection and metrics:

- **Reduction in emergency department visits and hospitalizations**: This metric requires collaboration with HPA (Health Policy Analytics) to establish how to effectively measure and track these outcomes.

- **Follow-up and all-cause readmission metrics**: These are already included in current data collection efforts.
- **Certification and compliance**: Monitored through licensing and certification processes.
- **Enrollment increases**: Tracked through caseload characteristics in metrics.
- **Comparison to community demographics**: Conducted through needs assessments, with consideration for adding demographic breakdowns if supported by the new data template.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

According to the 2023 Evaluation of the Oregon CCBHC program conducted by the OHSU-PSU School of Public Health,

> "The CCBHC program has increased access to behavioral health treatment for residents statewide (4.3%); this is proportionately higher in rural and remote areas (23.4% and 18.3%, respectively) where substance use disorder treatment services have substantially increased. Racial and ethnic diversity of service users also increased, primarily by Hispanic/Latino/a/x service users ... The prospective payment system (PPS) model enhanced service delivery "outside the four walls" of the CCBHC clinics, enabling CCBHCs to engage service users in non-clinic settings. CCBHCs have the potential to play a meaningful and central role in Oregon health systems reform and transformation ... Future CCBHC sustainability and expansion efforts need to build the capacity of CCBHCs to provide greater access, improve coordination of care, and center equity."

The Department of Administrative Services Legislative Fiscal Office directed OHA to pursue CCBHC program funding via a POP. In addition, OHA reviewed its budget and funding sources and determined there was no alternative financial mechanism for supporting direct payment of CCBHC

services for new clinics in the 2025-27 Biennium. Regarding the two new positions requested in this POP, OHA reviewed its current staffing resources and determined that existing resources cannot meet the staffing needs for CCBHC expansion.

7. What alternatives were considered and what were the reasons for rejecting them?

The only alternative to this POP would be to restrict the CCBHC program to the current 12 clinics, preventing OHA from meeting its statutory obligation to seek a state plan amendment and expand the program statewide. This would further inequities across Oregon because some communities would have CCBHCs, and others would not.

According to the evaluation of Oregon's CCBHC program conducted in 2022, CCBHCs demonstrated a 4.9% increase in number of individuals served between 2017 and 2021. Rural and remote communities saw the greatest increase in number of individuals served, with a 16.1% and 22.5% increase, respectively. In addition to serving more individuals, CCBHCs provided more mental health services and substance use services per person between 2017 and 2019. CCBHCs saw additional increases in mental health services per person between 2019 and 2021.

Populations with the greatest increase in access to services are individuals under 25, individuals over 65, women, and the Hispanic/Latino/a/x population. CCBHCs also demonstrated an increase in services provided within schools, homes, inpatient and residential treatment settings, shelters, and carceral settings. The flexibility to provide services "outside the four walls" allows CCBHCs to reach the most vulnerable populations where they are and provide more flexible, low-barrier treatment options.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   Acute care hospitals, Oregon State Hospital, SRTFs, Disabilities Rights Oregon, Oregon Law Center, System of Care Advisory Council, NAMI, ODHS, Providers

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?**

    Most clinics in the CCBHC demonstration program are community mental health programs (CMHPs), and we expect that CMHPs will continue to be a provider type that has strong interest in joining the program in the future. Therefore, the funding in this POP directly enables CMHPs across Oregon to pursue CCBHC status.

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): April 2026 for first eight clinics, October 2026 for another seven clinics

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

Two main assumptions impact the pricing of this policy package:

1. All future costs for expanding CCBHCs match present costs. This, in turn, is predicated on the assumption that the way clinics are financed and operated will not substantially change from the current state.
2. All 15 clinics will come online within the first year, and all 12 current clinics will remain online. OHA will work to expand as much as possible, but House Bill 4002 explicitly made participation in the CCBHC voluntary, which limits OHA's ability to control market entry.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

Other than establishing the two requested staff positions, this POP does not create additional impacts or responsibilities associated with the CCBHC program beyond those already expected from implementing of House Bill 4002.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Adding 15 additional clinics will increase the number of services and the number of individuals and families served.

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 establish two permanent, full-time positions for Medicaid as follows:

- **Research Analyst 3:** Review and analyze clinic data associated with Medicaid compliance, rate setting for Medicaid Fee for Service (FFS) and Coordinated Care Organization (CCO) populations, and coordinate with the MMIS business team to make appropriate system changes for appropriate payments to clinics. Based on clinical data and rate review, the position will also research appropriate payment models to maximize services and leverage Medicaid match for CCBHCs. The RA3 will also research, recommend, and implement ways to make the wraparound payment process for the CCO population more efficient and reduce risks of retroactive error correction in payments.

- **Operations and Policy Analyst 3**: Support Program & Policy Development for statewide infrastructure. The primary role of this Medicaid position will include supporting the CCBHC Program Administrator (OPA4) in BH in developing and implementing program development and policy changes to the federal CCBHC program via its State Plan Amendment. Lead one-off research/application on policy academies and initiative development within the CCBHC model/integration with Oregon initiatives like 988 and M110. Help foster relationships/develop applications for CCBHC expansion grantees who may later join the CCBHC State Plan Amendment. Support workload and coordination needed for new contract administration, rule changes, and steering/advisory committee recruitment/retention for the program of 30+ CCBHCs. Develop topics/supporting documents/agendas for the ongoing learning collaborative for all CCBHCs statewide; facilitate information sharing for clinics. Support the development of contract negotiations with CCO from a programmatic lens. This position is distinct from the current position, whose primary role is supporting the operations of CCBHC billing, such as cost

report review, support for rate setting, technical assistance on billing issues, support for MMIS for operationalizing billing requirements, and billing guidance and support for current and on-boarding clinics.

16. What are the start-up and one-time costs?

There is no specific allocation of funds for one-time or start-up costs. However, these costs may be factored into a CCBHC's PPS payments, funded through this POP.

17. What are the ongoing costs?

Two full-time, permanent staff positions in Medicaid; direct payments for CCBHC services via the PPS for the 2025-27 biennium, which will fluctuate based on daily service utilization.

18. What are the potential savings?

Oregon should see the greatest cost savings via reduced utilization of acute care, such as emergency department and inpatient hospital stays, based on historical CCBHC performance. For example, in the first four years of the demonstration program, emergency department use for mental health conditions declined by 11–14 percent, and inpatient hospitalizations for mental health conditions declined by 13–22 percent. There was also a statistically significant decline in emergency department and inpatient stays for physical health conditions.

19. What are the sources of funding and the funding split for each one?

This policy package includes General Fund and Medicaid Federal Funds. Positions are priced at 50 percent General Fund and 50 percent Federal Funds, which is the Medicaid administrative match

rate. The fund split for clinics/services was calculated using a weighted average match rate based on eligibility category.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$184,917	$0	$184,917	$369,834	2	1.50
Services & Supplies	$9,244	$0	$9,244	$18,488		
Capital Outlay						
Special Payments	$13,902,761	$0	$33,514,134	$47,416,895		
Other						
Total	**$14,096,922**	**$0**	**$33,708,295**	**$47,805,217**	**2**	**1.50**

Fiscal impact by program

	Medicaid				Total
General Fund	$14,096,922				**$14,096,922**
Other Funds	$0				**$0**
Federal Funds	$33,708,295				**$33,708,295**
Total Funds	**$47,805,217**				**$47,805,217**
Positions	2				**2**
FTE	1.50				**1.50**

Alcohol & Drug Policy Commission
2025-27 Policy Package

Division:	Budget is situated within the OHA Behavioral Health Division
Program:	Alcohol & Drug Policy Commission
Policy package title:	Alcohol & Drug Policy Commission Sustainability
Policy package number:	557
Related legislation:	HB 4002 (2024); HB 4098 (2022); HB 4137 (2018); HB 3353 (2009)

Summary statement:

The Alcohol and Drug Policy Commission (ADPC) aims to enhance the efficiency and effectiveness of substance use disorder (SUD) services in Oregon. Created in 2009, ADPC develops and implements a comprehensive addiction, prevention, treatment, and recovery plan for the state. This policy package would provide permanent funding for three positions within the ADPC, initially funded temporarily for a specific study in 2024. These positions are crucial for maintaining subject matter expertise, stakeholder communication, and research analysis. It also requests $225,000 for ongoing strategic plan contracts. Without these positions, ADPC will lack expertise and resources, impairing guidance on SUD practices, stakeholder communication, and data analysis. This can worsen health outcomes, increase disparities, and elevate the economic burden of SUDs in Oregon.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$750,181**	**$0**	**$92,682**	**$842,863**	**0**	**2.25**

Alcohol & Drug Policy Commission: 2025-27 Policy Package

Purpose

1. **What problem is OHA trying to fix or solve?**

   The Alcohol and Drug Policy Commission (ADPC) was created by the Legislative Assembly in 2009, via passage of House Bill 3353. The statutory charge of the ADPC is to improve the efficiency and effectiveness of substance use disorder services in Oregon. The ADPC develops, disseminates, and implements the comprehensive addiction, prevention, treatment and recovery plan for the state.

   In line with this charge, the ADPC must be appropriately staffed to study substance use-related issues, convene stakeholders and state agencies, and bring forth recommendations to the Governor and the Legislature. The requested positions are necessary to achieve the minimum statutory requirements for the ADPC. The 2024 legislature approved and funded the positions, but only for a limited duration related to a specific study directed by HB 4002 (2024).

2. **What would this policy package buy and how and when would it be implemented?**

   The POP would fund the three (3) permanent FTE allocated to the ADPC for a limited duration during the 2024 legislative session related to studies directed by House Bill 4002 (2024). If ADPC had been fully staffed before the 2024 session, the limited duration positions would not have been necessary. Studies such as those directed in HB 4002 are likely to become more frequent and are in line with the ADPC statutory role. Making the positions permanent will provide stability and sustainability to the ADPC to continue serving its advisory and oversight role with state agencies, the Governor and the legislature.

   Without these positions, the ADPC will be unable to provide necessary subject matter expertise on substance use disorder (SUD) treatment best practices; adequate communication with community

partners and policymakers on SUD trends, barriers and responses in the state; and adequate research analysis and data sharing to effectively track outcomes and indicators in alignment with the strategic plan.

The POP also requests the continuation of $225,000 in contract funding, which is one-half of the $450,000 allocated in the 2024 short session. This funding will allow the ADPC to continue contracting subject matter experts and consultants for the development and implementation of the 2026-2030 and beyond strategic plans.

Given the state's SUD prevalence, rates of overdose and other substance use-related deaths, the quickly evolving illicit drug market and health disparities related to substance use disorder, there is a high need for continued contracts to study emerging issues and treatments, evaluate best practices and make recommendations to the Governor, the legislature and state agencies.

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?**

   Reduced racial and ethnic disparities related to substance use disorder is one of the three main impacts of the ADPC Strategic Plan. Adequate staffing will support ADPC refined strategies in the 2026-30 strategic plan, implementation of those strategies, and tracking of outcomes, particularly outcomes related to health disparities. Without ongoing support of the positions, the ADPC will not have a dedicated Research Analyst to develop enhanced data across state agencies, a Public

[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.

Affairs Specialist to develop strategic communications to all communities and stakeholders, or an additional Policy Advisor to further develop strategies and move forward health equity outcomes.

Quantifying results

4. What are the long-term desired outcomes?

The long-term outcomes of the ADPC work are to reduce the prevalence of SUDs in Oregon, reduce deaths related to SUDs, and reduce health disparities related to SUDs. Progress toward these outcomes will also reduce the economic burden to the state resulting from SUDs.

5. How will OHA measure the impacts on health inequities of this policy package?

The ADPC tracks a number of health equity measures over time to measure our progress as a state. For instance, if ADPC strategies are implemented, we would expect racial and ethnic disparities in deaths related to overdose to decrease over time.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

The ADPC unsuccessfully advocated for permanent positions during the 2024 legislative session.

7. What alternatives were considered and what were the reasons for rejecting them?

None.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   The ADPC Commissioners support the package. The additional positions will support all of the ADPC participating state agencies.

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 would affect the ADPC 14 participating state agencies by supporting collaboration, reducing duplication and increasing efficiency, and moving forward a cohesive strategy on SUDs across 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): July 1, 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

Assumptions include that the Governor and state agencies, including OHA, will continue to prioritize the need for a comprehensive strategy for SUD services. Oregon continues to experience increasing rates of overdose and overall high numbers for SUDs. Overdose death rates for America Indian/Alaska Native and Black Oregonians continue to increase. Oregon also experiences one of the highest prevalence rates of SUDs in the country.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

No. The positions will already be hired and receiving shared services support.

14. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

N/A.

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 POP would modify three limited duration positions by making them permanent:

- 1 Research Analyst 4 (RA4): The purpose of this position is to play both lead and support roles in various ADPC data-related projects. These projects include a cross-agency substance use disorder data assessment, research and recommendations for substance use disorder outcome and performance measures as they relate to policy and strategy, and the creation and facilitation of a committee of data analysts from ADPC participating state agencies aimed at improving efficiency and effectiveness of substance use services. This position will work

closely and collaboratively with another Alcohol and Drug Policy Research Analyst within the OHA Public Health Division and will collaborate with senior policy and communications staff at the ADPC.

- 1 Public Affairs Specialist (Public Affairs Specialist 3 (PA3)) responsible for developing the ADPC long-term communications and stakeholder engagement strategy. The ADPC develops and publishes a 5 year comprehensive plan, along with progress reports to the Legislature, Governor and public in July of each even-numbered year. The ADPC also holds monthly public meetings of the Commission and its 5 committees. The position is responsible for developing a strategy to engage policymakers and the public in the work of the ADPC as well as best practice strategies for substance use disorder (SUD) services, as well as reducing stigma and addressing health disparities. A key component to breaking down siloes between state agencies, local governments and SUD service providers will continue to be communicating on best practice research, emerging trends, available funding and community education and engagement to reduce stigma and address health disparities.
- 1 Senior Policy Advisor (OPA4) to serve as a subject matter expert and policy and implementation lead for SUD treatment and recovery services related to the ADPC and the state strategic plan and all related studies and implementation strategies directed by the legislature and Governor. This requires expertise in relating state policies to quality clinical outcomes. This Senior Policy Advisor is currently leading the ADPC study and strategic plan development on opioid use disorder treatment access directed by HB 4002 (2024). The need for a subject matter expert in treating an ever-evolving illicit drug supply will remain an essential component of the ADPC team through the next five year strategic plan and beyond. It is also expected that the ADPC will move forward with standardized definitions and standard pathways for treatment across all state agencies. This work cannot be accomplished without this position.

16. What are the start-up and one-time costs?

None.

17. What are the ongoing costs?

$806,244 ongoing GF, $908,818 TF. This includes the ongoing costs of staff and ongoing contract needs anticipated for ADPC's statutorily required strategic plans and bi-annual progress reports.

18. What are the potential savings?

There are potential savings across state agencies through the avoidance of duplication and implementation of strategies that will maximize federal funding.

19. What are the sources of funding and the funding split for each one?

The total request is for $908,818. Of the total request, 89 percent is General Fund and 11% is Medicaid Federal Funds.

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$525,181	$0	$92,682	$617,863	0	2.25
Services & Supplies	$225,000	$0	$0	$225,000		
Capital Outlay						
Special Payments						
Other						
Total	**$750,181**	**$0**	**$102,574**	**$842,863**	**0**	**2.25**

Alcohol & Drug Policy Commission: 2025-27 Policy Package

Fiscal impact by program

	Behavioral Health – A&D Policy Commission				**Total**
General Fund	$750,181				**$750,181**
Other Funds	$0				**$0**
Federal Funds	$102,574				**$102,574**
Total Funds	**$842,863**				**$842,863**
Positions	0				**0**
FTE	2.25				**2.25**

System of Care Advisory Council
2025-27 Policy Package

Division:	Budget is situated within the OHA Behavioral Health Division
Program:	System of Care Advisory Council
Policy package title:	Strengthening the System of Care Advisory Council
Policy package number:	559
Related legislation:	SB 1 (2019), SB 4 (2021), HB 2992 (2021), SB 968 (2023)

Summary statement:

OHA aims to strengthen the System of Care Advisory Council (SOCAC) to address gaps in support for children with complex needs across various state systems, such as juvenile justice, child welfare, and health services. Established by Senate Bill 1 in 2019, SOCAC is a 25-member council tasked with improving state and local youth service systems through centralized policy development and planning. SOCAC focuses on enhancing service coordination, promoting culturally competent practices, and ensuring equitable access to services for youth. The council collaborates with state agencies, evaluates system effectiveness, and recommends improvements. To support SOCAC's legislative mandates, the policy package proposes sustained staff support for SOCAC's operations. Implementation is set to begin on July 1, 2025, with recruitment and onboarding processes for the new position commencing thereafter.

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Policy package pricing:	**$571,098**	**$0**	**$0**	**$571,098**	**3**	**2.25**

Oregon Health Authority: 2025-27 Policy Package

Purpose

1. What problem is OHA trying to fix or solve?

In January 2018, the Children and Youth with Specialized Needs work group was formed by the Governor, the President of the Senate, and the Chief Justice of the Supreme Court, to address unique challenges faced by children with distinctive mental or behavioral health needs who come to the attention of different systems (such as the juvenile justice system, the child welfare system, or the health system). The recommendations from this work group included the formation of a statewide system of care advisory council empowered to incentivize, change, and address gaps in current state systems meant to support children and youth with complex needs.

As a result, Senate Bill 1 was passed during the 2019 legislative session, establishing a 25-member System of Care Advisory Council (SOCAC) to improve state and local systems that serve youth by centralizing statewide policy development and planning. The council consists of 25 members appointed as follows:

- The Chief Justice of the Supreme Court shall appoint one representative from the Judicial Department.
- The Governor shall appoint:
    - Two members who are representatives of the Department of Human Services with extensive knowledge of systems of care, one of whom must have direct experience with intellectual and developmental disabilities programs.
    - One member who is a representative of the Oregon Youth Authority with extensive knowledge of systems of care.
    - One member who is a representative of the Oregon Health Authority with extensive knowledge of systems of care.

- One member who is a representative of the Department of Education.
- Two members who are representatives of coordinated care organizations meeting the criteria adopted by the Oregon Health Authority under ORS 414.625, at least one of which must provide services to rural communities.
- One psychiatrist, one psychologist and one pediatric physician, each of whom must have clinical experience with youth.
- One member who is a representative of an entity that offers commercial insurance.
- Three members who are representatives of agencies that provide different services and supports to youth and families of youth.
- One member who is a representative of organizations that advocate for youth.
- One member who is a representative of organizations that advocate for families of youth.
- Two members of the public, each of whom are family members of:
  - Persons with intellectual or developmental disabilities or mental illness; or
  - Persons who are currently or were previously in the foster care system or the youth criminal justice system.
- Two members of the public who are no more than 25 years of age and who:
  - Are persons with intellectual or developmental disabilities or mental illness;
  - Are currently or were previously a ward, youth or youth offender, as those terms are defined in ORS 419A.004.
- One member who is a county juvenile department director.
- One member who is a county mental health program director.
- One member who is a member of a federally recognized Indian tribe in this state or a designee of the Indian tribe.
- One member who is a representative of Oregon's federally mandated disability protection and advocacy agency.

SOCAC plays a critical role in enhancing the efficiency and effectiveness of state and local youth service systems in Oregon. At the core of its mission is the development and upkeep of a comprehensive, long-term plan aimed at coordinating services across various sectors including public health, child welfare, education, juvenile justice, mental and behavioral health, and support for individuals with intellectual or developmental disabilities. SOCAC is primarily responsible for formulating policies that address the capacity, utilization, and types of services available, integrating services like in-home behavioral health and crisis intervention into existing programs to ensure seamless service delivery.

Additionally, SOCAC conducts assessments to evaluate the effectiveness of current systems and identifies areas where coverage may be lacking. It places a strong emphasis on promoting culturally competent practices, ensuring that services are accessible and responsive to the diverse needs of youth and families across different backgrounds. Collaborating closely with state agencies such as the Oregon Health Authority, Oregon Youth Authority, and Oregon Department of Human Services, SOCAC oversees service implementation, provides oversight, and recommends improvements to enhance overall system effectiveness. Through joint studies, legislative recommendations, biennial plan updates, and the maintenance of a comprehensive data dashboard, SOCAC remains committed to achieving equitable access to high-quality care for all youth in Oregon, aiming to reduce barriers to service implementation and support their well-being comprehensively.

OHA is directed to provide staff support to SOCAC. The legislature approved funding for two positions (1.50 FTE) to support SOCAC during the 2019-2021 biennium, as well as two positions (2.0 FTE) during the 2021-2023 biennium. Senate Bill 4 (2021) created a permanent Executive Director (BOA1) position for SOCAC. Currently, SOCAC is staffed by one permanent position

(OPA4), one Limited Duration position (AS2), and one non-budgeted Limited Duration position (OPA3).

SOCAC was created to ensure appropriate access to services and supports for youth with high acuity needs in Oregon. A large part of this mandate requires agencies to partner across what have traditionally been siloes – funding, policies, program guidelines all exist at each agency or division without regard to how the people who are using these systems navigate through systems. SOCAC facilitates improved communication and collaboration between agency partners, to reduce barriers to care and improve efficiency. SOCAC also brings the voices of people with experience navigating our complex systems directly into conversation with system managers. This allows the people who best understand our system challenges, our clients, to take leadership in solving these challenges, in equal partnership with executive branch agency partners.

2. What would this policy package buy and how and when would it be implemented?

The policy package would buy permanent staff support for SOCAC. The policy package would purchase two permanent positions to replace the two current Limited Duration positions (OPA3 and AS2). These roles are necessary for SOCAC to meet various legislative mandates. This policy package includes funding for a new permanent position focused on public affairs (PA2). Providing ongoing, stable funding for these positions will enable SOCAC to meet legislative requirements without burning out staff members or resorting to contracts which are time consuming to create and manage. Beginning July 1, 2025, the limited duration positions would be converted to permanent positions, and recruitment, hiring, and onboarding of a public affairs position would commence.

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?

Equity work demands that those who have been impacted by disparities, racism, and systemic barriers are involved in the conversation. This policy package will significantly benefit populations impacted by health inequities by ensuring that voices of people with lived experience are integral to system improvement efforts. The current AS2 position at SOCAC is crucial in connecting equity strategies to these individuals, ensuring that youth and families who have experienced Child Welfare, Juvenile Justice, Medicaid Behavioral Health Services, Intellectual and Development Disability supports, and educational interventions are meaningfully engaged. Without sustained engagement from these individuals, crafting a system that truly meets their needs is impossible. The current AS2 and OPA3 work diligently to build relationships with people with lived experience advisors, provide them with necessary information and technology, ensure timely stipend payments as mandated by HB 2992 (2021), and facilitate supportive services such as American Sign Language or Spanish interpretation. This ensures that every interested person with lived experience can join and contribute meaningfully to the discussions.

Historically, the lack of sustainable funding for these positions has perpetuated a dynamic where equity is prioritized rhetorically but not financially. By committing to sustainably fund the OPA3 and AS2 positions, SOCAC aims to break this cycle and demonstrate a genuine commitment to equity. This funding will ensure that people with lived experience, particularly those from historically oppressed populations, can build trust with SOCAC staff and engage meaningfully in the system

[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.

change efforts. This will enhance SOCAC's ability to address and eliminate health inequities in Oregon by creating a system that is truly responsive to the needs of all its users. The involvement of people with lived experience will ensure that the services and supports developed are culturally responsive, accessible, and effective, thereby promoting equitable health outcomes across the state.

Quantifying results

4. What are the long-term desired outcomes?

The long-term desired outcomes of this policy package are stability in staffing for these two critical positions for building and maintaining relationships with people with lived experience, and increasing the number and amount of stipends being paid quarterly to people with lived experience by 25%. This will lead to stronger engagement of people with lived experience, which will result in better planning and improved structural changes so our state-funded systems better meet the needs of those who have the hardest time getting the supports and services they're entitled to.

5. How will OHA measure the impacts on health inequities of this policy package?

SOCAC will measure the impact of this funding in the following ways:

- Maintain both staff positions with the same employees;
- Document and monitor the number and dollar amount of stipends being paid quarterly to people with lived experience;
- Surveying people with lived experience to determine how engaged they feel, how well the stipends process is working for them, and how welcome they feel in various public meetings to share their lived expertise.

How achieved

6. What actions have occurred to resolve the issue prior to requesting a policy package?

In 2022, SOCAC hired a limited duration OPA1 to do some of this work. The candidate pool was very limited due to candidates seeking long-term/permanent roles rather than the Limited Duration position SOCAC was able to recruit for. The candidate selected to fill this role was not meeting performance requirements, but they remained in the role due to the risk of losing the position all together if the employee were to be terminated. When the Limited Duration OPA1 position expired, the position description for that work was reclassified to a Limited Duration AS2 and us currently funded through General Fund dollars.

SOCAC is also using General Funds for a Limited Duration Youth & Family Engagement Coordinator (OPA3). These funds will be redirected to investing in improving local or regional systems of care once permanent funding can be acquired for the current position.

To meet other staffing needs, SOCAC has tried ‘borrowing’ staff from partner agencies for specific projects. This approach has been challenging due to the existing demanding workload of the additional staff, and this has caused conflict and stress for both the borrowed staff as well as the team they left behind.

7. What alternatives were considered and what were the reasons for rejecting them?

SOCAC members considered continuing with the two funded positions and rejected that idea because they firmly believe the people closest to the problem are the ones who best know the solution. SOCAC members firmly believe people with lived experience are entitled to be fairly compensated for their work on the Council in the same way employees of agencies and partners

who participate in councils and commissions. SOCAC is not able to manage the volume of work with two staff, even if members were willing to forgo their values and do all the work without the wisdom and context provided by partners who have lived expertise.

SOCAC also tried to use contracts to address workload challenges. However, DOJ recently informed SOCAC that it does not have legal authority to enter into contracts, so OHA must enter into any contracts on behalf of SOCAC. This is time-consuming, confusing for contractors, and could lead to legal challenges if there is a disagreement between the contractor, SOCAC, and/or OHA about whether the deliverables were met, funds were paid out, or other common contracting conflicts. This strategy does not improve SOCAC's bandwidth or help meet legislative mandates. Instead, this approach directs the SOCAC Executive Director's time into contract procurement with OHA, DOJ, and the potential contractor, which is time that could have gone to meeting SOCAC's legislative requirements.

8. **What other agencies, programs, community partners or stakeholders are collaborating on this policy package?**

   SOCAC's DEI Committee, Youth Council, Legislative Committee, CCO-employed local System of Care Coordinators.

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. SOCAC's Legislative Concept 429 relating to the System of Care Advisory Council includes authority to enter into contracts as an entity and adds four additional membership appointments (two for youth with lived experience and two for family members) to bring better balance to the voices on the Council.

10. What other state, tribal, and/or local government agencies would be affected by this policy package? How would they be affected?

Every child-serving state agency (DELC, ODHS-CW, ODHS-ODDS, ODHS-VocRehab, Youth Development Division, ODE, OHA-BH, OHA-Medicaid, OYA, county juvenile departments, etc.) have an opportunity to benefit from the work these two positions complete. The people with lived experience that engage with SOCAC receive extensive training on advocacy and are well-supported to engage with systems change. The positive impact on all these systems will be enhanced by permanently funding these two positions.

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, 2025

End date (if applicable): Ongoing

12. What assumptions affect the pricing of this policy package?

It is assumed that SOCAC will continue to have legislative mandates and requirements moving forward. It is assumed that people with lived experience will continue to show interest in participating in policy change.

13. Will there be new responsibilities for OHA and/or Shared Services? Specify which programs and describe their new responsibilities.

- One new permanent FTE Public Affairs PA3

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.

- One permanent FTE AS2.
- One permanent FTE OPA3: Youth & Family Engagement Strategist.
- One permanent FTE PA3.

16. What are the start-up and one-time costs?

There are no costs outside the position funding.

17. What are the ongoing costs?

This POP will result in ongoing CSL funding for four total SOCAC employees. Ongoing costs for the two positions we're requesting at this time will be $571,098 per biennium, with cost of living or other bargained increases leading to adjustments in that rate over time.

18. What are the potential savings?

SOCAC will not have to hire underqualified candidates due to an inability to offer permanent roles. That reduces turnover and improves productivity, saving the state money. SOCAC also won't have time lost to recruitment, hiring, onboarding, or termination of underperforming staff, saving the state funds expended on underperforming employees. Funding this POP ensures SOCAC meets legislative requirements regarding HB 2992.

19. What are the sources of funding and the funding split for each one?

General Fund 100%

Total for this policy package

	General Fund	Other Funds	Federal Funds	Total Funds	Pos.	FTE
Personal Services	$543,366	$0	$0	**$543,366**	3	2.25
Services & Supplies	$27,732	$0	$0	**$27,732**		
Capital Outlay						
Special Payments						
Other						
Total	**$571,098**	**$0**	**$0**	**$571,098**	**3**	**2.25**

Fiscal impact by program

	Behavioral Health - SOCAC				**Total**
General Fund	$571,098				**$571,098**
Other Funds	$0				**$0**
Federal Funds	$0				**$0**
Total Funds	**$571,098**				**$571,098**
Positions	3				**3**
FTE	2.25				**2.25**

Oregon State Hospital Capital Improvement

Expenditures by fund type, positions and full-time equivalents

Capital Improvements	General Fund	Other Funds	Federal Funds	Total Funds	Positions	FTE
Leg. Approved 2023-25	$0.82	$2.22	$0.00	$3.04	0	0.00
Gov. Budget 2025-27	$0.85	$0.85	$0.00	$1.71	0	0.00
Difference	$0.03	-$1.36	$0.00	-$1.33	0	0.00
Percent	4%	-62%	0%	-44%	0%	0%

Overview

The Oregon State Hospital's Governor's Budget includes one capital construction project for the 2025-2027 biennium. The policy option package is for OSH Facility Conservation and Development, made up by two components: Capital Improvement and Equipment Replacement.

The Salem campus of the Oregon State Hospital consists of 1.2M sq. ft. of buildings and interior secure perimeter court yards, and 23 cottages with a current replacement value (CRV) as reported to the Capital Advisory Board (CPAB) of $495M. This makes the Oregon State Hospital among the highest replacement value of any single facility owned by the state. The Junction City campus is 229,816 sq. ft. with a current CRV of $180M. The Pendleton Cottages facility consists of several older buildings with a total of 39,390 sq. ft. and a current replacement value of $10M. OSH is at a crossroads where its facilities have reached an age where a robust long-term investment strategy is needed to ensure that it can effectively meet OHA's strategic plan to support all Oregonians in need of mental health treatment. This policy option package provides the support OSH needs in the interim to ensure business continuity, and to reduce long term escalation in capital outlay as building systems are added to the deferred maintenance backlog.

Oregon State Hospital Capital Improvement

Project Costs and purpose

The costs described below are for the 2025-27 biennium. This project funding includes investments that help support the Oregon State Hospital's current operations and some facility infrastructure needs. The objective is to ensure that all Oregon State Hospital facilities can meet programming needs, promote a safe and healthy workplace, are functional, are nimble to accommodate programming changes, and resilient during emergency declarations (e.g., climate change, wildfires, power outages, etc.). OSH campuses in Salem and Junction City have a considerable volume of equipment at or near the end of their useful lifecycle that are at a point of replacement; equipment that supports the critical 24/7 level of care to patients needing intensive psychiatric treatment for severe, acute, and persistent mental illness.

This OSH policy option package is expected to cost an estimated total of $9.3 million in the 2025-27 biennium, which includes approximately $7,463,000 of bond-funded project costs. Additional costs of $232,000 for bond issuance, and $1,638,669 for debt servicing in shall be paid in 2025-27. Debt service payments will extend into the 2035-37 biennium and will be funded with General Fund.

Capital Improvement investments fund high priority infrastructure projects determined critical to hospital operations. Major requests with this package include workspace expansion to accommodate an additional 32 staff in the existing Vocational Services area, adding a water connection to Salem Campus, replacing the roofing on cottages at the Salem Campus, adding sewage storage tanks, and a public address system for communication throughout the hospital.

OSH strives to achieve the highest standards and outcomes in all aspects of our work. Good stewardship of the public dollar includes maintaining the facility to the highest standards and making regulatory and infrastructure improvements to meet the needs to patients and staff. All the issues are infrastructure needs and are critical to providing patient care and ensuring the health and safety of patients, staff, and the public.

Oregon State Hospital Capital Improvement

The **Equipment Replacement** component of this policy option package will replace an outdated nurse call system, as well as pharmacy carousels and facilities maintenance assets. Ensuring patient and staff safety is paramount. The pharmacy carousels and facilities assets within the POP request are near their expiration or otherwise damaged or worn beyond repair. OSH Pharmacies require medication carousels that are due for replacement and are losing vendor support in 2025. Replacing Pharmacy equipment is vital to supporting efficient and safe provision of medications to individuals that require medication for psychiatric stability and critical to the recovery process and timely due process. This policy package will maintain and enhance the environment of care and overall hospital operations, while ensuring stable operations for the patients OSH serves.

Oregon State Hospital Capital Construction/Acquisition

As of the publishing of the Oregon Health Authority 2025-27 Governor's Budget document, there are no major construction or acquisition projects planned; however, there are multiple capital improvement projects included in the required 2% CRV facilities investments, as per ORS 291.215As the agency moves through the budget development process, more projects may arise in this area. If that occurs, a project report will be included in the applicable budget document.

Article XI-Q Bond Financing and Other Financing Request Form

Capital Acquisition, Construction or Improvement of Real Property, Equipment or IT Systems

Please return the completed Request Form by **May 17, 2024** to:

Rhonda Nelson, Capital Finance Manager
E-mail to Rhonda.Nelson@das.oregon.gov
Department of Administrative Services, Chief Financial Office
350 Winter St NE; Salem, OR 97301

If you have any questions, please call Rhonda Nelson at (971) 719-1998.

Agency:	Oregon Health Authority
Contact Person:	Karen Jamieson
Phone:	503-947-2676
E-mail:	Karen.M.Jamieson@oha.oregon.gov

Form Requirements: Use this form to request acquisition, construction or improvement of real property, equipment or IT systems that your agency is asking to finance using Article XI-Q Bonds or Leases (only leases that function as a vehicle to borrow money) over the next biennium beginning July 1, 2025. Article XI-Q bonds are limited to costs of a project that can be capitalized to the asset being financed (see OAM 15.60.10 and 15.60.40), with a few exceptions; thus, other non-capital and unallowed* capital costs of a project will need to be funded with other sources. The capital assets financed with XI-Q Bonds must be owned or operated by the State**. Financing agreements are defined in ORS 283.085(3) and include any agreement to finance real or personal property that is or will be owned and operated by the State. This includes lease purchase agreements and similar financing arrangements. Do not list leases on this form if the lease does not function as a vehicle to borrow money.

Acquisition, Construction or Improvement of Real Property, Equipment or IT Systems							
Description of Property/Equipment/ System Project	**Owned or Operated by the State (if operated, who owns?)**	**Estimated Useful Life of Capital Asset**	**Total Estimated Cost of Project**	**Amount Requested to be Financed in 2025-27[1]**	**XI-Q Bonds or Lease Financing**	**Date Financing Needed (list separate rows for different dates)[2]**	**Debt Service Funding Source**

Air handler returns - Junction City - equipment needed to properly address air quality in the event of environmental outside air concerns (such as forest fires).	Owned by the State	15	900,000	900,000	XI-Q Bonds	October 2025	GF
Addition of second floor - Salem - infill space within Vocational Services area to add second floor, creating 2,700 square feet of office space and approximately 32 additional work spaces.	Owned by the State	25(+)	1,775,000	1,775,000	XI-Q Bonds	October 2025	GF
Public Address system - Salem - install a separate PA system separate from the current fire panel-zoned system to assist with response and increase efficiency.	Owned by the State	10	1,700,000	1,700,000	XI-Q Bonds	October 2025	GF
Sewage Grinders - Salem - an essential component of the sewage system that is beyond useful life.	Owned by the State	10	168,000	168,000	XI-Q Bonds	October 2025	GF
Trash compactors with cart lifts - Salem - Equipment at end of useful life and necessary for hospital environmental control.	Owned by the State	10	282,000	282,000	XI-Q Bonds	October 2025	GF
Kubota full cab utility vehicles - Salem and Junction City - vehicles at end of useful life, utilized for a variety of functions around the campus including hauling and maintenance.	Owned by the State	10	375,000	375,000	XI-Q Bonds	October 2025	GF

Carousels for Pharmacy - Salem and Junction City - equipment used in conjunction with dispensing cabinets, purchased last biennium, to dispense medication. Equipment is beyond useful life and no longer vendor supported. Non-capital amounts have been removed from the total expense for this bond request.	Owned by the State	10	1,408,800	1,363,000	XI-Q Bonds	October 2025	GF
Cottage Roofs - Salem - replace the roofs on 10 of 18 Salem cottages.	Owned by the State	25	500,000	500,000	XI-Q Bonds	October 2025	GF
Cottage Roofs - Salem - replace the roofs on the remaining 8 of 18 Salem cottages.	Owned by the State	25	400,000	400,000	XI-Q Bonds	May 2026	GF
Totals			7,508,800	7,463,000			

Notes:

***Un-allowed XI-Q bond costs:**

a. Related Party Costs (costs paid from one State Agency to another and does not represent out-of-pocket costs to an unrelated third party).

b. Pollution Remediation and Demolition Costs (except when it is required to complete the project and is not the entire project; discuss with Capital Finance Analyst).

c. Indirect or Administrative Costs that are not directly related to a capital project or a series of capital projects.

Note: See Section 2.1.2 of the "Agency Guide to Financing Capital Projects with Article XI-Q Bonds" for more information on un-allowed uses.

**Capital assets funded with tax-exempt bonds cannot have more than 10% Private Business Use, where all or a portion of the asset is used by a private person or entity other than a state or local government unit, including the federal government, a for-profit or non-profit organization, or individuals acting in a trade or business.

[2] Sale dates for Article XI-Q Bonds are for budgeting purposes only, and are subject to change.

Facilities Summary Report

2025-27 Biennium

Facility Plan - Facilities Planning Narrative 107bf02a
2025-27 Biennium

Agency Name | **Oregon Health Authority (OHA) | Oregon State Hospital (OSH)**

1. What are the key drivers for your agency's facility needs, and how do you measure space/facility demand?

• The Oregon State Hospital is subject to standards determined by the Centers for Medicaid and Medicare Services (CMS) and reviewed and accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

• In addition to applying best management practices and standards for the maintenance/repair/replacement of buildings and equipment, the hospital is required to meet more stringent facilities requirements as determined by the CMS and JCAHO governing bodies.

• The occupancy of the hospital is primarily determined by the judicial system. Periodic legislative changes will impact the types and quantities of patients to be admitted to OSH. Depending on the changes in law, this can drive an increase or decrease to the facility demand, partially determined by the level of care required for new patient admissions and the associated adaptation of existing hospital space.

• Occupancy requirements and needs are dynamic. The measurement of space is completed through monitoring of legislative and regulatory requirements, with associated increases or decreases to staffing dependent on shifting requirements and the needs of the patients.

2. What are the key facility-related challenges over the next 10-years? (Please answer in order of priority)

• Increase demand in patient services.
• Above average use/wear of building systems due to the 24/7 operations schedule and hospital operations environment.
• Keeping up with the demand for hospital services programming.
• Deferred maintenance: the replacement of building systems and equipment that have met their useful life.
• Responding to regulatory changes requiring facility improvements.
• The need for the development of a long-term strategic planning framework.
• Emergency management and resiliency planning.

3. What do you need to meet these challenges?
• Completing a statewide building assessment of all OSH facilities; including Salem, Junction City, and Pendleton.
• Introducing a software platform (TRIRIGA or equal) to provide long-term strategic capital planning data.
• Updating the Oregon State Hospital Area Plan (125-125-0350).
• Completing a master plan for the Oregon State Hospital facility (including the cottages).

Capital Improvements Project Narrative

Agency: 443	OHA - Oregon State Hospital	Priority (Agency #):	1	Schedule	
Project Name:	OSH Facility Conservation and Development	Cost Estimate	Cost Est.Date	Start Date	Est. Completion
		$ 9,333,669		TBD	TBD
Address/Location:	Salem, Pendleton and Junction City campuses of OSH	GSF	# Stories	Land Use/Zoning Satisfied	
				Y	N

Funding Source(s): Show the distribution of dollars by funding source for the full project cost.	General Fund	Lottery	Other	Federal
	$ -	$ -	$ 9,333,669	

Description of Agency Business/Master Plan and Project Purpose/Problem to be Corrected

The hospital has identified an administrative and program staff space shortage requiring movement of staff and programs to the cottages on campus. As this movement has not alievated the problem, OSH has identified future space needs for staff.

The total cost of $9,333,669 is comprised of $7,463,000 in project costs, $232,000 in issuance costs, and debt servicing costs of $1,638,669

Project Scope and Alternatives Considered

OSH is at a crossroads where its facilities have reached an age where a robust long-term investment strategy is needed to ensure that it can effectively meet OHA's strategic plan to support all Oregonians in need of mental health treatment. This policy option package provides the support OSH needs in the interim to ensure business continuity, and to reduce long term escalation in capital outlay as building systems are added to the deferred maintenance backlog.

This investment is part of an over-arching long-term strategic facilities investment plan to ensure that OSH's strategic plan can be realized and managed in perpetuity, especially as its facilities and site systems are aging. The investments that are submitted via this policy package are one part of a multi part planning effort to ensure that all of OSH's facilities are mission ready and to ensure uninterrupted business continuity.

This long-term capital planning objective is to adopt a facilities portfolio management system that will provide a dynamic facilities condition index as a measuring metric to support informed decision making as investments in minor, major, capital improvement, and capital construction projects load continuously increase, and to ensure business continuity and adaptability needs are supported.

The maintenance projections that are created by the Facilities Program are based on a tracked metric called the Facility Condition Index (FCI). The FCI is a standard facility management benchmark that is used to objectively assess the current and projected condition of a building asset and provide a means for comparisons of facility or building conditions, as well as allowing for renewal funding needs and comparisons. The FCI is the ratio of current year required renewal cost to current building replacement value, or in other words, a calculated measure of facility condition relative to its current replacement value expressed as a percentage. Based on this index, a structure's condition can be ranked as Good (0-5% FCI), Fair (5-10%), Poor (>10%) or Very Poor (>60%). An FCI of 60% or greater usually indicates that the structure should be replaced rather than renewed.

The fundamental drivers of this plan include:
- Effective long-range capital planning for maximizing the use and value of our facilities via a consistent 10-year planning vision.
- Being good stewards of our investments: this is where public investments are properly maintained to ensure occupant safety, being nimble as programming needs change or evolve, and the reduction of long-term operating costs.

• Designing for quality: good building design contributes to higher employee productivity and adaptability and enhanced public service.
• Right sizing our portfolio: sustainability and resiliency being very high priorities, and meeting agencies programming needs.
• Conveying our identity: ensuring that our buildings have an image of accessibility and responsiveness (in-short, how adaptable are our buildings to program changes).
• Emphasizing resiliency: ensuring that buildings are prepared to withstand catastrophic events – both natural (earthquake) and man-made (climate change which could affect HVAC loads, snow loads, etc.).
• Applying best practices when maintaining and planning for new facilities: for example, utilizing Master Planning to help facilitate the long-term need when planning for larger capital improvement and capital construction projects.
• Facility investment tool: effective investment strategy that leverages matching dollars.

OSH is committed to comply with regulatory requirements and achieve good stewardship of state assets to provide a safe and therapeutic environment of care to Oregon's most vulnerable populations.

It's important to note that the investments requested in this policy package reflect less than the required biennial investment ask of 2% of OHA/OSH's portfolio CRV as per ORS 291.215. OSH will be implementing a long-term capital planning effort that will provide the necessary data to support a plan that will reduce future unplanned maintenance costs, support operational sustainability, and continued compliance with regulatory requirements; all while being good stewards of state assets and to provide a safe and therapeutic environment of care to some of Oregon's most vulnerable, as well as a safe and conducive work environment where the patients and staff can thrive.

ESTIMATED PROJECT COST

DIRECT CONSTRUCTION COSTS

		$	% Project Cost	$/GSF
1	Building Cost Estimate	$ 9,333,669		
2	Site Cost Estimate (20 Ft beyond building footprint)			
3	**TOTAL DIRECT CONSTRUCTION COSTS**	$ 9,333,669	100%	$ -

INDIRECT CONSTRUCTION COSTS

4	Owner Equipment / Furnishings / Special Systems			
5	Construction Related Permits & Fees			
6	Other Indirect Construction Costs Including 1% Art, 1.5% Renewable Energy and other state or unique regulatory requirements not in hard costs			
7	Architectural, Engineering Consultants			
8	Other Design and PM Costs	$ -		
9	**TOTAL INDIRECT COSTS**	$ -	$ -	$ -
10	**OWNER'S PROJECT CONTINGENCY** insert %			

	$	% Project Cost	$/GSF
TOTAL PROJECT COST	$ 9,333,669	100%	$ -

Capital Financing Six-Year Forecast Summary 2025-27

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2025-27 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	General Obligation Bonds	Revenue Bonds	Totals by Repayment Source	
	Bond Type			
Major Construction / Acquisition Projects				
General Fund Repayment	$ -	$ -	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment	4,580,000		4,580,000	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ 4,580,000	$ -	$ 4,580,000	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$ -	$ -	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$ 940,801	$ -	$ 940,801	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ 940,801	$ -	$ 940,801	
Total All Debt Issuance				
General Fund Repayment	$ 940,801	$ -	$ 940,801	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	4,580,000	-	4,580,000	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2025-27	$ 5,520,801	$ -	$ 5,520,801	

Capital Financing Six-Year Forecast Summary 2027-29

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2027-29 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$ 1,665,283	$	$ 1,665,283	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ 1,665,283	$ -	$ 1,665,283	
Total All Debt Issuance				
General Fund Repayment	$ 1,665,283	$ -	$ 1,665,283	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2027-29	$ 1,665,283	$ -	$ 1,665,283	

Capital Financing Six-Year Forecast Summary 2029-31

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2029-31 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

Use of Bond Proceeds	Bond Type: General Obligation Bonds	Bond Type: Revenue Bonds	Totals by Repayment Source	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF

Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Equipment/Technology	$ -	$ -	$ -	
Debt Issuance for Loans and Grants				
General Fund Repayment	$ 1,670,488	$	$ 1,670,488	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Loans and Grants	$ 1,670,488	$ -	$ 1,670,488	
Total All Debt Issuance				
General Fund Repayment	$ 1,670,488	$ -	$ 1,670,488	GF
Lottery Funds Repayment	-	-	-	LF
Other Funds Repayment	-	-	-	OF
Federal Funds Repayment	-	-	-	FF
Grand Total 2029-31	$ 1,670,488	$ -	$ 1,670,488	

Capital Financing Six-Year Forecast Summary 2031-33

Agency: OHA - Oregon State Hospital

Agency #: 443

Provide amounts of agency financing needs for the 2031-33 biennium, by expected use and repayment source. Include proposed project amounts only (do not include debt service from either previously issued debt or from new debt issuance).

	Bond Type			
Use of Bond Proceeds	**General Obligation Bonds**	**Revenue Bonds**	**Totals by Repayment Source**	
Major Construction / Acquisition Projects				
General Fund Repayment	$	$	$ -	GF
Lottery Funds Repayment			-	LF
Other Funds Repayment			-	OF
Federal Funds Repayment			-	FF
Total for Major Construction	$ -	$ -	$ -	
Equipment/Technology Projects over $500,000				

General Fund Repayment	$		$		$	- GF
Lottery Funds Repayment						- LF
Other Funds Repayment						- OF
Federal Funds Repayment						- FF
Total for Equipment/Technology	$	-	$	-	$	-
Debt Issuance for Loans and Grants						
General Fund Repayment	$	998,245	$		$	998,245 GF
Lottery Funds Repayment						- LF
Other Funds Repayment						- OF
Federal Funds Repayment						- FF
Total for Loans and Grants	$	998,245	$	-	$	998,245
Total All Debt Issuance						
General Fund Repayment	$	998,245	$	-	$	998,245 GF
Lottery Funds Repayment		-		-		- LF
Other Funds Repayment		-		-		- OF
Federal Funds Repayment		-		-		- FF
Grand Total 2031-33	$	998,245	$	-	$	998,245

Major Construction/Acquisition 10-Year Plan, Lease Plans, Disposals

2025-27 Biennium

Agency Name: OHA - Oregon State Hospital

Proposed New Construction or Acquisition - *Complete for 5 Biennia*

Biennium	Priority	Concept/Project Name	Description	GSF	Position Count	General Fund	Other Funds	Lottery Funds	Federal Funds	Estimated Cost/Total Funds
2025-27	1	OSH Facility Conservation and Development	**Salem Construction of 2nd Floor Office Space**	959,378	2215		1,775,000			1,775,000
2025-27	2	OSH Facility Conservation and Development	**Salem Public Address System**	959,378	2215		1,700,000			1,700,000
2027-29										-
2029-31										-
2031-33										-
2033-35										-
										-
										-

Proposed Lease Changes over 10,000 RSF - *Complete for 5 Biennia*

Biennium		Location	Description/Use	Term in Years	Total RSF[2] +/- (added or eliminated)	USF[3]	Position Count[1]	Biennial $ Rent/RSF[2]	Biennial $ O&M[4]/RSF[2] not included in base rent payment	Total Cost / Biennium
					A	B	C	D	E	(D+E)*A
2025-27										-
2027-29										-
2029-31										-
2031-33										-
2033-35										-

Planned Disposal of Owned Facility

Biennium		Facility Name	Description

Definitions:

Position Count: **1** Total Legislatively Approved Budget (LAB) Position Count assigned to (home location) each building or lease as applicable.

RSF **2** Rentable SF per BOMA definition. The total usable area plus a pro-rated allocation of the floor and building common areas within a building.

USF **3** Usable Square Feet per BOMA definition for office/administrative uses. Area of a floor occupiable by a tenant where personnel or furniture are normally housed plus building amenity areas that are convertible to occupant area and not required by code or for the operations of a building. If not known, estimate the percentage.

O&M **4** Total Operations and Maintenance Costs for facilities including all maintenance, utilities and janitorial.

Facilities Maintenance

Key drivers of facility needs and measuring demand

Oregon State Hospital is subject to standards set by the Centers for Medicaid and Medicare Services (CMS) and reviewed and accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In addition to standard repair and maintenance of buildings and equipment, the hospital may be required to meet more stringent facilities requirements as determined by those governing bodies. These will be related to patient and staff safety, such as anti-ligature efforts.

The occupancy of the hospital is primarily determined by the judicial system. Periodic legislative changes impact the types and number of patients admitted to OSH. Depending on the changes in law, this can drive an increase or decrease to the facility demand, partially determined by the level of care required for new patient admissions and the associated adaptation of existing hospital space. Space requirements are therefore fluid. The measurement of space is done through monitoring of legislative and regulatory requirements, with associated increases or decreases to staffing dependent on shifting requirements and the needs of the patients.

Challenges over next 10 years

- OSH facilities have a considerable number of building systems and equipment that is at or near the end of their useful lifecycle. Equipment and systems that support the critical 24/7 level of care to patients needing intensive psychiatric treatment for severe, acute, and persistent mental illness.
- Capital construction and capital improvement investment needs to ensure efficient and resilient hospital operations and sustainable performance.
- Responding to ongoing regulatory and legislative changes requiring consistent facility improvements, modifications, upgrades, and expansion investments.
- Increased space occupancy needs inside and outside of the secured perimeter, across all campuses and all programs.
- Ensuring that a 5- and 10-year building system and equipment replacement schedule is maintained.
- Adequate budget and funding for the replacement of equipment and buildings systems in advance of equipment failure or breakdown.

What is needed to meet challenges

- Adequate biennial operating and maintenance budget to effectively manage daily operational needs.
- Ongoing support for long-term budgetary funding that is adequate to meet capital improvement, and capital construction investment needs.
- Funding to ensure that all security access and camera technology system software and hardware is updated and supported.
- Funding to ensure that all building management systems (BMS) and direct digital control (DDC) system hardware and software are updated and supported.
- Collaboration with DAS to implement a robust building management software platform that will allow OSH to accurately reflect its Facilities Condition Index (FCI) and support long-range strategic capital planning.

Facilities Summary Report

2025-27 Biennium

Agency Name: **Oregon Health Authority (OHA) | Oregon State Hospital (OSH)**

	FY 2024 DATA			
Owned Facilities Over $1 million				
Number of Facilities	16			
Current Replacement Value $ (CRV)	$ 671,246,077	Source	Risk	Risk or FCA
Gross Square Feet (GSF)	*1,169,217*			
Usable Square Feet (USF)	*675,451*	*Estimate/Actual*	*73*	% USF/GSF
Occupants Position Count (PC)	1751	**USF/PC**		
Owned Facilities Under $1 million				
Number of Facilities	28			
CRV	$ 13,940,516			
GSF	59,367			
Leased Facilities				
Total Rentable SF	0			
Biennual Lease Cost	0			
Additional Costs for Lease Properties (O&M)	0			
Usable Square Feet (USF)	-	*Estimate/Actual*		% RSF/GSF
Occupants Position Count (PC)	0	**USF/PC**		

Definitions

CRV Current Replacement Value Reported to Risk ***or Calculated Replacment Value Reported from Facility Conditions Assessment (FCA)***

RSF Rentable SF per BOMA definition. The total usable area plus a pro-rated allocation of the floor and building common areas within a building.

USF Usable Square Feet per BOMA definition. Area of a floor occupiable by a tenant where personnel or furniture are normally housed plus building amenity areas that are convertible to occupant area and not required by code or for the operations of a building.
If not known, estimate precentage.

PC Legislatively Approved Budget (LAB) Position Count

O&M Total Operations and Maintenance Costs for facilities including all maintenence, utilities and janatorial.

Facilities Operations and Maintenance and Deferred Maintenance

2025-27 Biennium

Agency Name:	**Oregon Health Authority / Oregon State Hospital**

Facilities Operations and Maintenance (O&M) Budget	**2021-23 Actual**	**2023-25 LAB**	**2025-27 Budgeted**	**2027-29 Projected**
Personal Services (PS) Operations and Maintenance	$ 13,873,021	$ 14,940,668	$ 17,725,956	$ 18,396,219
Services and Supplies (S&S) Operations and Maintenance	$ 4,219,919	$ 3,695,019	$ 3,850,210	$ 4,011,919
Utilities not included in PS and S&S above	$ 3,708,322	$ 4,008,255	$ 4,176,602	$ 4,352,019
Total O&M	$ 21,801,262	$ 22,643,942	$ 25,752,768	$ 26,760,157
O&M $/SF	18.65	19.37	22.03	22.89
Personal Service (Utilties & Janitorial)	$ 13,568,556	$ 13,196,713	$ 15,230,785	$ 15,806,699
Services & Supplies (Utilties & Janitorial)	$ 4,764,083	$ 5,899,590	$ 6,147,373	$ 6,405,563
O&M $/GSF (Utilities & Janitorial)	$ 18,332,639	$ 19,096,303	$ 21,378,158	$ 22,212,262

	General Fund	**Lottery Fund**	**Other Funds**	**Federal Funds**
O&M Estimated Fund Split %	95.1%		1.6%	3.3%

Short and Long Term Deferred Maintenance Plan for Facilities Value Over $1M	**Current Value (2023)**	**Ten Year Projection**	**2025-27 Budgeted**	**2027-29 Projected**
Priorities 1-3 - Currently, Potentially and Not Yet Critical	$ 17,326,312	$ 15,355,356	$ 8,225,000	13424922
priority 4 - Seismic & Natural Hazard	$ -	0	0	0
Priority 5 - Moderization	$ -	0	0	0
Total Priority Need	$ 17,326,312.00	$ 15,355,356.00	$ 8,225,000.00	$ 13,424,922.00
Facility Condition Index (Need/CRV)				

Assets Over $1M CRV	$ 671,246,077

Process/Software for routine maintenance (O&M)	zLink Maintenance and Work Order Software
Process/Software for deferred maintenance/renewal	zLink Maintenance and Work Order Software
Process for funding facilities maintenance	Contained within the Oregon State Hospital Budget

Oregon Health Authority
AUDIT RESPONSE REPORT

1. 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 audit's 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)*

1. *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)*
2. *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.

2. 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.

Data connections are still being investigated to get more timely information connected to the OHA data environment to limit this issue. Dependencies on claims data leads to a large time lag allowing these types of claims to process.

- 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.

No cost-effective solution for more timely data exists in the current environment. Discussions with Health Analytics to develop report or shift to Program Integrity. The revised due date is June 30, 2025.

3. 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 medical loss ratio (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.

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.*

4. OHA: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program Has yet to Be Determined, audit #2023-03 (dated January 2023)

- We recommend the agency publish a plan by September 2023 for how the M110 program integrates into the overall behavioral health system in Oregon.

  OHA agrees that the behavioral health system in Oregon needs a comprehensive strategic plan that incorporates Measure 110. As new leaders join the agency, OHA will develop a strategic behavioral health action plan, which the agency will evolve and regularly adjust over time based on community engagement, ongoing data collection and funding available to address program priorities. OHA will issue the first iteration of this strategic priority framework (which will include M110) by September 30, 2023.

- We recommend the agency identify and document gaps that prevent detailed metrics from being implemented that would track the overall effectiveness and impact of M110. • Develop and communicate a plan for addressing the gaps to appropriate stakeholders. Emphasis should be placed on developing metrics that allow policy makers and the public to effectively assess the impact and effectiveness of the M110 program.

  OHA acknowledges that continued data collection is necessary to accurately measure the effectiveness of M110. Since the inception of M110, there have been barriers to adequate data collection due to changes to the behavioral health reporting system (MOTS) and challenges at the Partner level (e.g. experience level, capacity) that have hindered ideal data collection efforts.

In 2023, a state-level health records system, coined Resilience Outcomes Analysis and Data Submission (or ROADS), is expected to replace MOTS and allow all Providers to report client-level data on M110-related services. ROADS will have the capacity to store requirements specific to those outlined in SB755; BHRN Partners will be able to submit the client-level data necessary to evaluate the outcomes of M110. In addition to the creation of ROADS, OHA is nearing completion of a Behavioral Health Data Warehouse (BHDW) that will allow analysts to connect client-level information across reporting systems. This will ultimately create a system that connects information on Class E Violations and dismissals, access to treatment services, demographics, and outcomes at the client-level. Client level data on M110 services will allow OHA analysts to better determine metrics such as rates of screening waivers and subsequent treatment plan initiation and completion across different geographic and demographic categories. OHA acknowledges that many BHRN Partners are new to health care and reporting systems. To avoid over-burdening the Partners, and in accordance with the suggested removal of unnecessary burdens on behavioral health providers as described in HB5202, OHA and the OAC approved a Phased Data Work Plan for 2022-2023. The Work Plan requires aggregated data submission from all BHRN Partners, regardless of some organizations' capability to submit additional data. This will allow OHA to view trends and outcomes on an aggregate level and allows the BHRNs to submit data requirements at the same frequency. In addition to the Work Plan, OHA is currently monitoring M110-related data in other statewide reporting systems. This includes drug-related death and hospitalization data from the Center of Health Statistics, Medicaid claims data on SUD diagnoses and treatment services, and poison control data. Because these systems have historical data prior to M110 implementation, they can provide baseline information for evaluating the effect of M110 statewide. While the ultimate responsibility to ensure this happens falls to the M110 program, the actions needed will require a cross-agency collaboration between the Health Systems Division and Health Policy & Analytics to ensure effective implementation.

- We recommend the agency document policies and procedures for the M110 program, including:
    - Clear expectations, roles, and responsibilities; and,
    - Trainings for grant applicants and evaluators, grants management, stipends, and conflicts of interest.

a) The M110 program has documented policies and procedures for program interaction with the Oversight and Accountability Council, BHRN Grant administration processes, chapter 944 rulemaking/changing process in collaboration with the OAC. These policies and procedures include the roles and responsibilities for the involved parties. Currently the policies and procedures are up to date and will continue to be reviewed annually and revised as needed.

b) Trainings:

- *Grant applicant and evaluator: Once the OAC determines the next BHRN funding model, The M110 Program will create a webinar training for grant applicants and a training for grant evaluators. Grant applicant and evaluator training will be provided for the next request for grant applications (RFGA), which begins in 2025.*
- *Grant administration: The M110 program currently utilizes the DAS contract administration training as well as M110 contract administrator orientation focused on all foundational aspects of M110. The program will continue to utilize these avenues of training grant administrators. Once the OAC determines the process for the next funding cycle, OHA will assist the OAC by making recommendations for the next evaluation process. Due to the current grant expirations, this should be completed by December 31, 2024, for the next grant cycle.*
- *Stipends: Currently, OAC members are trained on claiming stipends on an individual, as needed basis. The M110 program is currently developing a training to be delivered to the entire council once a year. We expect to have this training developed and available for the council to add to their agenda by June 2023. The OAC will then determine if and when to complete the training.*

- *Conflicts of Interest: The M110 program has and will continue to provide the Oregon Government Ethics Training by the office of the Oregon Government Ethics Commission (OGEC). M110 will also continue to collect conflict of interest declarations from council members in writing and before council votes on funding decisions. OHA does not have the authority to limit the involvement of OAC members based on their declared or perceived conflicts of interest. The M110 team collaborated with the OGEC this year to create an ethics training more tailored to the unique position of the OAC, which was delivered on September 8, 2023.*

- OHA should recommend to the OAC to expand collaboration with:
  - The Department of Corrections to address substance use disorders of adults in custody;
  - Housing stakeholders such as Oregon Housing and Community Services and the Oregon Interagency Council on Homelessness to leverage expertise specifically on the intersection of housing and substance use disorder;
  - Opioid Settlement Prevention, Treatment and Recovery.

OHA will offer contacts within these various organizations to the OAC. If the OAC chooses to collaborate with any of the entities, OHA will offer to further assist in facilitating those discussions. Thank you for the opportunity to collaborate. We are excited about the value the M110 Program has and will continue to add to the lives of those living in Oregon.

5. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2022, audit #2023-21 (dated July 2023).

- Recommend management strengthen internal controls to ensure leased asset, lease liability, and accumulated amortization is appropriately valued and ensure all leases meeting the criteria of GASB 87 are recorded. We also recommend management strengthen internal controls to ensure expenditures and offsetting other financing sources related to leases are recorded to the appropriate governmental funds.

The Office of Financial Services (OFS) has reviewed and corrected all initial lease entries within the GASB87 software as per the audit findings. OFS has also created a new D23 fund per guidance to record entries in the appropriate financing source. OFS will create detailed GASB87 procedures to follow to ensure accurate reporting in the future years.

- Recommend management ensure accounting entries are complete, accurate, and made in accordance with accounting standards. Additionally, management should develop and implement a process to modify year-end entries if expected adjustments do not occur within expected timeframes.

  The Office of Financial Services Statewide Financial Reporting (SFR) Unit will engage more closely with staff providing year-end system transaction details to ensure all elements of the data are accounted for are still anticipated to be completed by September 30. Specific to this finding, SFR has also adjusted the year end process for the cash accrual to avoid missing transactions affecting cash. Additionally, written processes are being updated with greater details.

- Recommend department management ensure controls are properly designed and implemented to record only allowable expenditures to the appropriate federal programs.

  The identified expenditures were initially charged to the MHBG in error, and when the error was found by OHA staff, the funding source was corrected to SAPT for the authorized $8.1 million prior to the SOS audit beginning. There was still $2.3 million remaining coded to MHBG which after extensive review and leadership decision, has now been re-coded appropriately. OHA's existing internal controls identified this issue initially, no additional corrective action is needed.

- Recommend department management ensure controls are properly designed and implemented to record only allowable expenditures to the MHBG. We further recommend department management seek SAMHSA approval for minor alterations and renovations.

OHA intended to have an interagency agreement with ODHS to co-fund an improvement to a much-needed treatment facility for children. OHA submitted the payment per our agreement with the vendor with the expectation that ODHS would fund the non-SAMHSA allowable expenses. The vendor used the funds for minor safety related renovations as one would expect them to prioritize before programmatic costs. But unfortunately, the ODHS payment was never made to OHA which prevented any additional funds from being sent to the vendor. Then, pandemic constraints along with a lack of funding prevented the vendor from being able to finalize their plan in the initial time frame. OHA sought a legal review, and the recommendation was made to cleave the contract from ODHS and allow the vendor additional time to finish their work. Upon cleaving the contract, the elements that OHA knows to be unallowable for SAMHSA funding were left in the contract because the contractor had already performed the work. OHA is awaiting a final review of expenditure reports and will request SAMHSA approval if warranted or adjust funding codes as needed to align with SAMHSA allowable charges.

In August 2022, when SAMHSA questioned these expenditures, OFS moved the entirety of the expenditures to general funds while OHA awaited SAMHSA's formal determination. In September 2023, SAMHSA formally notified OHA that the expenditures were not an allowable expense for the mental health block grant (MHBG). OHA did not draw down MHBG funds for these expenditures and, therefore, did not have to pay these dollars back.

- Recommend department management ensure recipients of federal funds are appropriately identified as subrecipients or contractors and the corresponding disbursement of federal funds are appropriately reported as direct or pass-through expenditures. We further recommend department 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 according to risk assessment results.

The Contracts unit has now fully implemented a series of checkpoints to ensure Contract Administrators complete a Subrecipient Determination for all actions with federal funding. The survey, using Smartsheet, generates a determination document that clearly shows Contractor or Subrecipient. All results of Subrecipient then require a Grantee Risk Self-Assessment to be completed by the potential recipient. When that assessment is completed, the system auto-generates the Monitoring Plan based upon the Subrecipient Risk. All actions are processed through DocuSign CLM and the Contracts unit will not process any requests that do not have one or all three documents, depending on the determination. When the requests are submitted for Management review, the documents must be attached to the request or it will be rejected. The next initiatives, to reach 100% compliance, is to use functionality of CLM to require attaching the documents. Requests will not be processed if not attached. We are also developing a specialized training program on Subrecipient Determination that should be available in WorkDay in Spring of 2025.

- Recommend department management implement controls to ensure applicable expenditures are adequately tracked and calculations applicable to the maintenance of effort requirements are consistently performed across fiscal years. We further recommend department management work with the federal awarding agency to submit corrected maintenance of effort totals to ensure appropriateness of future maintenance of effort determinations.

  There were inconsistencies in how Maintenance of Effort (MOE) has been calculated. The applicable expenditures were not consistently or accurately calculated in each state fiscal year. The use of Marijuana paid expenses were not consistently used for both Mental Health and Substance Abuse Block Grant. We have met with SAMHSA MHBG State Project Office (SPO) for clarification on how Marijuana funds can be utilized in the calculation for the MOE. We have received guidance and clarification. We have recalculated MOE for the Block grants for SFY2022, SFY2021, and SFY2020. We also completed a written desk procedure to ensure applicable expenditures are adequately tracked and calculated to the maintenance of effort requirements and are consistently performed.

- Recommend department management resume FFATA reporting as soon as feasible and ensure all necessary subawards are reported. We further recommend department management implement controls to ensure all subawards are appropriately tracked and reported.

  On April 4, 2022, the federal government made a switch in the identifying information required for a subrecipient, changing from the previously used DUNS to a newly assigned Unique Entity Identifier (UEI). ODHS/OHA was not made aware of the upcoming federal switch until late March 2022. OHA's Office of Contracts & Procurement (OC&P) is working directly with Program Contract Administrator's to request the missing UEIs. As the data comes in from Program it is being validated for accuracy and updated in the appropriate systems, so when all missing UEIs from a given FAIN's report month are collected, all NTE changes can be made immediately. OC&P is confident all FFATA reporting related to this audit will be submitted by November 30, 2023.

- Recommend management ensure controls over the draw process are designed and implemented to review and identify calculation errors.

  This was a criteria filter error in the accountant's data query as developed in the transition from one query tool to another. This criteria filter has been corrected and the data query is now operating correctly. The referenced grant is currently in balance, revenue is balanced to expenditures. The reconciliation, which would have identified this anomaly, was delayed for this quarter. In the future, a full reconciliation to the general ledger system of record will occur quarterly to ensure this is not repeated.

- Recommend department management comply with subrecipient monitoring requirements by implementing and documenting a procedure that evaluates each subrecipient's risk of noncompliance for the purpose of determining and performing the appropriate monitoring for each subrecipient. We also recommend department management implement procedures to ensure federal subrecipient versus contractor determinations result in accurate reporting on the SEFA.

Contracts and program staff have piloted and implemented tools to help administrators determine if the NFP is a contractor or sub-recipient using the determination checklist. Department managers have communicated expectations related to the use of this tool and guidance to ensure that contract administrators understand how to determine if an agency is a contractor or sub-recipient. If determination identifies a subrecipient relationship, controls are in place to ensure the Federal Funding Accountability and Transparency Act (FFATA) form, self-assessment, and monitoring plan are completed. Further, mental health block grant planners will assess each new or amended contract for appropriate designation. OHA management plans to establish a single training for all staff to complete before developing a contract. This training will also include necessary messaging to all staff about terminology, location of resources, expectations as an administrator, and compliance/verification processes. OHA will provide this messaging and training through agency-wide emails, newsletters, and all staff meetings. OHA will continue refining its onboarding to incorporate these trainings and messaging. Additionally, the Office of Financial Services reviews each contract to determine the correct coding for each contracted service/deliverable and accurate code, such in State Financial Management Accounting (SFMA) system. Risk assessment survey has been developed that allows for self-assessment and documentation of the process. Administrators are requested to keep a copy of the assessment in their administrative file. Contract administrators create regularly scheduled meetings with the sub-awardee to monitor for compliance, depending on the risk of the sub-awardee. OHA-HSD has created a planning and implementation document to systematically identify the process of self-assessment and monitoring plan. In addition to the 11-module contract administration training required for all administrators. OHA plans to create an accessible folder for download to include the Contract Administration Plan (CAP), RACI Matrix, Monitoring, and closeout activities. Once all of the resources are socialized throughout the Program and Leadership staff, controls are still necessary to get as close to 100% compliance by the administrators. Controls that will be implemented are: · DocuSign CLM- During the automated workflow for approvals, administrators must verify that the determination document and, if applicable, the self-assessment and monitoring plan is attached. If not, the request will be rejected until the proper documentation is provided. BHD began working with OSU to create trainings that will be offered in WorkDay for all contract administrators to take.

- Recommend department management implement internal controls to ensure performance progress reports are complete and accurate prior to report submission.

  To ensure performance progress reports are complete and accurate prior to report submission, the department will review current internal controls and plans to implement revised or new controls. The current process steps we are reviewing include:

  - *Sending the completed report via email to the program manager requesting they review the report for completeness and accuracy.*
  - *Documenting approval via email confirmation that the report is complete and accurate prior to submission to federal funders.*

  There is a need to revisit the internal control of having only managers designated to review the federal performance progress reports; we plan to discuss having the following individuals designated to conduct this review: principal investigator, grant coordinator, active partner, or manager.

  The authority met in December 2023 to discuss how to refine the current process of reviewing reports. Further meetings and conversations have been on hold due to the split of HSD and need to build out behavioral health and Medicaid separately. The authority will resume meetings by December 2024 to further refine the process.

- Recommend department management correct the entries and reimburse excess cash drawn to the federal agency for unallowable costs. We also recommend department management revise the review procedures to verify that the same expenditure transactions are not duplicated in multiple batches.

  Corrective action plan:

  - *The agency has reviewed the questioned costs and has corrected the entries with BTCL7084 and reimbursed the federal programs.*

- *The department has regular processes to review for duplicate adjusting entries. However, this process was missed for this entry.*
- *Department management will work with department staff to reinforce their understanding of the need to follow these processes to ensure transactions are not adjusted more than once*

- Recommend management implement procedures to ensure that all employee payroll submissions are properly reviewed, and payroll is appropriately charged to the correct cost center or program.

  The Oregon Immunization Program (OIP) section manager immediately notified all supervisory managers and administrative support staff of the finding on June 5th. Finding: "As part of our testing of program expenditures, we found that 3 of 134 timesheets were not reviewed by a manager prior to release into the payroll system." Supervisory managers were reminded that it is an expectation of their position to ensure that payroll time entries are thoroughly reviewed, and discrepancies resolved, and final entries approve according to agency requirements – on time, every month.

  On June 5th, program administrative staff and the section manager began development of an internal standard operating procedure (SOP) that will thoroughly document the steps the program requires of supervisory managers to assure that all employee payroll submissions are properly reviewed and payroll is appropriately charged to the correct cost center or program. The final SOP will be signed by each supervisory manager in the program, and included in a quarterly Performance, Accountability and Feedback (PAF) session between each supervisory manager and the section manager.

- Recommend management correct the accounting error and ensure the expenditures are charged to the correct programs. We also recommend the department determine if there are additional questioned costs relating to the advanced cash draw as the federal programs have different timing for federal reimbursements.

  Corrective action plan:

- *Adjust the two identified payments charged to the grant in error*
- *Adjust the erroneous charges to the Federal Emergency Management Agency (FEMA) grant*
- *Complete internal audit of expenditures and adjust any non-grant compliant expenditures out of this grant prior to federal financial reporting and close-out.*

- Recommend management ensure wireless device charges are properly reviewed, and expenditures are charged to the correct cost center or program. We also recommend management implement procedures to ensure all employee payroll submissions are reviewed and approved by program management.

  The questioned costs related to cell phone charges appear to have resulted from a lack of formal process in the Coronavirus Response and Recovery Unit. This unit has closed and departments have returned to standardized formal processes.

  Corrective action plan:

  - *Prior to "COVID-19" processes and procedures will be followed*
  - *Administrative staff will parse cell phone charges and code invoices according to employee payroll*
  - *Approving manager will review coding for accuracy prior to approval*

- Recommend department management maintain the necessary internal controls to ensure the monthly financial reports are accurate and agree to the accounting records.

  Our financial reporting accuracy had been remedied for all historical and current reports by March 2023. Unfortunately, these improvements were not in place by June 30, 2022, and, for that reason, a finding was noted.

  Corrective action plan:

  - *All monthly financial reporting has been assigned to our Fiscal Analyst*

- *The Fiscal Analyst submits monthly financial reports and the query used to generate the reports to the Office of Financial Services (OFS) for review and approval*
- *The Fiscal Analyst revises monthly financial reports based on OFS feedback*
- *Following OFS approval, monthly financial reports are entered into CAMP by an ELC administrative staff member and verified by a second team member*

- Recommend department and authority management strengthen controls over the OR-PTC system to ensure transactions are adequately supported and reviewed.

  Regional Readiness Coordinators (RRCs) provide training, reinforce best practices, review business processes, and provide feedback on issues we are seeing to reduce incidences of human error. The department will also continue to review and research authorizations for Mileage and Time entries that do not align with existing claims to determine where additional RRC support is needed.

  Several system enhancements and changes slated for June 2023 are intended to help providers claim time accurately and reduce local office workload associated with reviewing pending entries. This will not fully resolve the issues noted by SOS, however, implementation of phase 2A of the Provider Time Capture (PTC) System, which is scheduled to go into production July 12, 2024, will eliminate the need for local offices to manually enter mileage or hours into the mainframe payment systems and will automatically flag discrepancies between OR PTC DCI and the Mainframe.

  The PTC Team initiated a series of Webinar and Learning lab in October of 2023. These will continue through November, December and January with topics that are intended to reinforce best practices and are reflective of issues that have been received or reviewed by PTC where authorizations or entries do not align with existing claims. The October webinar also contained an overview of the upcoming changes to the system "Phase 2A" in July 2024. This is on schedule and the first of 2 system updates that will create interfaces between the PTC-DCI system and the mainframe, automate payroll batch entry and eliminated the manual data entry, ideally reduce

errors. In preparation of this, PTC has found great value in using the Regional Readiness Coaches (RRC's) in local offices and is expanding the recruitment of these positions in December to assist with UAT, change management and more training.

- Recommend department and authority management strengthen controls over review to ensure transactions are adequately supported and reviewed. Additionally, we recommend the authority reimburse the federal agency for unallowable costs.

  ODHS Facilities Management Response for Finding #1: The Office of Facilities Management (OFM) is committed to providing accurate coding for payments. Communications have been made with staff responsible for coding invoices and the need to conduct thorough reviews to ensure coding is accurate and charged to the appropriate funding source for the goods or services the agency is being invoiced for. OFM will be communicating with the programs that provide coding to confirm that the information provided appropriately aligns with the intended use of the funds. The department will review current processes and forms to ensure there is sufficient detail to verify accuracy. Questioned costs of $1,361 in Federal Funds (and $2,722 in Total Funds) paid with invoice number VP815455, was corrected on 4/26/2023 with document BTCL1412.

  ODHS, Aging and People with Disabilities (APD) Response for Finding #2: The department is committed to storing and retaining supporting documentation for all authorized payments. The processes and procedures on contract bidding and approval associated with payment authorization for 1915k services and support are being reviewed and improvements such as central repositories are being explored. Once analysis and improvements are complete, they will be documented and communicated to staff within the department and to the Office of Financial Services for awareness. Additionally, as part of succession plan development, the department will create intentional opportunities for knowledge transfer, shared document storage, and increased transparency amongst work teams, which will assist with document location in the context of unexpected personnel changes.

  The department will reimburse the federal agency for any unallowable costs.

- Recommend authority management reimburse the federal agency for unallowable costs.

  As indicated in the report and as of January 1, 2020, authority management updated the MMIS data tables to ensure all future provider payments were made at the correct rate. Additionally, authority management updated control procedures to ensure MMIS data tables are updated timely and accurately. The recoupment of funds paid for incorrect rates will be completed through the FFS cost settlement process. We expect to have this completed on or before June 30, 2024. We will evaluate the use of alternate recoupment processes in the event of future corrections.

  Refund has been reported on the FFY2024 Q1 64 and has been loaded into MBES for Audit Finding 2022-056. The final refunded amount including all adjustments was $1,725,396 in total funds, federal portion was $1,340,158. The Q1 CMS 64 will be certified by January 30, 2024.

- Recommend department management strengthen controls to ensure documentation supporting a provider's eligibility determination and revalidation is complete.

  ODDS Response: The department is committed to having completed I-9 forms on file for all Personal Support Workers through our Fiscal Intermediary. The Provider Enrollment Unit now has a quality assurance staff who will conduct spot checks of the FI work. This is in process now and reviews will continue.

  APD Response: The department is committed to having completed I-9 forms on file for all employees and homecare workers. This expectation, as it relates to homecare workers, was reinforced by the department at the Client Employment Program Annual Summit held on 3/28/23 and 3/29/23. This Summit was attended by approximately 160 local office staff. Local office staff were instructed on how to properly fill out the I-9 form and retention requirements. Staff were also reminded of resources available to answer questions, including central office points of contact.

The department is also exploring short- and long-term solutions to mitigate this risk, including creating a peer review process on business procedures across the state intended to assist in not only accuracy, but knowledge transfer, developmental growth and mentoring opportunities. The department may also explore system changes that would automatically validate the completion of tasks related to provider enrollment and renewals, including the presence of required documentation.

6. OHA: Pharmacy Benefit Managers Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies, audit #2023-25 (dated August 2023).

- Recommend expanding contract provisions to more proactively monitor and enforce contract compliance and further develop monitoring processes that will give OHA reasonable assurance CCOs and PBMs are in compliance. Consider the following:
    - Require CCOs to obtain a yearly independent audit of their PBM for high-risk areas. An independent audit could help give OHA reasonable assurance that CCOs and their PBMs are in compliance. Note that a yearly audit should not replace a CCO's responsibility for on-going monitoring.
    - Incorporate monitoring results into the contracting process to improve oversight and program outcomes.
    - Update the CCO contract to apply the review requirement to all CCO-PBM amendments.
    - Require PBM contracts to be pass-through.

OHA conducts an annual CCO contract restatement process. These recommended considerations can be included in the 2025 restatement, which will begin in February 2024. The specific considerations identified are partially represented in the existing CCO contract.

- *Yearly independent audit – Currently a subcontractor performance audit is required for all high-risk subcontractors, which would include PBMs. The audits are conducted by CCOs. In addition, an annual PBM market check is conducted by a third party on behalf of the CCOs, for those not using OPDP. The*

contract could be changed to include an independent audit for PBMs; this would incur additional costs for all CCOs.

- *Incorporate monitoring results into contracting process – The addition of Quality Assurance staff with the background and experience to enable contract oversight without the appearance of conflict of interest.*
- *Update CCO contract to apply review requirements to all CCO-PBM amendments or contract renewals. Currently, this requirement only applies to pay-for-performance PBM subcontracts. This could be changed as part of the next contract restatement process to apply to all CCO-PBM amendments and contract renewals.*

OHA's CCO PBM readiness review includes a market check requirement, which could be expanded to include an audit of the PBM annually. The third-party nature of this market check requirement along with an annual audit would indeed give more assurances to OHA and better position CCOs to oversee their PBMs' behavior. As noted in the report, CCOs are permitted to utilize OPDP/ArrayRx as their PBM; only one CCO currently elected to utilize this option. It is important to note that OPDP/ArrayRx do perform a third-party review and market check for all programs participating in interstate cooperative agreement. Additionally, OPDP/ArrayRx conducts quarterly sample audits to ensure claim submission and payment accuracy for a diverse subset of claims processed for our participating programs. Annually, ArrayRx completes an audit representing in excess of 50% of its total claims. This audit assesses the accuracy of 100% of claims that are processed by our PBM for these programs (as opposed to audits that are conducted in quarterly PBM audits). The most recent audit results showed that OPDP/ArrayRx PBM had a 99.99% accuracy rate.

We agree that all subsequent contract amendments between PBMs and CCOs should be subject to OHA review and approval. This can be in place for the 2025 contract. OHA also agrees that PBM contracts should be pure pass-through contracts moving forward and will change the PBM readiness review process to reflect this. To successfully address the additional analytics and oversight necessary, it would be helpful to find a path to effectively resource OHA. A recent legal settlement between Oregon and a PBM highlights the need to have a

dedicated resource that can assist with audits, oversight, and review of PBM activities performed to best serve our Medicaid members. It would benefit all parts of OHA and other agencies to have a centralized pharmacy purchasing resource that can manage multiple pharmacy claims databases and ensure all Oregon agencies stay ahead of market changes that happen quickly and covertly within the pharmacy space.

Changes were made to the CCO contracts to address the audit that included:

- *End of Pay for Performance (P4P) agreements - End Pay for Performance (P4P) agreements - Currently, P4P is an exception to "pass through" funding requirements. The change removes the exception. "Pass through" requires the amount the CCO paid to the PBM to be equal the amount the pharmacy received. P4P allows the PBM to negotiate lower prices with the pharmacy network and then share some of the difference (the "spread") back with the CCO. In pass through pricing, the CCO pays for the PBM's services as a fixed per-claim administrative fee. In a P4P agreement, the PBM keeps a portion of "spread" as payment for services.*
- *Requirement that CCOs submit all PBM Subcontracts and amendments for OHA review and approval - Currently, CCOs must submit only new PBM subcontracts and amended P4P subcontracts. All submissions must be evaluated and approved by OHA before effective. This change requires submission of new and amended PBM subcontracts, along with an attestation form developed by OHA that demonstrates compliance with PBM requirements. Upon submission of the subcontract and attestation form, the subcontract can go into effect without OHA approval*
- *Require CCOs to perform an annual third-party PBM audit. Currently, audits are optional. This change is makes it mandatory. Auditor would validate the CCO's attestation that all PBM requirements were met and would verify that "pass through" funding occurred.*

- Recommend assigning staff without a conflict of interest to monitor CCO and PBM compliance.

OHA agrees with this recommendation; however, staffing challenges have led to leveraging staff who have knowledge and expertise in the PBM contracting and pharmacy space. It was noted by OHA staff and confirmed by DOJ that a potential conflict of interest existed if OPDP/ArrayRx staff—who currently have this expertise—were to review CCOs' PBM materials. After the first CCO PBM readiness review, OHA did take steps to mitigate the conflict of interest by removing OHA's Director of Pharmacy Policy, Programs and Purchasing from all subsequent reviews. However, the remaining staff member—the OPDP/ArrayRx Operations Manager—still has a conflict of interest. It should be noted that other divisions within OHA and other Oregon agencies struggle to identify independent pharmacy analytic, policy, and purchasing resources, which suggests these resources are needed statewide. OHA intends to pursue adding resources to ensure availability of staff without a conflict of interest.

OHA does not have sufficient staffing to sustain comprehensive review of all CCO PBM contracts and recent LC/POP limitations have dashed hope of additional staff. Therefore, as of March 1, 2024, Health Policy & Analytics' Delivery System Innovation Pharmacy team has reassigned all of this work to two members of the team who do not have OPDP contracting or procurement responsibilities. This has also involved creating an attestation process for CCO's PBM contracting practices that is validated by a third party hired by CCOs. At the moment this is the only strategy that can at least meet the spirit of agreement OHA has with the SOS audit.

7. OHA: Funding and Delivery of Measure 110 Substance Use Disorder Services Shows Progress, but Significant Risks Remain, audit #2023-39 (dated December 2023).

- Recommend development of a strategic plan with specific M110 outcome metrics and timelines and present it in the 2024 legislative session. Consider working with outside researchers for outcome evaluation if needed.

OHA agrees to create and present a draft strategic plan specific to outcome metrics to the legislature in the 2024 session with a finalized version by August 1, 2024. OHA sees this plan as an opportunity to use the experience and knowledge gained over the first 18 months of this grant with our 230 BHRN Partners, and their capacity for

data collection. It is OHA's goal to set strategic parameters around data collection, managing expectations around the type of data that is appropriate to collect, modifying our systems to collect data needed for outcomes metrics, and the role administrative burden plays in the provision of service. Due to the timeline of the 2024 legislative session, OHA cannot contract with an outside research expert prior to session, but OHA will consider that recommendation for future work.

- Recommend working with providers to better track and report:
    - Specifics on staffing, service expansion, and capital projects;
    - Youth services and virtual services; and
    - The availability of culturally and linguistically specific services.

OHA agrees and acknowledges that reporting on the expansion of staffing and services are important measures to track. OHA continues to balance collecting high-quality data and the administrative burden on BHRN Partners to report on their program activities. The Measure 110 team will ask BHRN Partners for a count of the number of newly hired positions beginning in the Quarter 5 expenditure reports (for services provided between July 1, 2023 – September 30, 2023). The Measure 110 team has also worked to ensure that all BHRN Partner budgets are uniform and that all funded positions are listed including their corresponding salary and FTE for the grant extension period, beginning January 1, 2024. The program will add a question about how Measure 110 funding aided in the expansion of services to the Quarter 7 expenditure report, corresponding with the grant extension period (January 1, 2024 – June 30, 2025). BHRN Partners will be asked to provide a retrospective answer to both questions of hiring and service expansion for all quarters in the final report for this grant.

Current and future data collection efforts include client age, which allows OHA to report on services provided to youths. Additionally, Quarter 5 reporting included an opportunity for Partners to identify if they provide outreach services to K-12 schools and/or minors. Future report forms, starting in the Quarter 7 grant extension period, will include an option for Partners to select if they provide services in-person, virtually, or both, and if they provide culturally and linguistically responsive/specific services.

However, OHA would like to note that in evaluating and selecting applicants for BHRN funding, the Measure 110 Oversight and Accountability Council (OAC) could not consider race, gender, or other protected identity of the applicants, because to do so is unlawful under the Equal Protection Clause of the 14th Amendment to the U.S. Constitution. Rather, the OAC could appropriately consider what types of services were proposed in the applications, such as whether applicants proposed to provide services to historically underserved populations in alignment with Measure 110's purpose.

- Recommend working with providers to improve the consistency and reliability of service expenditures and client data.

  OHA agrees that technical assistance and partnership are the keys to successful grant administration. The Measure 110 team will continue to provide 1:1 guidance and technical assistance throughout the end of this funded grant cycle, June 30, 2025, to BHRN partners when appropriate to facilitate the collection of high-quality expenditure and programmatic data. These efforts also include developing a roadmap for improving our data collection systems to better support this and other recommendations. With the addition of new Measure 110 grant administration staff, the capacity for technical assistance to our 230 BHRN grantees will increase over time. The Measure 110 team seeks to continually improve reporting templates and internal processes in response to partner feedback and SOS recommendations.

- Recommend improving the application and review process moving forward: Work with communities and providers to identify the most critical service gaps by county and barriers to increasing services.

  OHA agrees that identifying critical service gaps and barriers increasing services is important to improve the state's behavioral health and substance use treatment system. OHA is conducting a residential and facility study, due June 2024, and a SUD financial analysis, due April 2024, that will help the agency better identify service gaps and barriers to care. Additionally, under HB 2513 (2023), local alcohol and drug policy committees have been directed to coordinate with BHRNs to identify needs and establish priorities for alcohol and drug

prevention and treatment services and report their findings to OHA. Together, these analyses will be presented to the Measure 110 Oversight and Accountability Council to inform their decision-making process in the future. OHA will also incorporate the results of these analyses and any identified gaps into the 2025 Measure 110 BHRN Request for Grant Application (RFGA) process to better inform the community of cri tical opportunities. By statue, the Oversight and Accountability Council is the sole body that can award Measure 110 funding.

- Recommend improving the application and review process moving forward: Make the application clear and direct and improve review process transparency and consistency.

  OHA agrees that a clear and direct grant application is essential. Acting on Recommendation 3 from the SOS Real Time Audit (January 2023) and the agency's newfound authority from HB 2513 (2023), OHA will work to ensure that the next iteration of the BHRN grant applications includes standard grant requirements including a statement of work, uniform budget documents, and enforced word counts. The M110 program will also work to create clear documentation that Measure 110 Oversight and Accountability Council can complete to accompany funding decisions and discussion in their public meetings. Taken together, these steps will ensure the application and review process is transparent, consistent, and clear to the public.

- Recommend improving the application and review process moving forward: Require providers to clearly detail what they plan to do with M110 funds and the experience, capability, and plans for providing services to clients from linguistically diverse or culturally specific backgrounds.

  OHA agrees that the new grant application should include a detailed statement of work outlining how providers will provide Measure 110 services with specificity regarding how they will render services to clients who are culturally and linguistically diverse and how they will utilize funds to ensure the services are provided. Using the new authority under HB 2513 (2023), OHA will require all future BHRN applicants include a detailed statement of work as part of their application, including detailed information on how applicants plan to provide culturally and linguistically specific/responsive services. In addition, there will be detailed and standardized budget

documents in the new grant application process that will ensure all applicant budgets are clear and directly speak to the statement of work provided.

8. ODHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2023, audit #2024-14 (dated April 2024).

- Recommend department management update accounting and review procedures to ensure entries prepared to address issues originating in prior fiscal years do not incorrectly impact the current year financial statements.

  The Office of Financial Services (OFS) is reviewing documentation from prior audits and direction from the Department of Administrative Services (DAS), Statewide Accounting and Reporting, to identify the most effective and efficient process going forward for refinancing prior year activity in the current fiscal year. As mentioned in the audit, the complexity of deferred revenue reimbursement, across multiple fiscal years, from FEMA during the pandemic increased the complexity of these accounting transactions. The office will write up a new process and train relevant staff on the new methodology.

- Recommend department management ensure recipients of federal funds are appropriately identified as subrecipients or contractors and the corresponding disbursement of federal funds are appropriately reported as direct or passthrough expenditures. We further recommend department 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 according to risk assessment results.

  Contracts and program staff have piloted and implemented tools to help administrators determine if the NFP is a contractor or sub-recipient using the determination checklist. Department managers have communicated expectations related to the use of this tool and guidance to ensure that contract administrators understand how to determine if an agency is a contractor or sub-recipient. If determination identifies a subrecipient relationship, controls are in place to ensure the Federal Funding Accountability and Transparency Act (FFATA) form, self-

assessment, and monitoring plan are completed. Further, mental health block grant planners will assess each new or amended contract for appropriate designation. OHA management plans to establish a single training for all staff to complete before developing a contract. This training will also include necessary messaging to all staff about terminology, location of resources, expectations as an administrator, and compliance/verification processes. OHA will provide this messaging and training through agency-wide emails, newsletters, and all staff meetings. OHA will continue refining its onboarding to incorporate these trainings and messaging. Additionally, the Office of Financial Services reviews each contract to determine the correct coding for each contracted service/deliverable and accurate code, such in State Financial Management Accounting (SFMA) system.

Risk assessment survey has been developed that allows for self-assessment and documentation of the process. Administrators are requested to keep a copy of the assessment in their administrative file. Contract administrators create regularly scheduled meetings with the sub-awardee to monitor for compliance, depending on the risk of the sub-awardee. OHA-HSD has created a planning and implementation document to systematically identify the process of self-assessment and monitoring plan. In addition to the 11-module contract administration training required for all administrators. OHA plans to create an accessible folder for download to include the Contract Administration Plan (CAP), RACI Matrix, Monitoring, and closeout activities.

Once all of the resources are socialized throughout the Program and Leadership staff, controls are still necessary to get as close to 100% compliance by the administrators.

Controls that will be implemented are:

- *DocuSign CLM- During the automated workflow for approvals, administrators must verify that the determination document and, if applicable, the self-assessment and monitoring plan is attached. If not, the request will be rejected until the proper documentation is provided.*

- *Team audit- The program analyst will perform random audits of grant/contracts administrator folders to confirm documentation is complete for each grant/contract, including monitoring activities, reports, invoices, and grant compliance requirements.*

- Recommend department management implement controls to ensure applicable expenditures are adequately tracked and reviewed for compliance with federal Earmarking requirements.

  As noted in the audit report, OHA has already taken corrective actions to ensure controls are in place for tracking applicable expenditures in SFMA to ensure compliance with federal Earmarking requirements. The Office of Financial Services, OHA Budget Unit, and block grant planners meet at least once a month to review budgeted earmarked requirements and expenditures to ensure compliance. Block grant planners meet at least once a month with the crisis team and children and family team to review required earmark budgets and expenditures.

- Recommend management ensure compliance with federal program requirements by prioritizing the completion and documentation of hospital audits.

  The authority agrees with this finding and has completed the work to reconstitute the required tools necessary to perform these audits. As of January 2024, the authority has sent cost statements to the hospitals for review and response and is working to collect other reports required for completing the audits from actuaries and intermediaries. The authority will begin processing full audits starting April 2024 for outstanding Fiscal Year 2016 forward. The authority anticipates that the audits through Fiscal year 2020 will be completed by December 31, 2024.

- Recommend department and authority management strengthen controls over review to ensure documentation supporting a provider's eligibility determination and revalidation is complete. Additionally, we recommend the authority reimburse the federal agency for questioned costs related to ineligible providers including ineligible providers identified in prior year findings.

The authority will provide two separate training modules to enrollment staff and staff responsible for the CCO enrollment and validation regarding complete ownership and disclosure documents. We will perform the trainings on April 18, 2024, during our monthly staff meeting and a separate ownership form only training on May 30, 2024.

The Office of Developmental Disability Services has implemented new contractual language for our fiscal intermediary to review I-9 for providers with stricter criteria. This was added earlier this year and is already in place in the contract and implemented. Further, upon enrollment, state staff are validating older I-9s for providers who have submitted their I-9 historically.

The Office of Aging and People with Disabilities is committed to ensuring Provider Enrollment Agreements and accurate I-9 forms are on file and ensuring records are stored and retained properly for all Home Care Workers. The department will reinforce the requirements concerning the collection and storage of agreements at both the Quarterly Home Care Coordinators meeting on May 30, 2024, and at the AAA/APD Local Line Leadership meeting on May 16, 2024. The department will also create a reference guide in the new ODHS Field Business Procedure Manual implemented in February 2024. The department will make provider enrollment agreements and I-9 forms available statewide via DocuSign as an optional tool for state staff that guides them through accurately completing information on the form and capturing electronic signatures. This will ensure that all required fields in forms are filled out correctly including ensuring the presence of required documentation to mitigate human error.

Additionally, we will continue to explore developing a training module for front office staff and office managers as well as a peer review process on business procedures and exploring ways that we can leverage technology such as the replacement Electronic Data Management System (EDMS) "Laserfiche" implemented by Imaging and Records Management Services (IRMS) to store provider records electronically.

The Office of Aging and People with Disabilities released updated guidance and clarification on I-9 forms through an Information Memorandum transmittal on January 24, 2024 (APD-AR-23-099) During the February 19, 2024, at the Home Care Coordinators quarterly convening meeting the revisions from the prior transmittal were discussed along with the importance of ensuring timely renewals and accurate documentation and retention of PEA/I-9's. During the May 30, 2024, at Home Care Coordinators Quarterly convening, Laserfiche project team shared information on status of new system implementation and timing of transition from EDMS along with Q&A. Laserfiche implementation began on July 15, 2024. The DocuSign contract administrator has provided an update noting that the DocuSign contract to go from pilot to statewide is currently behind schedule due to the Office of contracts and Procurement backlog, once available. During the July APD/AAA Local Line managers meeting, APD leadership discussed with line managers the results of the audit, reinforced the importance of accurate documentation and retention of records and discussed ways we are looking to strengthen the process such as leveraging new software and solicited ideas or best practices they have. We will continue to explore training options for onboarding front office staff, develop procedures for the Field Business procedures manual.

The questioned costs of $1,786 is being reported on the FFY24 Q4 CMS64 on line 10A (along with $680 in other funding sources totaling $2,466).

- Recommend department management strengthen controls over review to ensure transactions are adequately supported and reviewed. Additionally, we recommend the department reimburse the federal agency for unallowable costs.

  The ODHS Office of Facilities Management coordinates care of a 168-building portfolio. Part of this work is coordination of furniture reconfiguration, minor and major remodels of office spaces and other building maintenance work. For these projects we rely on program staff with understanding of their funding sources to provide us with accurate coding to support the project related costs. Our office does not work directly with funding source management only coding and billing.

To better track who is providing us the coding and maintain a record of payment approval we have revised our workorder form to include who from the program is providing the coding and what authority they have to provide the coding. This will allow us to assure that important details are captured regarding funding application and coding for billing and protect from funds being drawn from sources that do not support and/or are not appropriate for a given project.

The questioned costs of $3,849 were corrected and refunded to CMS using document BTCL1485 with an April 17, 2024, effective date. The refund will be reported on the Q3 FFY 2024 CMS 64 which will be submitted by June 30, 2024.

- Recommend program management implement additional internal controls over payroll related costs to ensure all costs charged to the program are related to employees who work directly on the award.

  WIC Leadership is dedicated to reviewing and integrating existing reports into their time review process and will also ensure that staff responsible for employee time approval have been adequately trained on how to use those reports and features in Workday to review time. Questioned costs in the amount of $121,953 were refunded in August of 2024.

9. OHA: Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate Medicaid Payments, audit #2024-29 (dated October 2024).

- Recommend submitting a budget request for an additional four FTE for the Data Matching Unit.

  Office of Payment Accuracy and Recovery (OPAR) will be submitting a policy option package (POP) for four additional FTE's in the next legislative session for approval and funding.

- Recommend developing a process to triage PARIS matches within the Data Matching Unit.

The Data Match Unit (DMU) will relook at how PARIS matches are done and prioritized. The team will research and work towards completing cases in a more efficient way by working the oldest cases on the report as well as processing low-effort cases first.

- Recommend working with the U.S. Treasury's Do Not Pay Business Center on a join Washington and Oregon pilot project for concurrent enrollment.

  The Data Match Unit (DMU) is open to working with U.S. Treasury's Do Not Pay Business Center on a joint WA/OR pilot project for concurrent enrollment. Data sharing agreements, policy and procedures will need to be developed by both states. Once the data sharing agreements are executed, and matching is completed, OPAR will know more on specifics on how this work will be completed.

- Recommend implementing a process by 2026 to recoup duplicate enrollment payments from CCOs for recipients who live out of state.

  OPAR Data Match Unit will develop and implement a process for identifying CCO members who live out-of-state. The process will include the recoupment of capitation payments made to a CCO for these out-of-state CCO members where it has been validated that the member was living out-of-state at the time of Oregon CCO enrollment.

2023-2025 Mandatory Special Report on Community Mental Health

Treasury Account Report

July 2022 to November 2024

Per ORS 426.506 Community Mental Housing Fund; Community Housing Trust Account

Restricted Funds- Permanent Fund Principle		$5,726,586.00
Unrestricted 21-23 Balance Forward		1,606,892.54
Prepayment of Funds		610,645.41
Awarded Amounts Funded July 2022 through November 2024		(635,000.00)
	Total	
Revenue		**$8,092,925.43**
Restricted Funds - Permanent Fund Principle		$5,726,586.00
Amount Reserved for Awarded Housing Development		1,362,122.00
Amount Reserved for Awarded Institutional Housing		0
Available to be Awarded – Housing Development		598,662.04
Available to be Awarded – Institutional Housing		405,555.39
	Total	
Expenditures		**$8,092,925.43**

Policy Group	Agency Name	IT Project Name	PPM Idea/ Project ID	Fiscal OIS / Acct	PPM Idea/Project Name	Mandate	Short Description	Start Date	End Date	Total Budget $ (PPM)	Total Cost	Previous Biennia (2023 -2025) GF Cost	Previous Biennia (2023 -2025) OF Cost	Previous Biennia (2023 -2025) LF Cost	Previous Biennia (2023 -2025) FF Cost	Current Biennium (2025-2027) GF Cost	Current Biennium (2025-2027) OF Cost	Current Biennium (2025-2027) LF Cost	Current Biennium (2025-2027) FF Cost	Future Biennia (2027 - and ongoing) GF Cost	Future Biennia (2027 - and ongoing) OF Cost	Future Biennia (2027 - and ongoing) LF Cost	Future Biennia (2027 - and ongoing) FF Cost	Comments
Healthy People	OHA	ALERT IIS Replacement	P50009	Steve/Randa	ALERT IIS Replacement Project	Federal	The Oregon Health Authority (OHA) Oregon Immunization Program (OIP) uses the ALERT IIS system, a database that records all immunization doses administered by participating providers in Oregon, as a powerful tool for managing immunization records and supporting healthier communities. The ALERT IIS Replacement Project will ensure continued administration of immunization records and promote modernization of OIP's processes and applications. This project aligns with the national Data Modernization Initiative (DMI) and with the Oregon Health Authority's strategic goal to eliminate health inequities in Oregon by 2030. This project must be executed before 12/31/2027, prior to the end of the existing vendor contract with Gainwell Technologies.	2022-10-20	2027-12-31	$ 1,205,000	TBD	$ 271,886	$ -	$ -	$ 271,886	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Alert is just in the intitial planning stages, the current projected costs are minimal and do not reflect the total expected costs for this project. Project management is still collecting information for this project
Healthy People	OHA	COMPASS - MOTS Replacement	P80023/P80027	Said/Steve	Community Outcomes Management System (COMPASS)	None	The Measures and Outcomes Tracking System (MOTS) replacement will replace the existing siloed, aged, and fragmented MOTS system. The new system will support the administration, planning, and monitoring of substance abuse disorder and mental health treatment programs.	2020-01-23	TBD	$ 11,342,630	$ 9,296,386	$ 1,341,912	$ -	$ -	$ 4,249,387	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Current MOTS spend plan through June 2024. Another phase is anticipated (APD in progress) but unprojected at this time. Does not include any M&O estimates.
Healthy People	OHA	GO Priority - 1115 HRSN - Community Information Exchange	-	Lisa/Randa	GO Priority - 1115 HRSN - Community Information Exchange	Federal	Oregon recently received Centers for Medicare and Medicaid Services (CMS) approval for the 2022-2027 1115 Medicaid Waiver. Provisions in the new waiver will be implemented over the course of the 5-year demonstration period and will include significant changes to Coordinated Care Organization (CCO) contract requirements; revision of Oregon Administrative Rules (OAR) that impact all providers; substantial changes to IT systems to support financial disbursement, claims activity, and data submission; and management of the adoption and utilization of statewide community information exchange (CIE) platforms for referrals.	2023-05-01	2026-02-24	$ -	TBD	$ -	$ -	$ -	$ -	TBD	TBD	TBD	TBD	TB D	TBD	TBD	TBD	
Healthy People	OHA	HIV-E (HIV-Electronic)	500001	Steve/Randa	HIV-E (HIV-Electronics)	None	Develop a solution that will replace the existing CAREAssist 1.0 application with a new, custom developed CAREAssist 2.0 application that addresses current system issues.	2015-11-30	2027-06-29	$ 23,700,949	$ 24,946,537	$ -	$ 10,305,584	$ -	$ -	$ -	$ 9,739,443	$ -	$ -	$ -	$ -	$ -	$ -	M&O has not been included in these estimates. Currently this project is projected to be completed March 2027. Total cost is a DDI estimate only.
Healthy People	OHA	Improving Medicaid Enterprise Data	P80041	Lisa, Said	N/A		OHA will expand the Behavioral Health Data Warehouse (BHDW) Person Index (PI) and enhance the BHDW, two primary building blocks from the Compass Modernization initiative, to improve data quality, sharing, and analytical capacity for the Medicaid population. Oregon's modular Medicaid Enterprise System (MES) will require a data environment capable of matching, cleaning, and storing integrated and interoperable data from various sources. Incremental expansion and improvement of the BHDW will improve Oregon's analytic and operational capabilities in the near term and will be consistently evaluated for inclusion as part of the state's Enterprise Data Warehouse (EDW) module.	2023-10-01	TBD		N/A	TBD	$ 819,253	$ -	$ -	$ 7,371,714	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	End date TBD, project extending. New APD coming. Date/scope TBD.
Healthy People	OHA	MES Modernization (formerly Modularity) Planning Phase	P80014	Chad/SAID	N/A	None	Medicaid Enterprise System (MES) Modularity strategy development is being facilitated by the consulting vendor.	2022-07-01	TBD		N/A	TBD	TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	Project still in planning, but projected to continue for some time. 25-27 POP in progress.
Healthy People	OHA	MMIS Infrastructure Replacement	P80039	Chad/SAID	MMIS Infrastructure Replacement Project	None	The industry-wide move toward Cloud hosting solutions solves a number of IT challenges. Cloud hosting is cost effective, scalable, flexible, secure, and redundant, which all bring large benefits to the the Medicaid Management Information System (MMIS) and is our largest step in preparing for Modularity. 1) Existing MMIS Infrastructure is reaching end of lifecycle in 2024. Project must be completed before 2024 with a duration estimated at 3 years. 2) CMS supports moving MMIS to the Cloud by providing 90/10 funding. 3) Gainwell is transitioning its national data centers to the Cloud, and we will leverage their existing support model.	2022-01-03	2025-12-25	$ 20,318,175	TBD	$ 712,409	$ -	$ -	$ 6,411,685		TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	
Healthy People	OHA	MMIS Private Public Providers	P80034	Chad/SAID	MMIS Private Public Providers	None	Update Medicaid Management Information System (MMIS) system to enable distinction between public and private providers for the purposes of adjusting claims.	2021-08-02	2026-09-30	$ 1,066,342	$ 1,164,065	$ 59,256	$ -	$ -	$ 533,304		TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	
Healthy People	OHA	MMIS TMSIS	P80029	Chad/SAID	MMIS T-MSIS Phase 2	Federal	This project will involve modifications to the Medicaid Management Information System (MMIS) system to collect and submit required data for Centers for Medicare & Medicaid Support (CMS) to perform necessary data analytics for decision-making. Specifically, this project addresses Transformed Medicaid Statistical Information System (TMSIS) data quality elements and CMS dashboard issues.	2020-05-01	2025-09-30		TBD	$ 4,974,719	$ 202,142	$ -	$ -	$ 1,819,274.40		TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	APD currently scheduled through 09/2025, but project is expected to go beyond that date. Subject to change.
Healthy People	OHA	OEBB-PEBB Benefit Management System (BMS) Replacement	P70003	Chad/Said	OEBB-PEBB Benefit Management System (BMS)	Legislature	Replace two aging and highly customized benefits management systems (BMS) with a single, modernized Software-as-a-Service (SaaS)/Commercial-Off-The-Shelf (COTS) system that supports delivery of required functionality in order to meet legislative requirements and improved user experience (UX).	2019-07-01	2026-04-30	$ 14,448,785	$ 14,470,785	$ -	$ 8,423,956	$ -	$ -	$ -	$ -		TBD	$ -	$ -	$ -		TBD	$ -	$ -	Project has POP to go for 9 months into 25-27.
Healthy People	OHA	Oregon State-Based Marketplace	P70004	Carol/Randa	Oregon State-Based Marketplace	None	The Oregon Health Authority (OHA), Oregon Health Insurance Marketplace is seeking to transition Oregon from a State-Based Marketplace using the Federal Platform (SBM-FP) to a state-based marketplace (SBM). Becoming an SBM requires that a state acquire and implement its own enrollment technology and accompanying consumer assistance center (CAC) to provide over-the-phone support for enrollees.	2023-07-06	2027-03-31	$ 14,880,000	$ 79,380,000	$ -	$ 2,059,864	$ -	$ -	$ -	$ -	$ 38,000,000	$ -	$ -	$ -	$ 39,320,136	$ -	$ -	Total cost assumed to be the estimate provided in the IT Investment form, and includes operating costs.
Healthy People	OHA	Oregon Trauma Registry (OTR) Replacement	P50007	Carol/Chad/Randa	Oregon Trauma Registry (OTR) Replacement	Other	Replace the current Oregon Trauma Registry (OTR) system with a new Commercial-Off-The-Shelf (COTS) or Software-as-a-Service (SaaS) solution that will meet the requirements mandated by ORS 431A.050.	2022-04-28	2026-01-31	$ 636,888	$ 1,077,656	$ -	$ 1,073,657	$ -	$ -	$ -	$ -		TBD	$ -	$ -	$ -		TBD	$ -	$ -	PPM Budget accomodates project through 12/8/23, end of the planning phase.
Healthy People	OHA	OSPHL LIMS Replacement	P50006	Steve/Randa	OSPHL LIMS Replacement	None	Conduct open procurement for replacement of the four Oregon State Public Health Laboratory (OSPHL) Laboratory Information Management Systems (LIMS).	2022-06-03	2027-03-16	$ 1,877,187	TBD	$ -	$ -	$ -	$ 1,688,784	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	LIMS has only been projected through December 2024. Total build costs and timing is TBD. LIMS is funded by Federal Grants. This is a Public Health Project.
Healthy People	OHA	TWIST TO WEB		Carol	TWIST To Web	None	Replace the current electronic Women, Infants, and Children (eWIC) management information system, TWIST.	2017-06-12	TBD	$ 16,359,475	$ 16,359,475	$ -	$ -	$ -	$ 2,965,894	$ -	$ -	$ -	$ 5,274,733	TBD	TBD	TBD	TBD	Future M&O costs to be determined. Development and Implementation 100% Federal Funds. Project has been put on hold by DAS EIS, and end date is yet to be determined.
Healthy People	ODHS|OHA	IT Service Management	-	Crystal	IT Service Management (ITSM)	None	Implementation of Ivanti into OIS for IT Service Management (ITSM).	2023-03-20	2025-07-24	$ 4,137,792	$ 14,303,667	$ 6,229,812	$ 612,768.42	$ -	$ 3,370,226.31	$ 1,562,596	$ 153,697.92	$ -	$ 845,338.56	$ 932,829	$ 91,753.68	$ -	$ 504,645.24	
Healthy People	ODHS|OHA	Mainframe Modernization	TBD	Carol/Randa	Mainframe Migration Provider and Client Payments			2023-07-01	2027-07-01	$ 25,444,863	TBD	$ 4,944,276	$ 5,109,564	$ -	$ 3,079,871	$ 2,902,941	$ 619,809	$ -	$ 7,527,500	TBD	TBD	TBD	TBD	Project is still in the planning phase. Completed scope and M&O estimates are yet to be determined.
Healthy People	ODHS|OHA	REALD and SOGI Registry Implementation	P45002	Lisa, Said	REALD and SOGI Registry Implementation	Legislature	Developinng a repository and registry to collect, clean, store, and use complete race, ethnicity, language, or disability & sexual orientation and gender identity (REALD & SOGI) data is a long-term solution that requires focused agency investment. 2021's HB 3159 mandates the creation of a central registry to collect demographic data using the REALD & SOGI standards and requires providers, insurers, and Coordinated Care Organizations (CCO) to submit data at least annually. This enables the Oregon Health Authority (OHA) to monitor data quality and compliance, obtain timely information, and utilize this data to inform culturally-specific interventions to reduce or eliminate inequities and reduce health care costs.	2022-07-19	2028-05-08	$ 11,500,000	TBD	$ 27,912,675	$ -	$ -	$ 5,717,054	TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	
Healthy People	ODHS|OHA	Summer EBT Project	TBD	Carol/Randa	Summer Electronic Benefits Transfer (Summer EBT)	Legislature	The Summer Electronic Benefits Transfer (Summer EBT) Program is a new federal nutrition program that provides low-income families a $120 summer grocery benefit for each eligible school-aged child. Project funding for this initiative will be used to design and implement a permanent Summer EBT program in Oregon. As this program is independent from SNAP, the request to establish this new permanent program includes new positions, administration costs, vendor costs for 2024 Summer EBT Project, system development for the 2025 Summer EBT Program, EBT card services, and communications to households.	2024-03-04	2025-06-30	$ -	$ 96,285,132	$ 11,984,958.00	$ 1,793,739.00	$ -	$ 82,506,435.00	$ 3,400,000	$ -	$ -	$ 3,400,000	$ 3,400,000	$ -	$ -	$ 3,400,000	$0 PPM budget takes project through 06/01/2024.

Policy Group	Agency Name	IT Project Name	PPM Idea/ Project ID	Fiscal OIS / Acct	PPM Idea/Project Name	Mandate	Short Description	Start Date	End Date	Total Budget $ (PPM)	Total Cost	Previous Biennia (2023 -2025) GF Cost	Previous Biennia (2023 -2025) OF Cost	Previous Biennia (2023 -2025) LF Cost	Previous Biennia (2023 -2025) FF Cost	Current Biennium (2025-2027) GF Cost	Current Biennium (2025-2027) OF Cost	Current Biennium (2025-2027) LF Cost	Current Biennium (2025-2027) FF Cost	Future Biennia (2027 - and ongoing) GF Cost	Future Biennia (2027 - and ongoing) OF Cost	Future Biennia (2027 - and ongoing) LF Cost	Future Biennia (2027 - and ongoing) FF Cost	Comments
Healthy People	ODHS	Case Management System	P35010	Lisa, Said	Case Management System	Federal	The Oregon Department of Human Services (ODHS) seeks to develop a state case management solution that will support maintenance all of Oregon Intellectual & Developmental Disabilities (I/DD) case management services. The solution will leverage existing interfaces between Medicaid Management Information System (MMIS) and Express Payment & Reporting System (eXPRS) to maintain data integrity and support the case management activities for the Medicaid I/DD programs. The solution will automate the billing activities for case management services provided by Medicaid providers.	2022-05-24	2025-12-31	$ 6,110,500	TBD	$ 446,374	$ -	$ -	$ 3,640,754	TBD	$ -	$ -	TBD	$ -	$ -	$ -	$ -	
Healthy People	ODHS	CCWIS - Project 1 & 2	P10011	Randa/Steve	CCWIS Modernization Program CCWIS Resource Parent Respite Provider Inquiry and			2020-01-01	2035-12-31	$ 51,336,000	$ 36,580,378	$ 5,794,766	N/A	N/A	$ 5,785,611	TBD	N/A	N/A	TBD	TBD	N/A	N/A	TBD	Took current burn rate to get the biennium estimate
Healthy People	ODHS	ODDS Electronic Visit Verification - Non-Web Solution	P35016	Chad/Carol/Randa	ODDS Electronic Visit Verification - Non-Web Solution	None	Implement an Electronic Visit Verification (EVV) solution for areas with limited to no internet or cell service reception available where client services are being delivered for the Office of Developmental Disabilities Services (ODDS).	2023-02-01	2025-03-31	$ 4,642,020	TBD	TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	TBD	$ -	$ -	TBD	Project direction still being determined. Expected to go beyond the current 03/2025 end date.
Healthy People	ODHS	ONE System Enhancements	P40005	Steve/Randa	ONE Program Cloud Migration ONE Program - Integrate Voice Response (IVR) ONE Program Youth with Special Health Care Needs YSHCN		Ongoing enhancements to the ONE system	2021-09-01	N/A	$ 4,642,020.00	TBD	$ -	$ 2,439,276	$ -	$ 8,648,344	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	System enhancements will be necessary for the life of the ONE system. State portion will be paid via Bonds for AY23-25.
Healthy People	ODHS	Provider Enrollment Maintenance System	P35015	Lisa, Said	Provider Enrollment and Maintenance System	Other	Support the state's Medicaid Information Technology Architecture (MITA) initiative. The project includes modules that will be used to manage and standardize enrollment, maintenance, and communication activities across Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) programs. The system will leverage existing interfaces with the Oregon Criminal History and Abuse Records Data System (ORCHARDS), Medicaid Management Information System (MMIS), and Express Payment & Reporting System (eXPRS) to maintain data integrity and support provider authorization and billing activities for case managers, reducing administrative tasks and allowing providers to bill without delay.	2022-05-24	2025-11-30	$ 9,200,000	TBD	$ 511,971	$ -	$ -	$ 4,664,441	TBD	$ -	$ -	TBD	$ -	$ -	$ -	$ -	
Healthy People	ODHS	Provider Time Capture (PTC)	DOLRUL	Steve/Said	Provider Time Capture	None	Provides the Oregon Department of Human Services (ODHS)/Oregon Health Authority (OHA) with a time capture system for home care workers (HCW) and personal support workers (PSW).	2024-11-01	2027-06-30	$ 31,367,810	$ 41,130,916	$ 3,764,029	$ -	$ -	$ 26,885,029	$ 1,287,283	$ -	$ -	$ 9,194,575	TBD	TBD	TBD	TBD	The PPM budget only accomodates phase 1 through 01/20/2025. 6/30/37 date assumes Phase 2 is approved. PTC including Ph2a and Ph2b through June 2027, M&O costs have been projected has its own project No P30002

Oregon Health Authority

Annual Performance Progress Report

Reporting Year 2024

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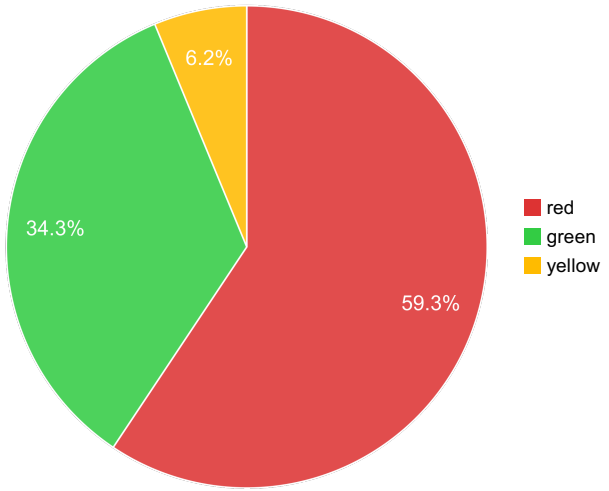
KPM #	Approved Key Performance Measures (KPMs)
1	INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Percentage of members with a new episode of alcohol or other drug dependence who received initiation of AOD treatment within 14 days of diagnosis.
2	ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE 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).
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.
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).
23	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
25	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
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.
35	HEALTH EQUTY MEASURE – COMPONENT #1: MEANINGFUL LANGUAGE ACCESS TO CULTURALLY RESPONSIVE HEALTH CARE SEVICES 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.
36	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.
37	INFANTE MORTALITY RATE - Numerator: # of deaths of infants <365 days of age in specified time period Denominator: # of live births in specified time period. Rate calculation: (Num/Denom)*1,000
38	REDUCTION OF SEVERE MATERNAL MORBIDITY - Numerator: # of cases of severe maternal morbidity* in specified time period Denominator: # of delivery hospitalizations in specified time period Rate calculation: (Num/Denom)*10,000 (read out as “[number] per 10,000 delivery hospitalizations”) *Note: Severe maternal morbidity cases are determined by using a validated set of ICD-10 diagnosis and procedure codes to examine hospital data.
39	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.
40	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.
41	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.
42	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.
43	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 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.
44	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.
45	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.
46	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.
47	MORTALITY FROM DRUG OVERDOES - 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.
48	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.
49	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.

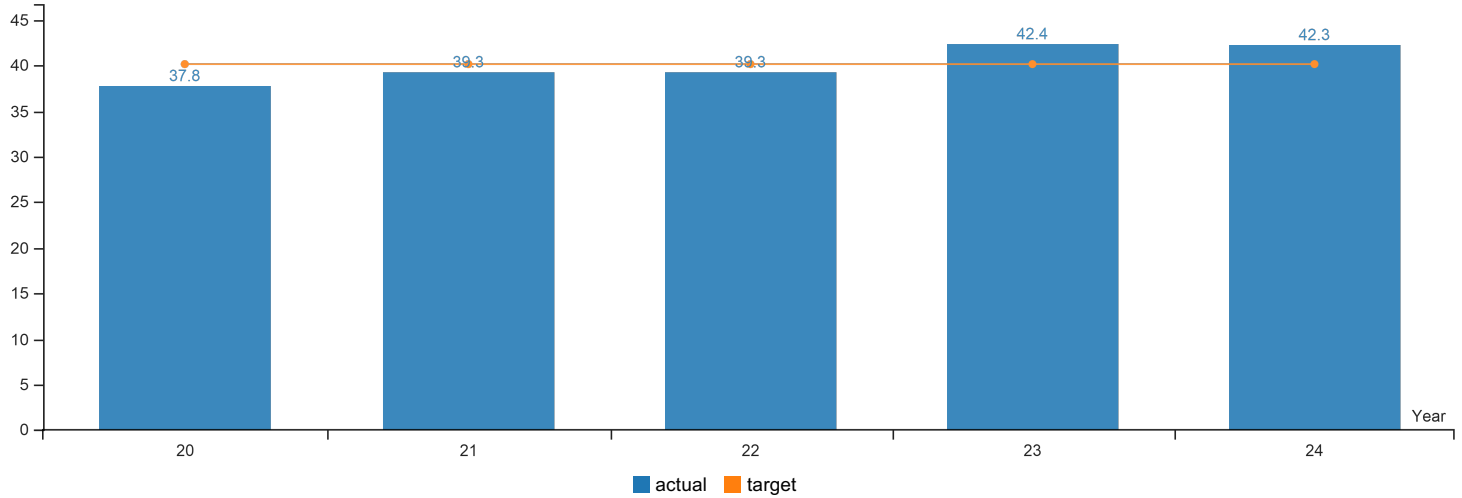
KPM #	Approved Key Performance Measures (KPMs)
50	STATEWIDE SUSTAINABLE COST OF CARE - Comparison of health care cost changes to personal income changes. Any value 0 or higher is green because we want per capita income growth to equal or exceed per capita health care cost growth. By way of background, the statewide sustainable cost of care measure is a comparison between per person growth in income in Oregon and health care spending growth in Oregon. Historically, health care costs have grown faster than income and Oregon is trying to change that with the Cost Growth Target program and other initiatives. When the result from subtracting per person income growth minus per person health care cost growth is 0 or positive, it means income is growing at the same pace or faster than health care costs, which is good. When the measure is a negative number, it means health care costs are growing faster than income, which is not good.
51	OHA SUSTAINABLE COST OF CARE - Difference between real personal income and health care inflation. Any value 0 or higher is green because we want per capita income growth to equal or exceed OHA's per person spending on PEBB, OEBB, and OHP. By way of background, the OHA sustainable cost of care measure is a comparison between per person growth in income in Oregon and health care spending growth for OHA's three health programs: Oregon Health Plan, Public Employees Benefits and Oregon Educators Benefits. When the result from subtracting per person income growth in Oregon minus per person spending on PEBB, OEBB, and OHP is 0 or positive, it means income is growing at the same pace or faster than OHA's health care costs, which is good. When the measure is a negative number, it means the cost of OHA's three health care programs is growing faster than income, which is not good.
52	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.
53	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
54	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.
55	PENDING REDETERMINATION APPLICATIONS OVER 45 DAYS OLD - Total number of pending applications for redetermination that are over 45 days old.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	34.38%	6.25%	59.38%

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%	42.40%	42.30%
Target	40.20%	40.20%	40.20%	40.20%	40.20%

How Are We Doing

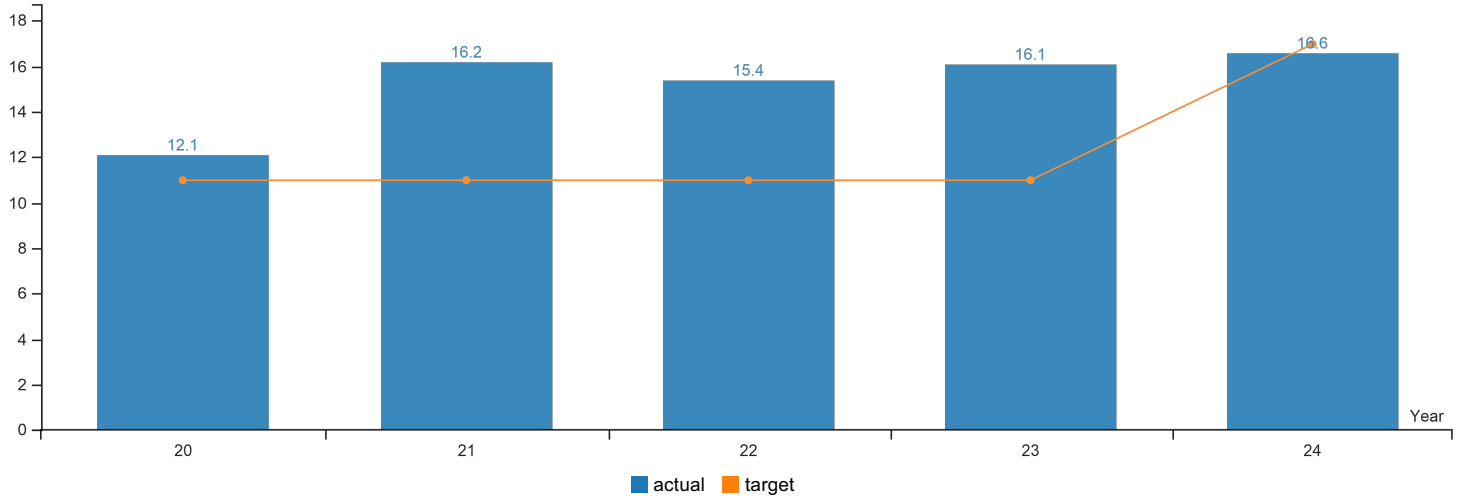
The percentage of members age 18 and older newly diagnosed with alcohol or other drug dependencies who initiated treatment within 14 days stayed was 42.3% in 2023. This stayed steady from 2022 to 2023, and is above the 2019 pre-pandemic rate. Data prior to 2022 are not directly comparable due to a methodology change.

Factors Affecting Results

It is possible that the increased statewide emphasis on alcohol and drug use screenings (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%	16.10%	16.60%
Target	11%	11%	11%	11%	17%

How Are We Doing

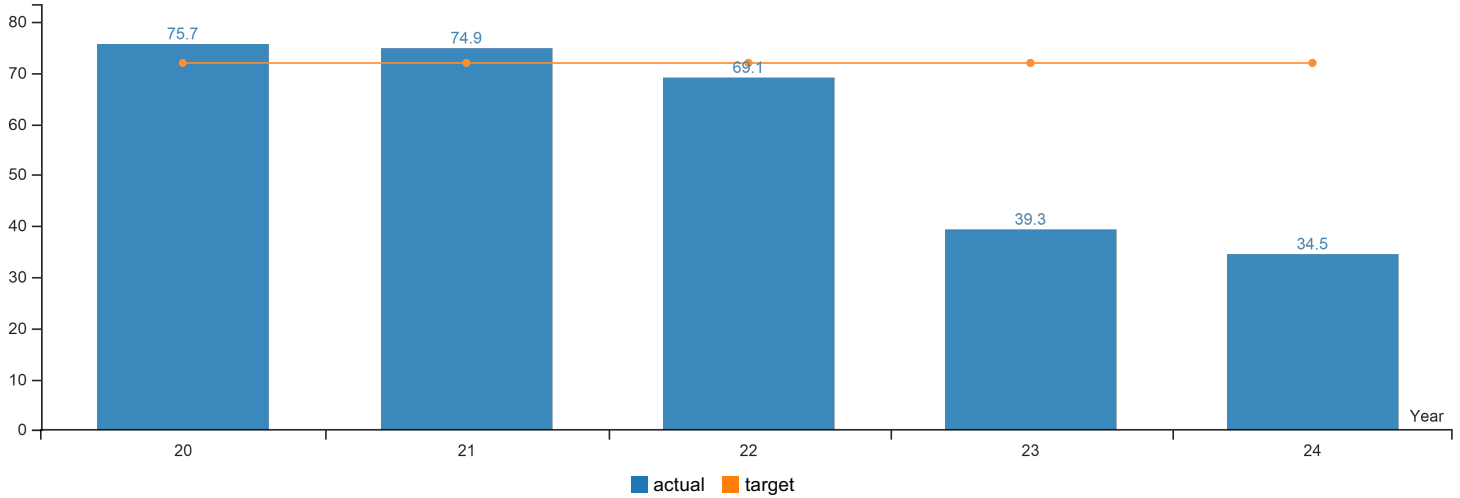
The percentage of members who continued their treatment was 16.6% in 2023. This rate slightly improved from 2022 to 2023, but is still below the 2019 pre-pandemic rate. Data prior to 2022 is not directly comparable due to a methodology change.

Factors Affecting Results

This was selected to be an incentive measure beginning in 2020, which possibly brought increase focus on this measure.

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%	39.30%	34.50%
Target	72%	72%	72%	72%	72%

How Are We Doing

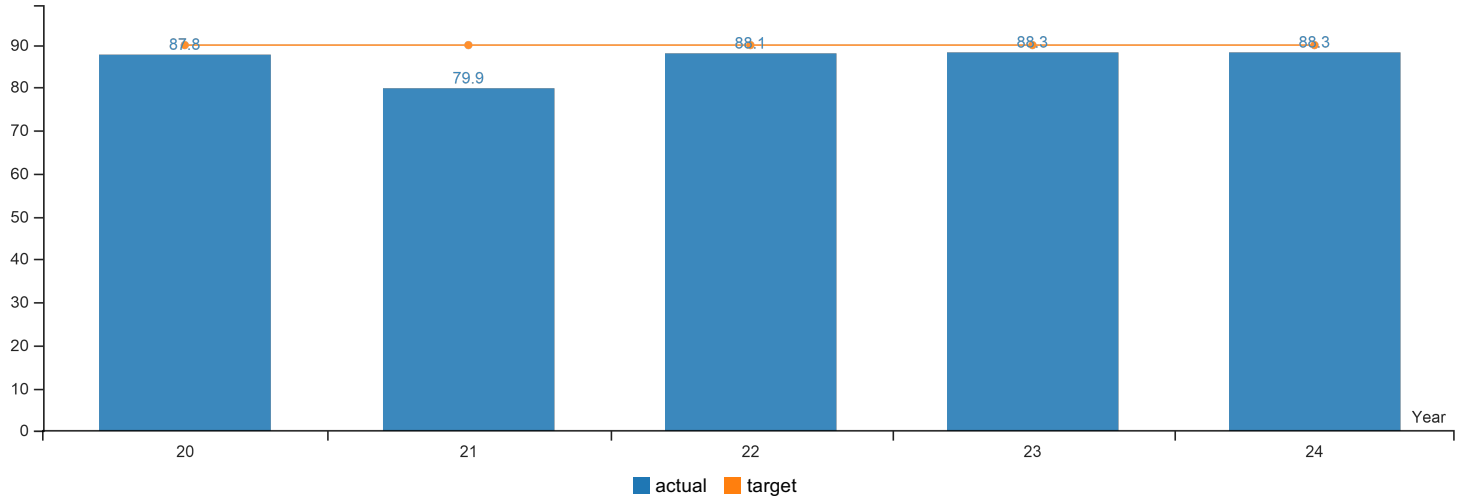
The percentage of members who received a follow-up visit within seven days after a mental illness-related hospitalization was 34.5%. This rate worsened from 2022 by 4.8 percentage points, and is below the 2019 pre-pandemic rate. Results prior to 2022 are not directly comparable to later years.

Factors Affecting Results

Starting in 2022, this measure now aligns wit HEDIS specifications, which require services to be provided by mental health providers and not to be on the same day as discharge.

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%	88.30%	88.30%
Target	90%	90%	90%	90%	90%

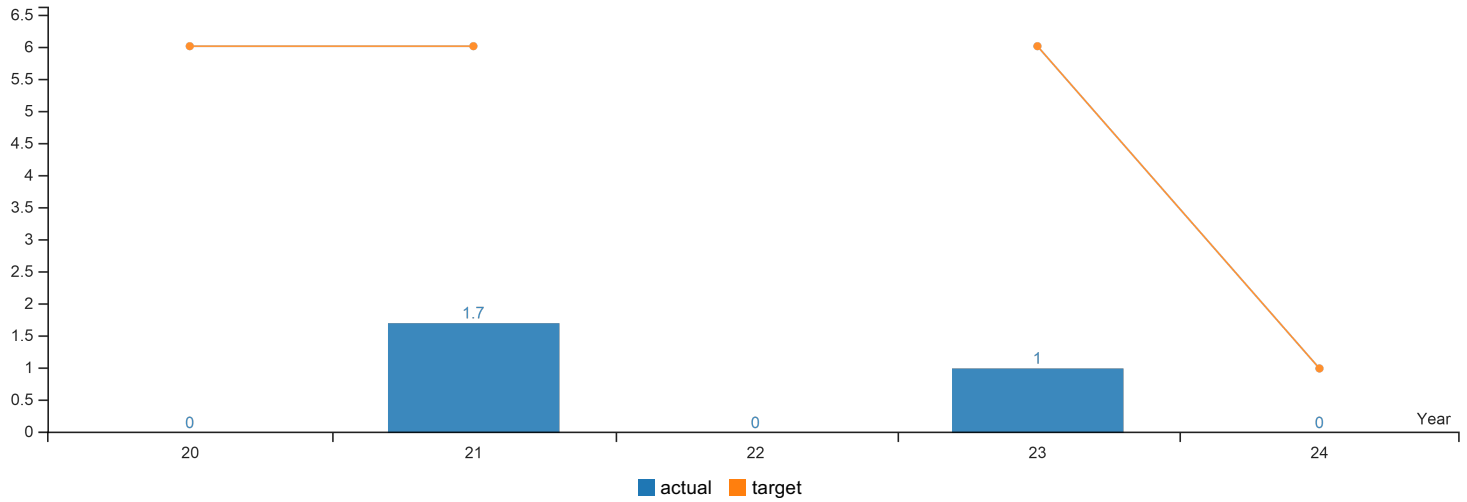
How Are We Doing

Data represents performance in calendar year 2022

Factors Affecting Results

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*



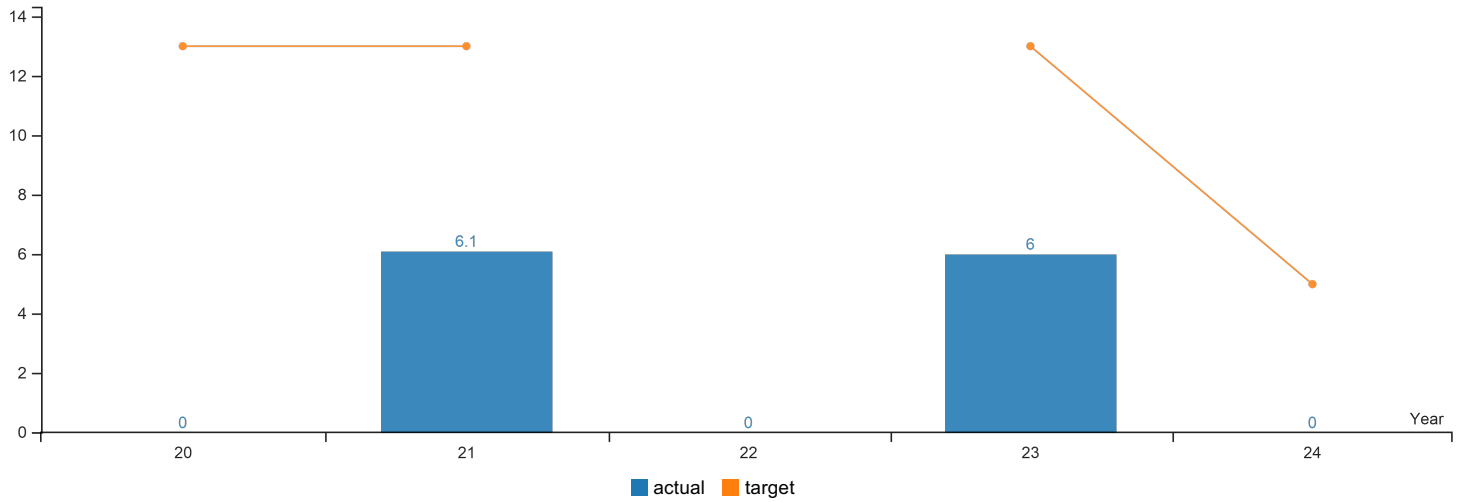
Report Year	2020	2021	2022	2023	2024
30 day illicit drug use among 8th graders					
Actual		1.70%		1%	
Target	6%	6%		6%	1%

How Are We Doing

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*

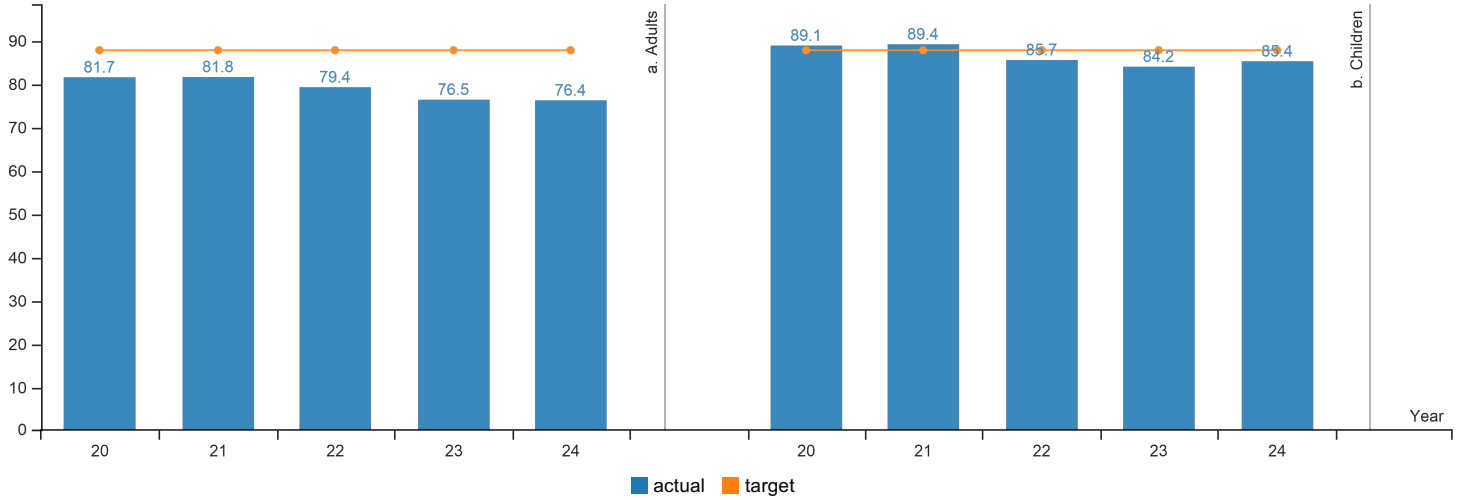


Report Year	2020	2021	2022	2023	2024
30 day alcohol use among 8th graders					
Actual		6.10%		6%	
Target	13%	13%		13%	5%

How Are We Doing

Factors Affecting Results

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%	76.50%	76.40%
Target	88%	88%	88%	88%	88%
b. Children					
Actual	89.10%	89.40%	85.70%	84.20%	85.40%
Target	88%	88%	88%	88%	88%

How Are We Doing

The percentage of adult members who reported they received appointments and care when needed was 76.4% in 2023. This rate held steady from 2022 to 2023, below the 2019 pre-pandemic rate.

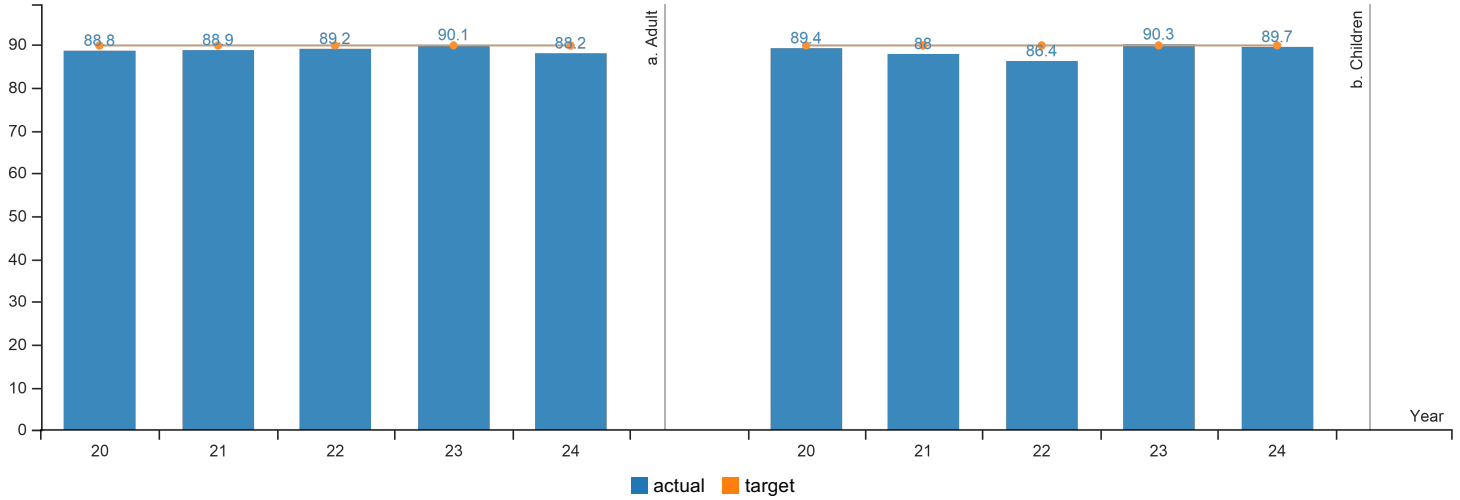
The percentage of child members who received appointments and care when needed was 85.4% in 2023. This rate held steady from 2022 to 2023, below the 2019 pre-pandemic rate.

Adult and Child data from 2022 onward are not directly comparable to previous years. Staring in 2020, OHA refined calculations for composite metrics. Starting in 2021, we began including the oversamples of target race and ethnicity groups in our results.

Factors Affecting Results

The COVID-19 pandemic may have affected the 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%	90.10%	88.20%
Target	90%	90%	90%	90%	90%
b. Children					
Actual	89.40%	88%	86.40%	90.30%	89.70%
Target	90%	90%	90%	90%	90%

How Are We Doing

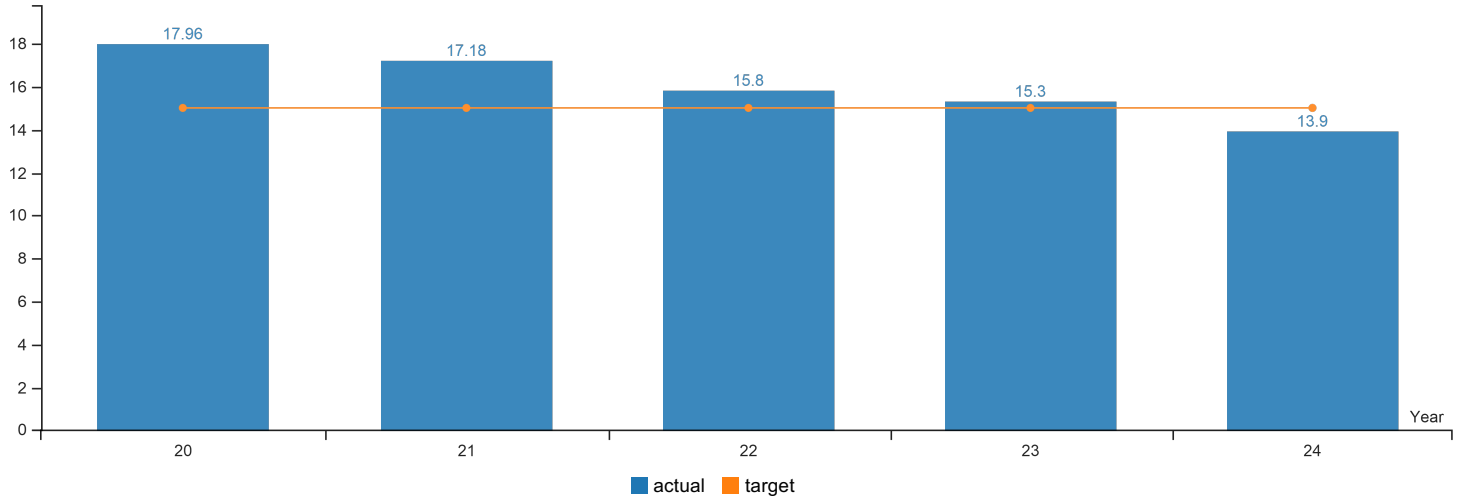
These rates held steady from 2022 to 2023, below the 2019 pre-pandemic rate. Data from 2022 onward are not directly comparable to previous years. Starting in 2020, OHA refined calculations for composite metrics. Starting in 2021, we began including the oversample of target race and ethnicity groups in our results.

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 #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%	15.30%	13.90%
Target	15%	15%	15%	15%	15%

How Are We Doing

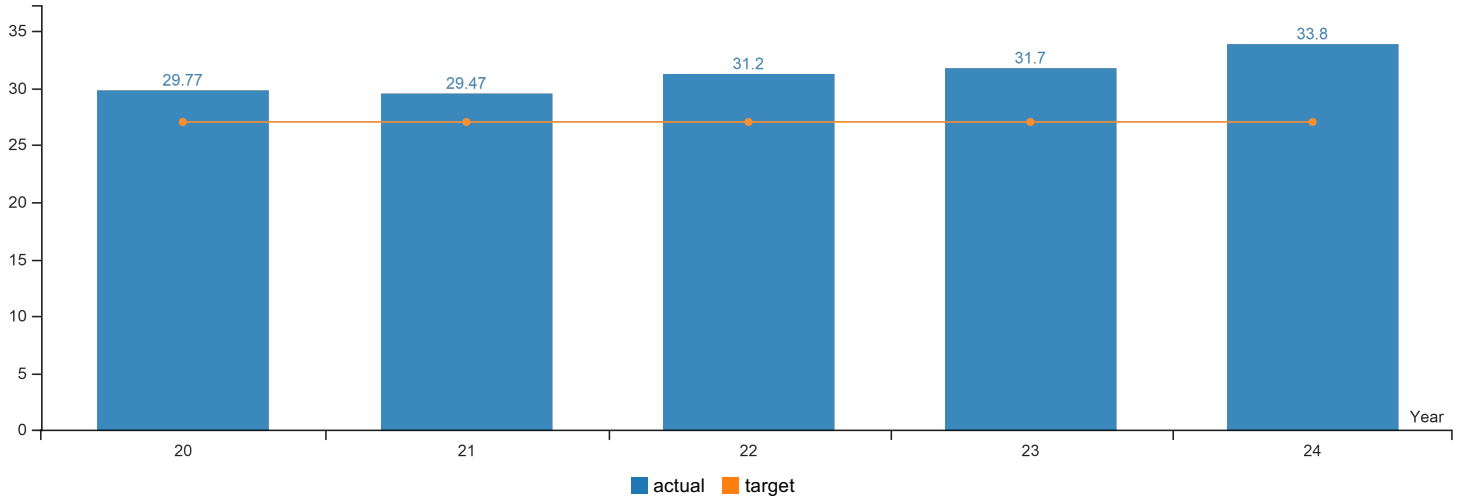
Oregon has exceeded both the threshold of less than 15.8% of Oregon adults using tobacco (cigarette and smokeless tobacco) and the target of 15.0%.

Factors Affecting Results

This decrease comes after voters increased the taxes on tobacco products and that state implanting a fully operational Tobacco Retail Licensure Program. This measure does not include the increase in use of e-cigarettes.

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%	31.70%	33.80%
Target	27%	27%	27%	27%	27%

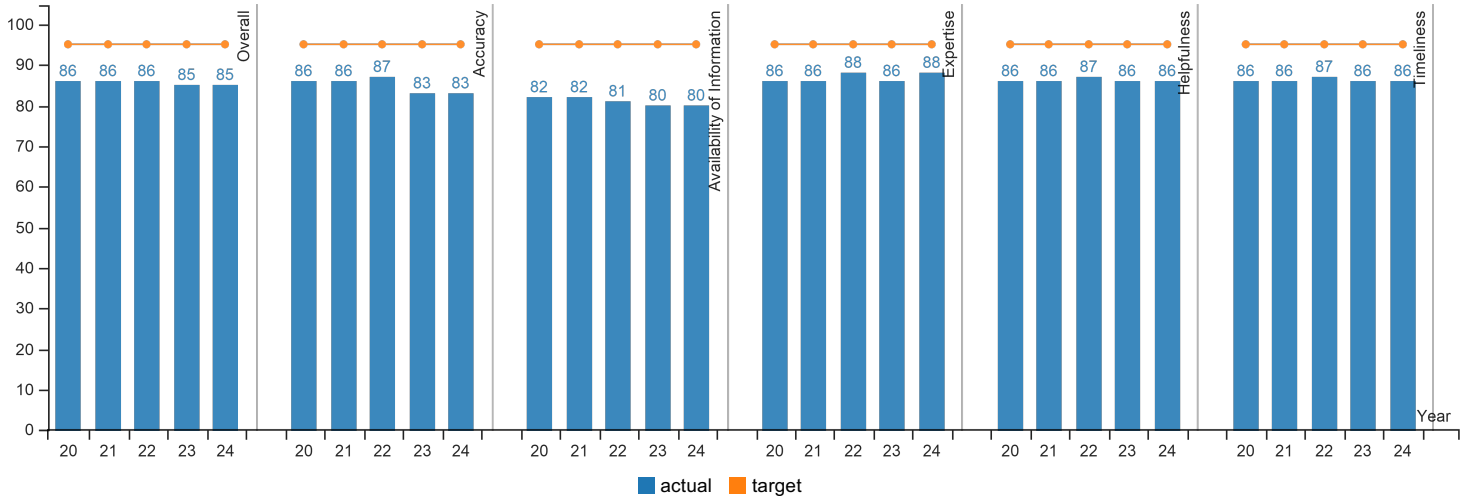
How Are We Doing

The obesity rate continues to increase (worsen) in Oregon.

Factors Affecting Results

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.

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%	85%	85%
Target	95%	95%	95%	95%	95%
Accuracy					
Actual	86%	86%	87%	83%	83%
Target	95%	95%	95%	95%	95%
Availability of Information					
Actual	82%	82%	81%	80%	80%
Target	95%	95%	95%	95%	95%
Expertise					
Actual	86%	86%	88%	86%	88%
Target	95%	95%	95%	95%	95%
Helpfulness					
Actual	86%	86%	87%	86%	86%
Target	95%	95%	95%	95%	95%
Timeliness					
Actual	86%	86%	87%	86%	86%
Target	95%	95%	95%	95%	95%

How Are We Doing

Overall - Results continue to be stable year over year.

Availability of Information - Results continue to be stable year over year, with a slight improvement over 2021 results.

Expertise - We saw improved results in this category this year.

Helpfulness - Results continue to be stable year over year, with a slight improvement over 2021 results.

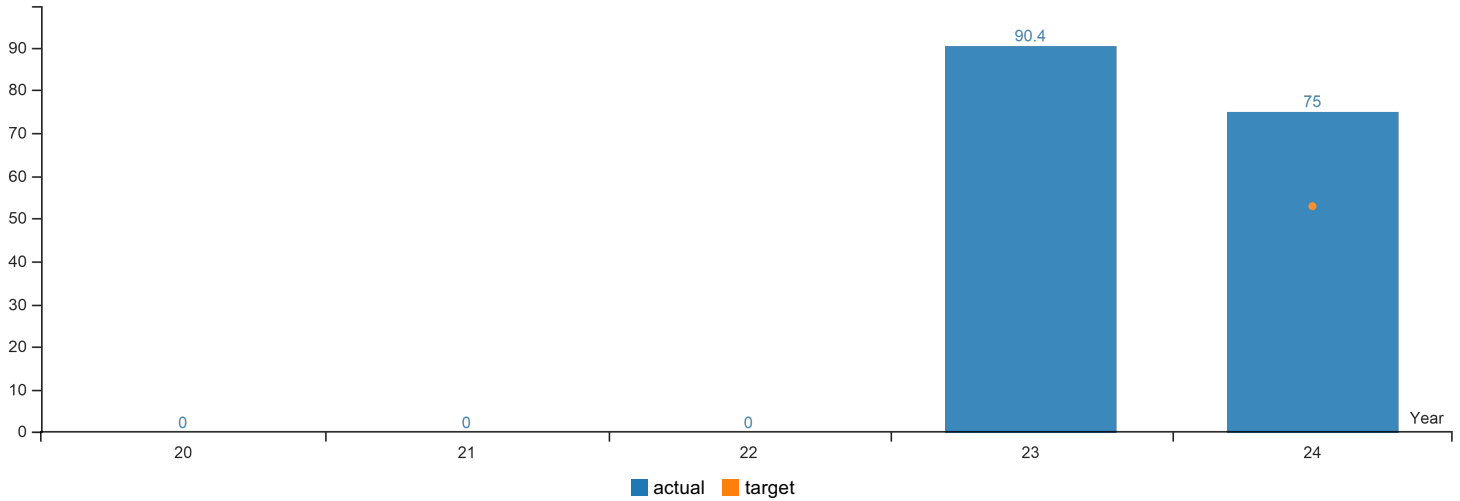
Timeliness - Results continue to be stable year over year.

Factors Affecting Results

While we send the survey to the same audience (all PEBB members) each year, only about 20-25% of members respond. It’s not always the same members, so it's difficult to really gauge improvement or lack thereof. We hope to see improved results in our next survey. We have implemented a monthly newsletter and are updating our website. We are focusing on language and reading level accessibility in outgoing communications, resources, and web pages.

KPM #35	HEALTH EQUTY MEASURE – COMPONENT #1: MEANINGFUL LANGUAGE ACCESS TO CULTURALLY RESPONSIVE HEALTH CARE SEVICES 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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Health Equity Measure – component #1: Meaningful language access to culturally responsive health care services for CCO members					
Actual				90.40%	75%
Target					53%

How Are We Doing

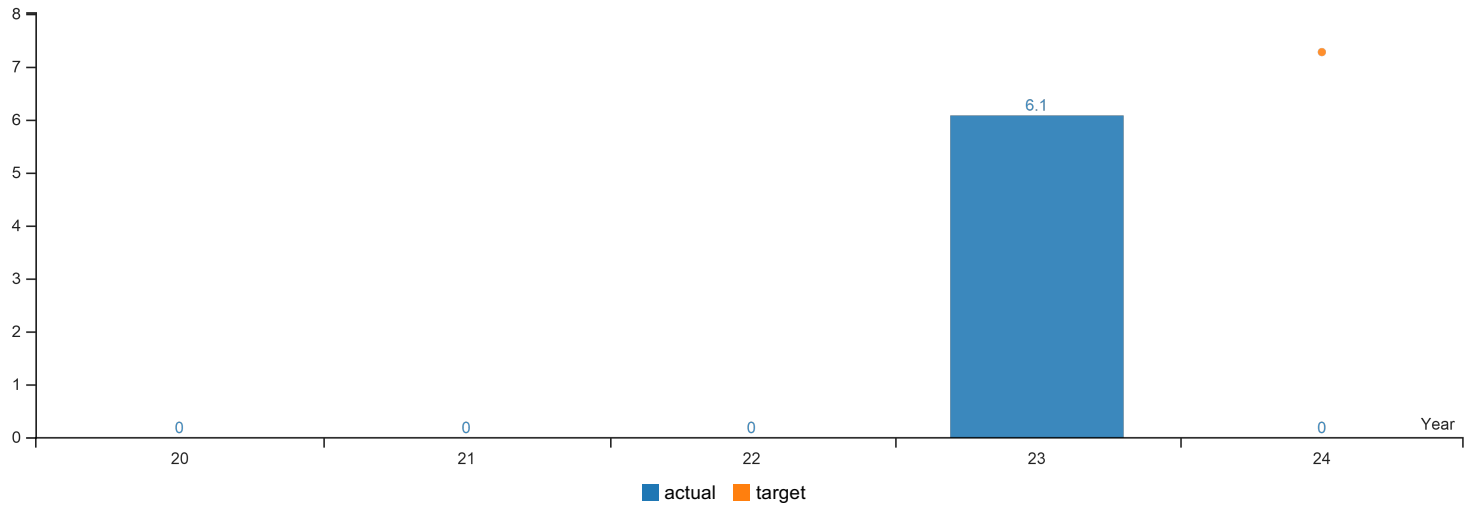
The total score for 2023 is 102 and the minimum percentage score is 75%.

Factors Affecting Results

While each CCOs percentage score for 2023 is higher than 75%, one of the sixteen CCOs failed component 1 because they did not pass all must pass questions in all 4 domains of component 1. A passing score for this component has 2 parts, meeting the minimum percentage score and passing all must pass questions in all domains for the measurement year.

KPM #36	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



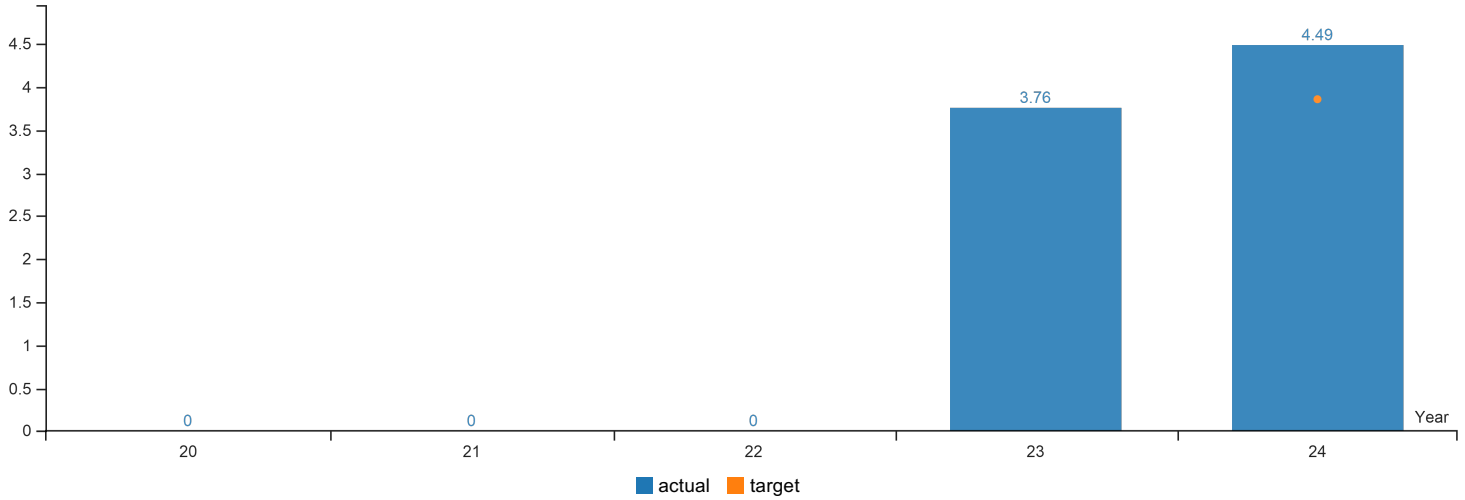
Report Year	2020	2021	2022	2023	2024
Health Equity Measure – component #2: Meaningful language access to culturally responsive health care services for CCO members					
Actual				6.10%	
Target					7.30%

How Are We Doing

Factors Affecting Results

KPM #37	INFANTE MORTALITY RATE - Numerator: # of deaths of infants <365 days of age in specified time period Denominator: # of live births in specified time period. Rate calculation: (Num/Denom)*1,000
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



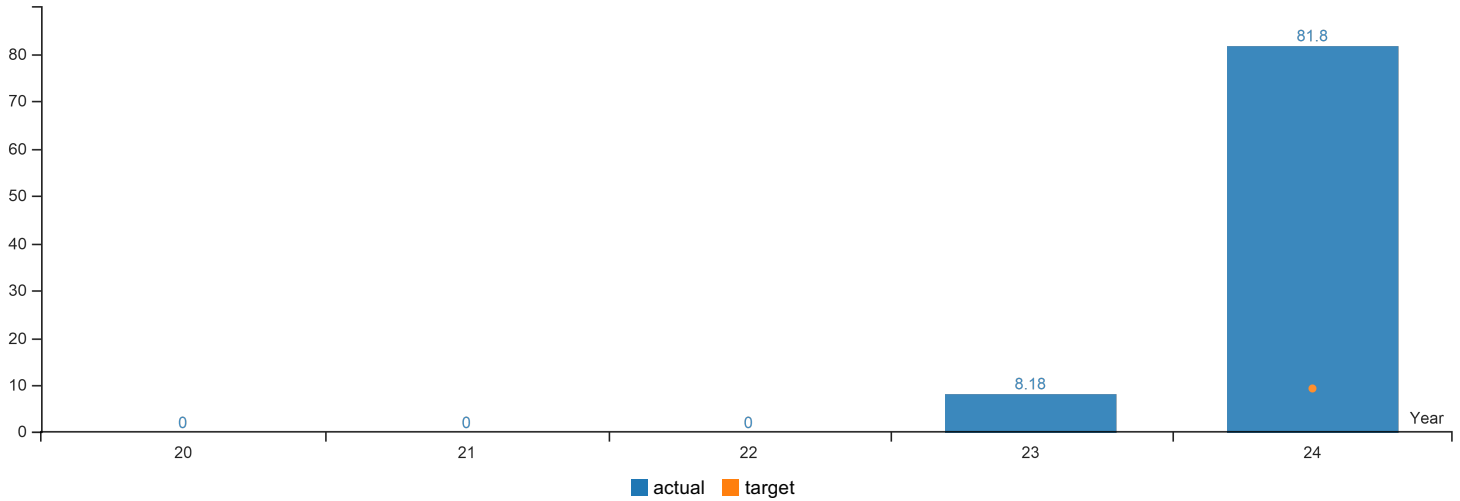
Report Year	2020	2021	2022	2023	2024
Infant Mortality Rate					
Actual				3.76%	4.49%
Target					3.86%

How Are We Doing

Factors Affecting Results

KPM #38	REDUCTION OF SEVERE MATERNAL MORBIDITY - Numerator: # of cases of severe maternal morbidity* in specified time period Denominator: # of delivery hospitalizations in specified time period Rate calculation: (Num/Denom)*10,000 (read out as “[number] per 10,000 delivery hospitalizations”) *Note: Severe maternal morbidity cases are determined by using a validated set of ICD-10 diagnosis and procedure codes to examine hospital data.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



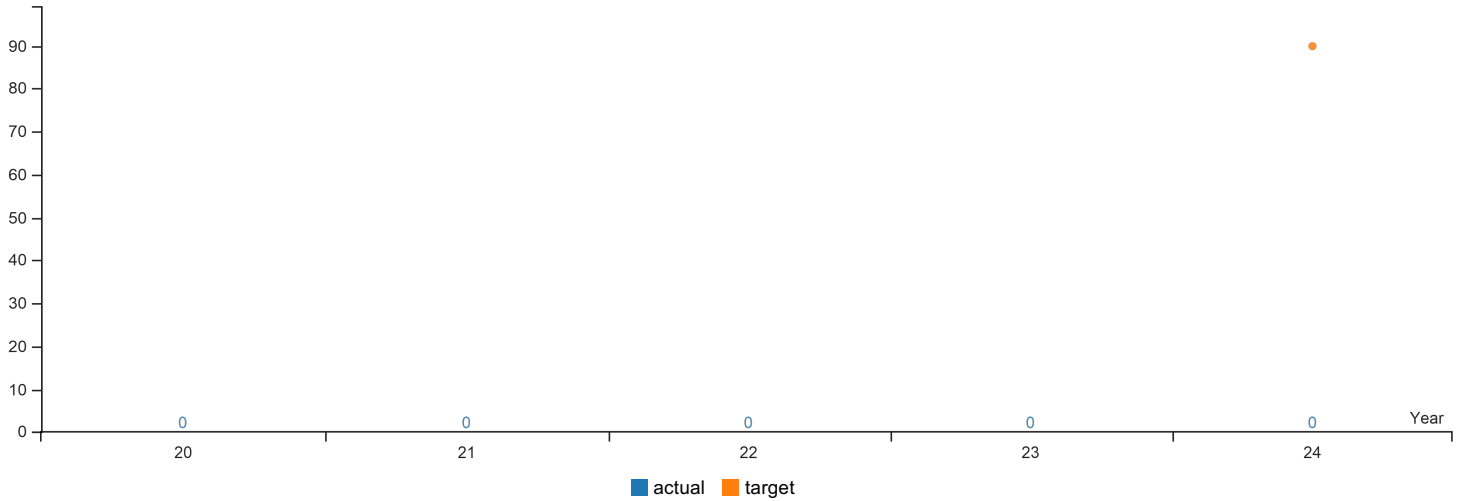
Report Year	2020	2021	2022	2023	2024
Reduction of Severe Maternal Morbidity					
Actual				8.18%	81.80%
Target					9.40%

How Are We Doing

Factors Affecting Results

KPM #39	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



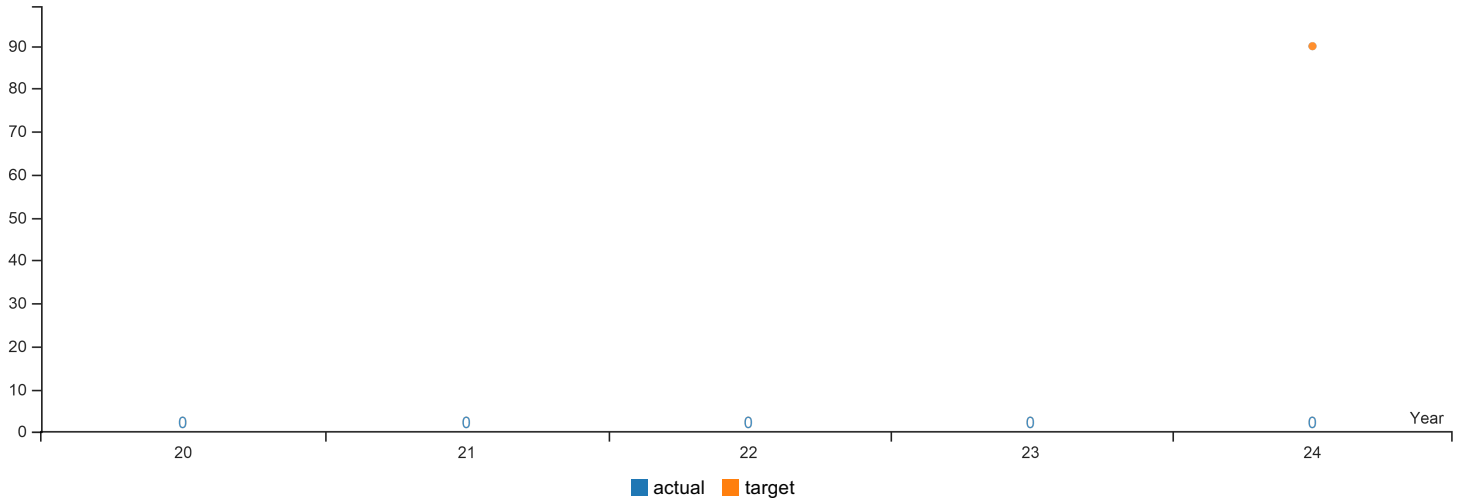
Report Year	2020	2021	2022	2023	2024
Comparison of OHA Workforce to Potential Labor Market					
Actual					
Target					90%

How Are We Doing

Factors Affecting Results

KPM #40	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



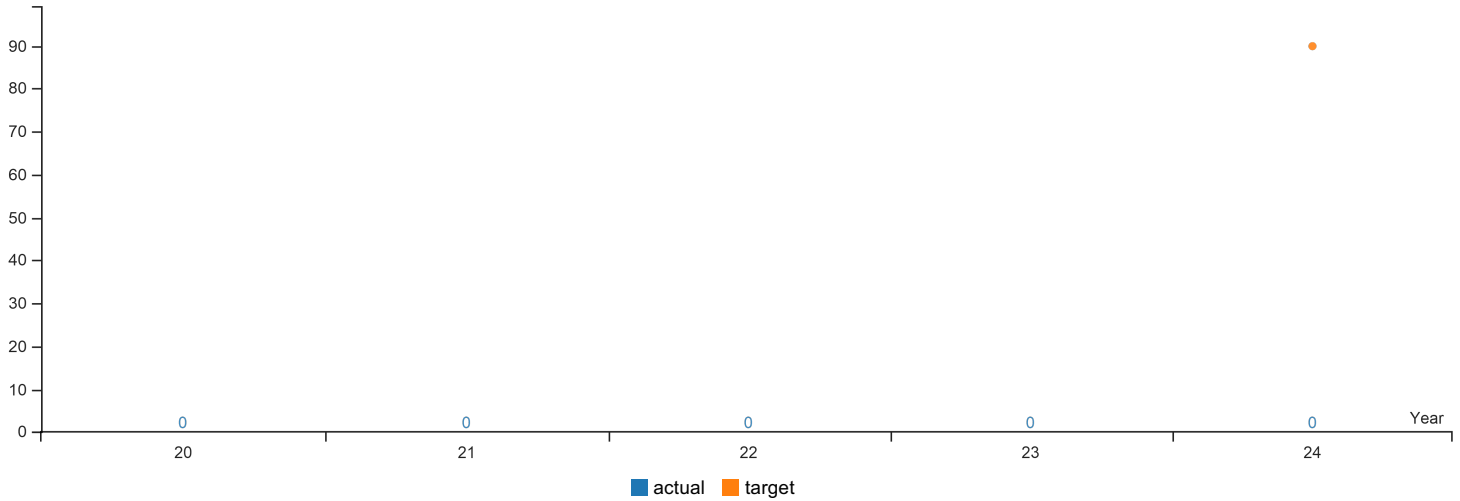
Report Year	2020	2021	2022	2023	2024
Comparison of OHA Non-Supervisory Managers to Potential Labor Market					
Actual					
Target					90%

How Are We Doing

Factors Affecting Results

KPM #41	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



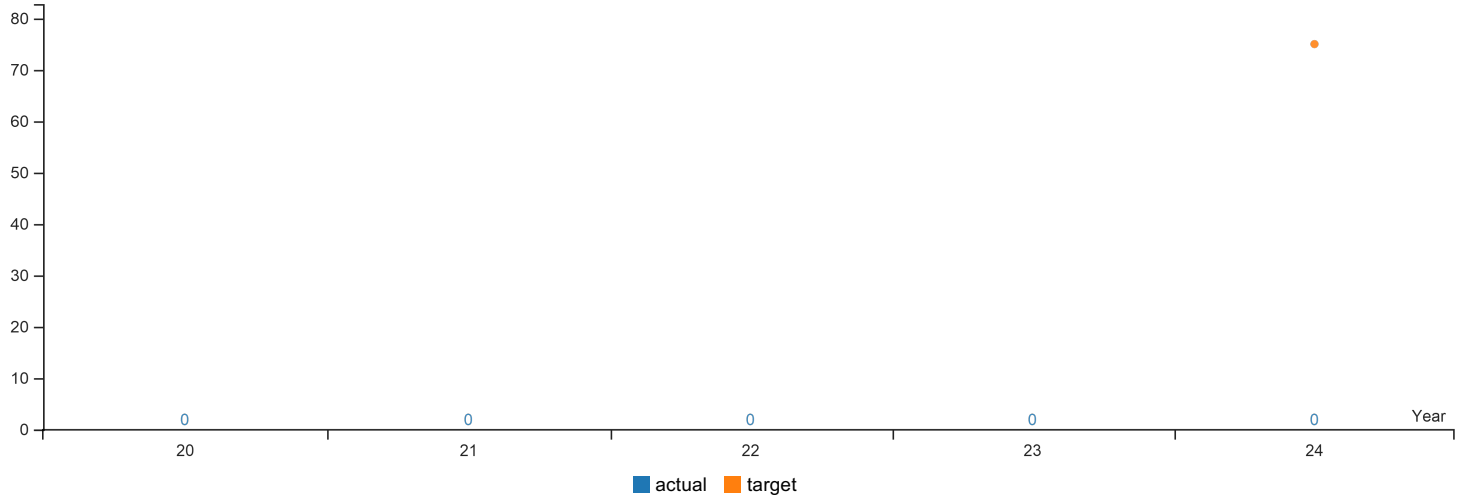
Report Year	2020	2021	2022	2023	2024
Comparison of OHA Supervisory Managers to Potential Labor Market					
Actual					
Target					90%

How Are We Doing

Factors Affecting Results

KPM #42	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



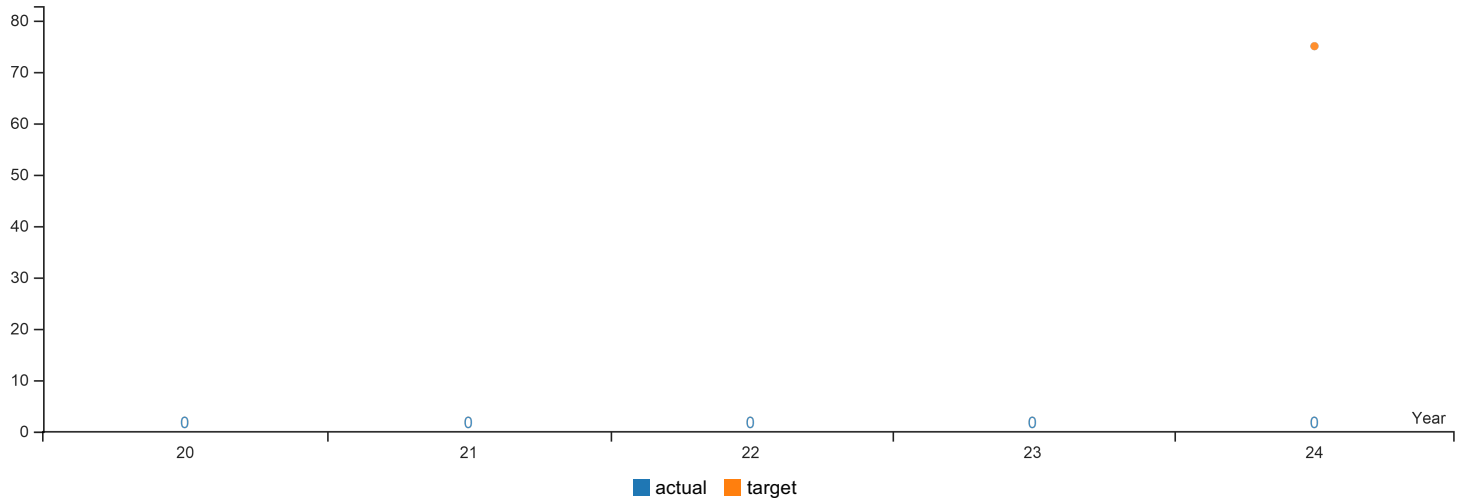
Report Year	2020	2021	2022	2023	2024
Comparison of OHA Voluntary Separations to All Agency Separations					
Actual					
Target					75%

How Are We Doing

Factors Affecting Results

KPM #43	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 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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



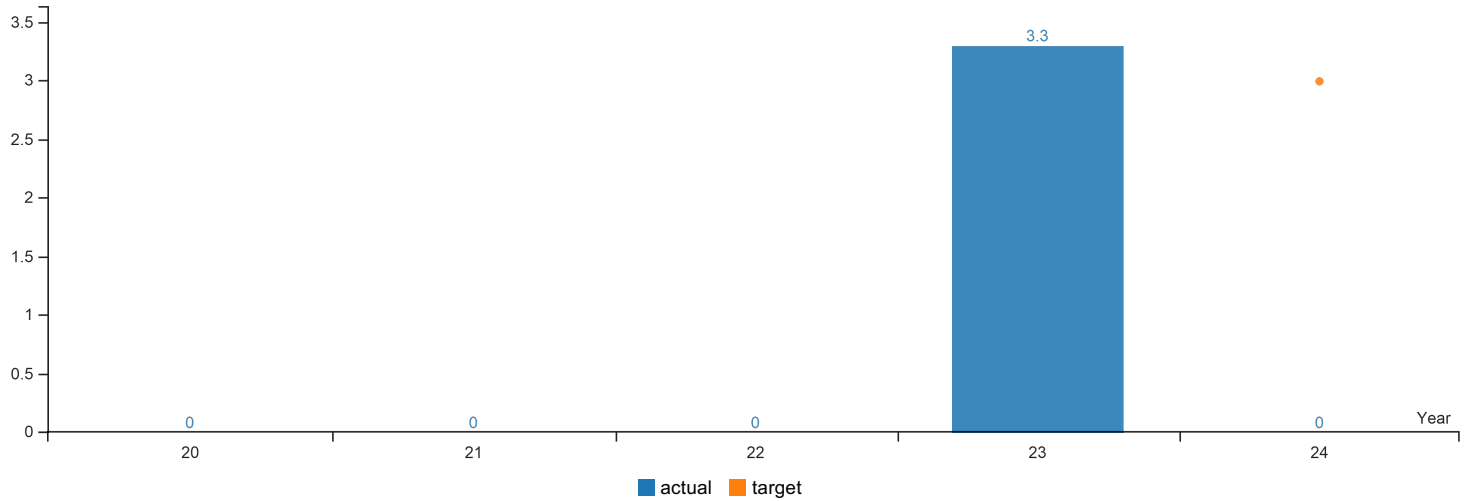
Report Year	2020	2021	2022	2023	2024
Comparison of OHA Involuntary Separations to All Agency Separations					
Actual					
Target					75%

How Are We Doing

Factors Affecting Results

KPM #44	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



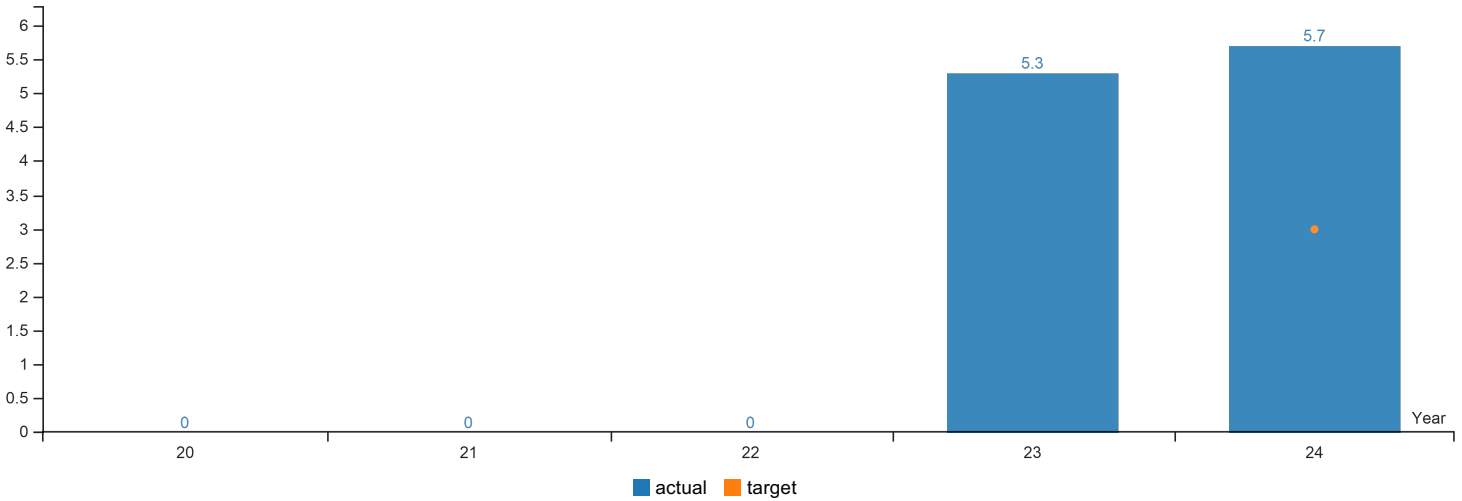
Report Year	2020	2021	2022	2023	2024
Quality of Life - Poor Physical Health					
Actual				3.30	
Target					3

How Are We Doing

Factors Affecting Results

KPM #45	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



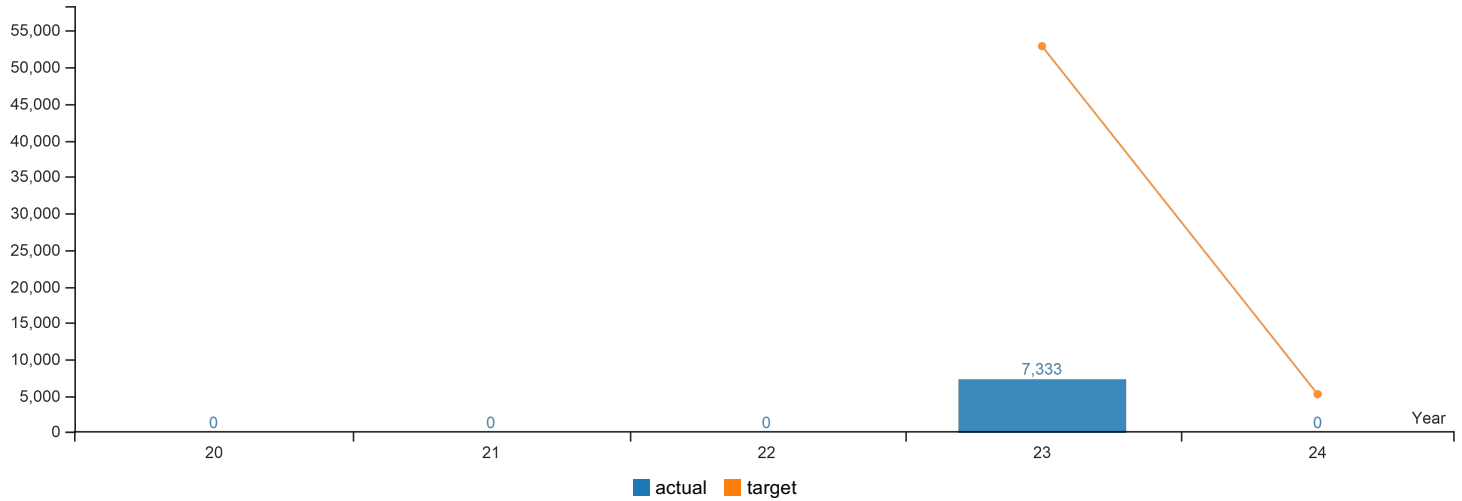
Report Year	2020	2021	2022	2023	2024
Quality of Life - Poor Mental Health					
Actual				5.30	5.70
Target					3

How Are We Doing

Factors Affecting Results

KPM #46	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



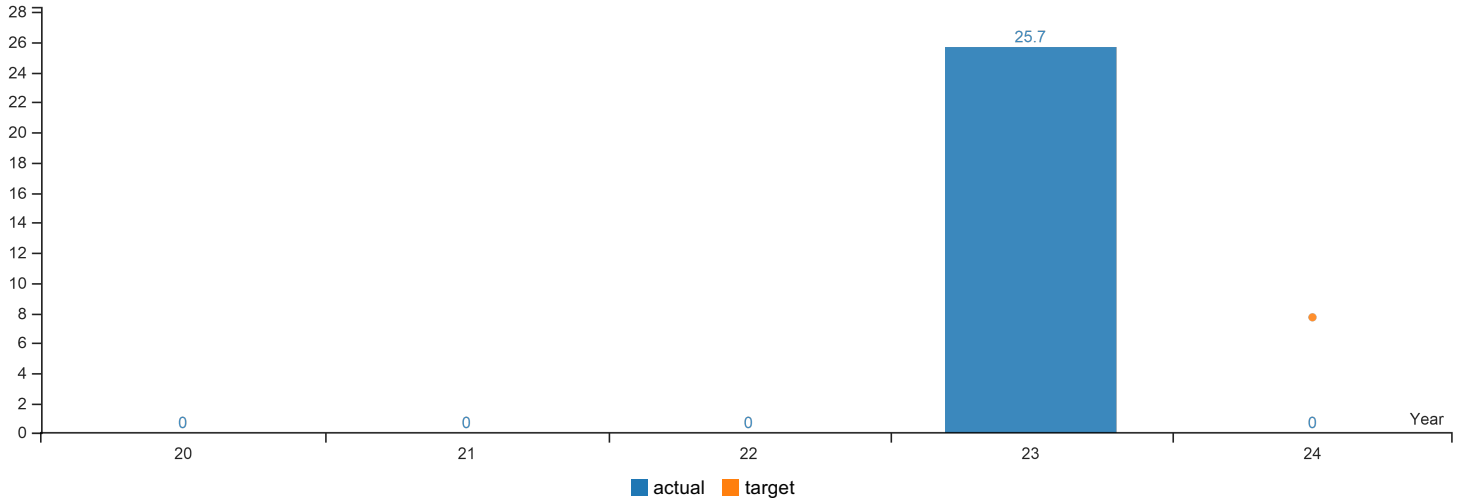
Report Year	2020	2021	2022	2023	2024
Premature Death					
Actual				7,333	
Target				53,000	5,300

How Are We Doing

Factors Affecting Results

KPM #47	MORTALITY FROM DRUG OVERDOES - 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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



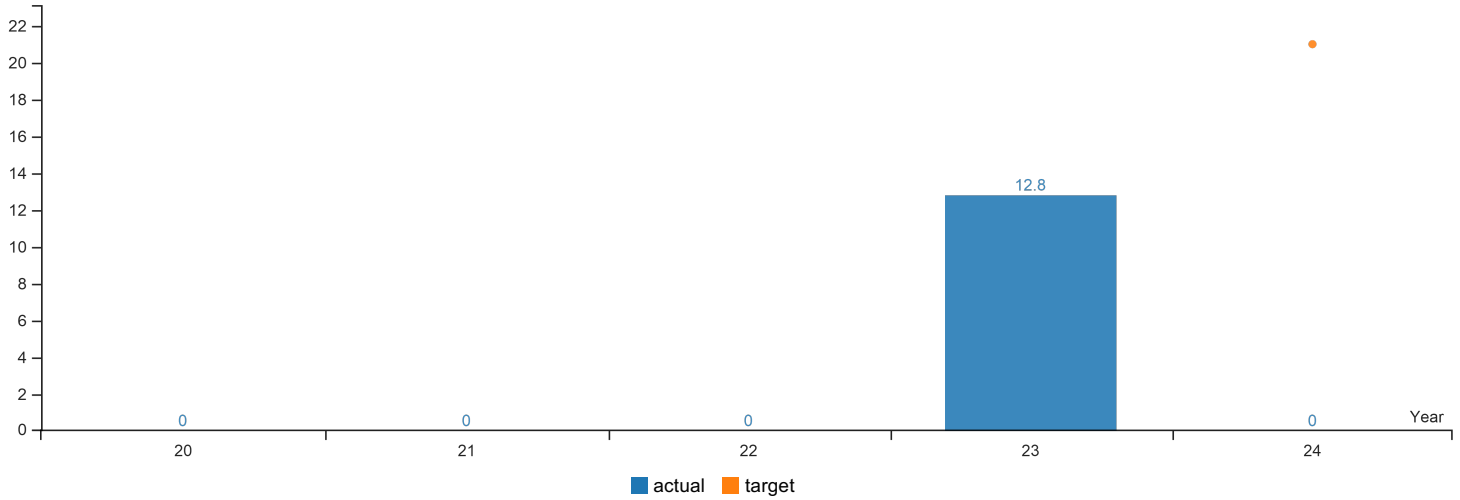
Report Year	2020	2021	2022	2023	2024
Mortality from Drug Overdose					
Actual				25.70	
Target					7.70

How Are We Doing

Factors Affecting Results

KPM #48	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = negative result*



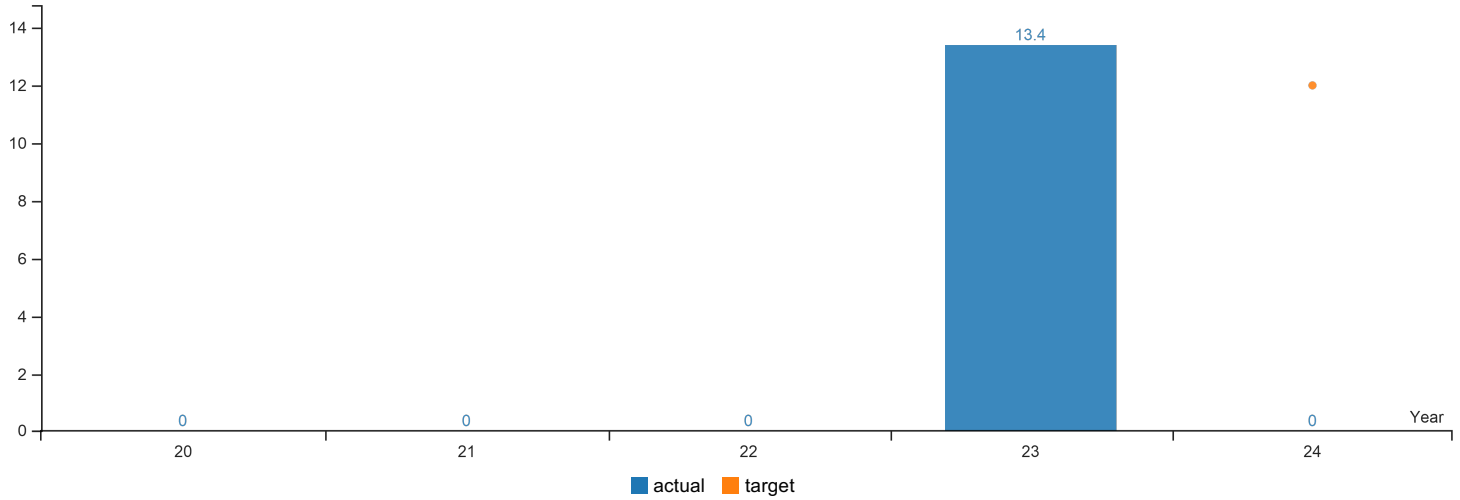
Report Year	2020	2021	2022	2023	2024
Tobacco Use - Teens					
Actual				12.80%	
Target					21%

How Are We Doing

Factors Affecting Results

KPM #49	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



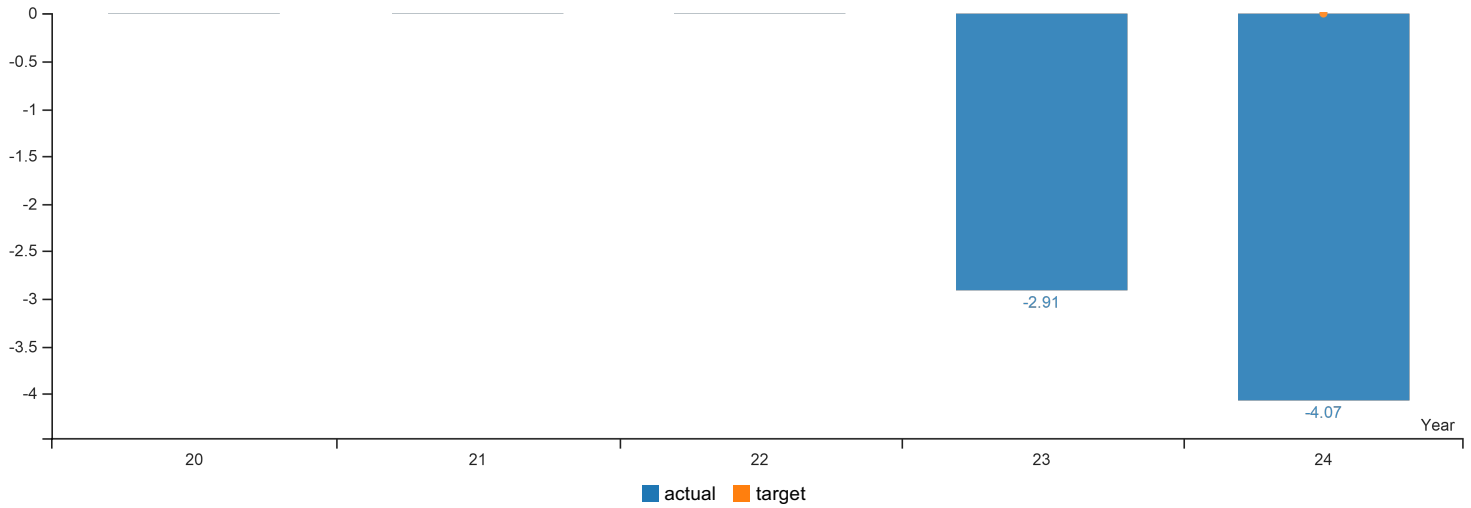
Report Year	2020	2021	2022	2023	2024
Obesity - Teens					
Actual				13.40	
Target					12

How Are We Doing

Factors Affecting Results

KPM #50	STATEWIDE SUSTAINABLE COST OF CARE - Comparison of health care cost changes to personal income changes. Any value 0 or higher is green because we want per capita income growth to equal or exceed per capita health care cost growth. By way of background, the statewide sustainable cost of care measure is a comparison between per person growth in income in Oregon and health care spending growth in Oregon. Historically, health care costs have grown faster than income and Oregon is trying to change that with the Cost Growth Target program and other initiatives. When the result from subtracting per person income growth minus per person health care cost growth is 0 or positive, it means income is growing at the same pace or faster than health care costs, which is good. When the measure is a negative number, it means health care costs are growing faster than income, which is not good.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
Statewide Sustainable Cost of Care					
Actual				-2.91	-4.07
Target					0

How Are We Doing

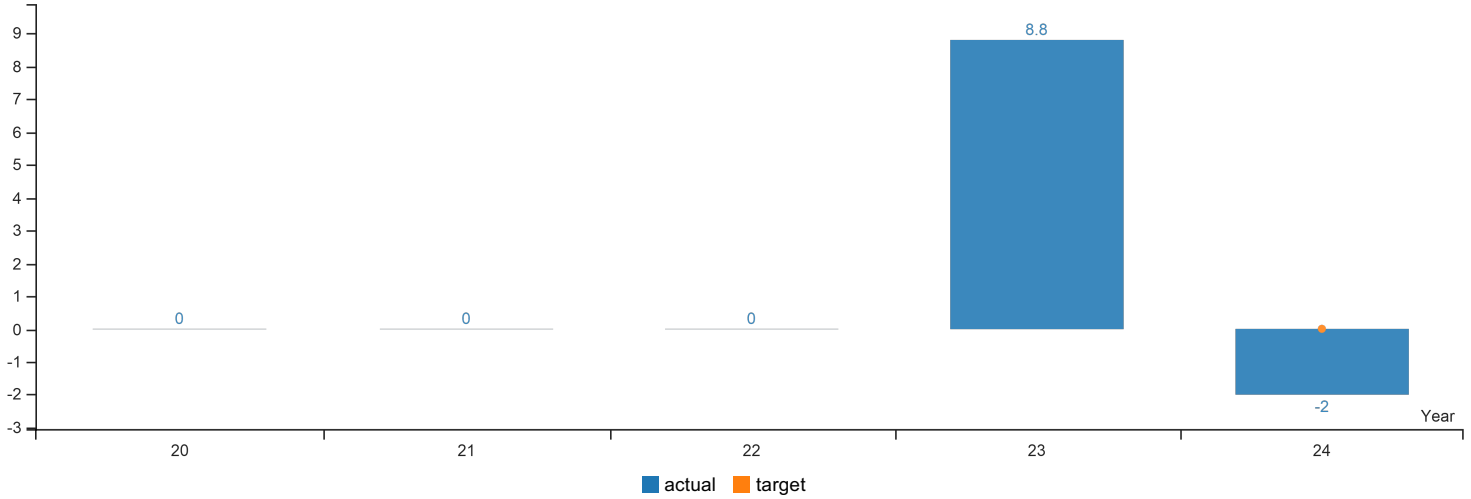
We are facing challenges in sustaining the cost of care putting more financial strain on households.

Factors Affecting Results

Per Capita income decreased by 0.5%, while per person health care spending increased 3.6%. Income growth minus health care cost growth was -4.07%

KPM #51	OHA SUSTAINABLE COST OF CARE - Difference between real personal income and health care inflation. Any value 0 or higher is green because we want per capita income growth to equal or exceed OHA's per person spending on PEBB, OEBB, and OHP. By way of background, the OHA sustainable cost of care measure is a comparison between per person growth in income in Oregon and health care spending growth for OHA's three health programs: Oregon Health Plan, Public Employees Benefits and Oregon Educators Benefits. When the result from subtracting per person income growth in Oregon minus per person spending on PEBB, OEBB, and OHP is 0 or positive, it means income is growing at the same pace or faster than OHA's health care costs, which is good. When the measure is a negative number, it means the cost of OHA's three health care programs is growing faster than income, which is not good.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



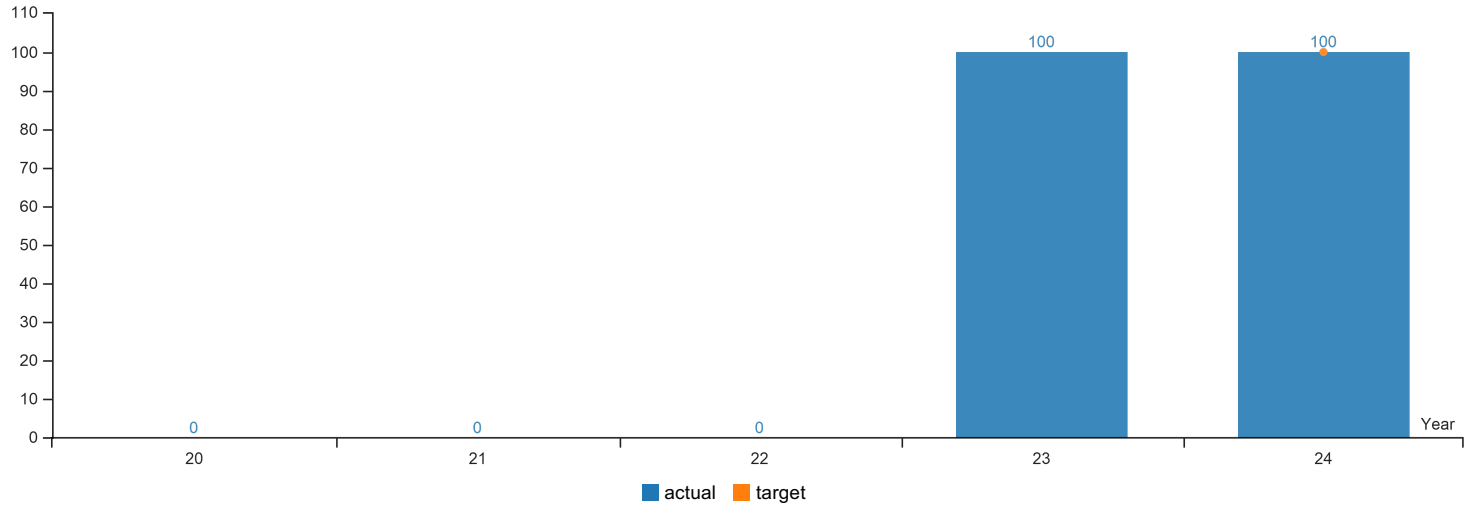
Report Year	2020	2021	2022	2023	2024
OHA Sustainable Cost of Care					
Actual				8.80	-2
Target					0

How Are We Doing

Factors Affecting Results

KPM #52	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



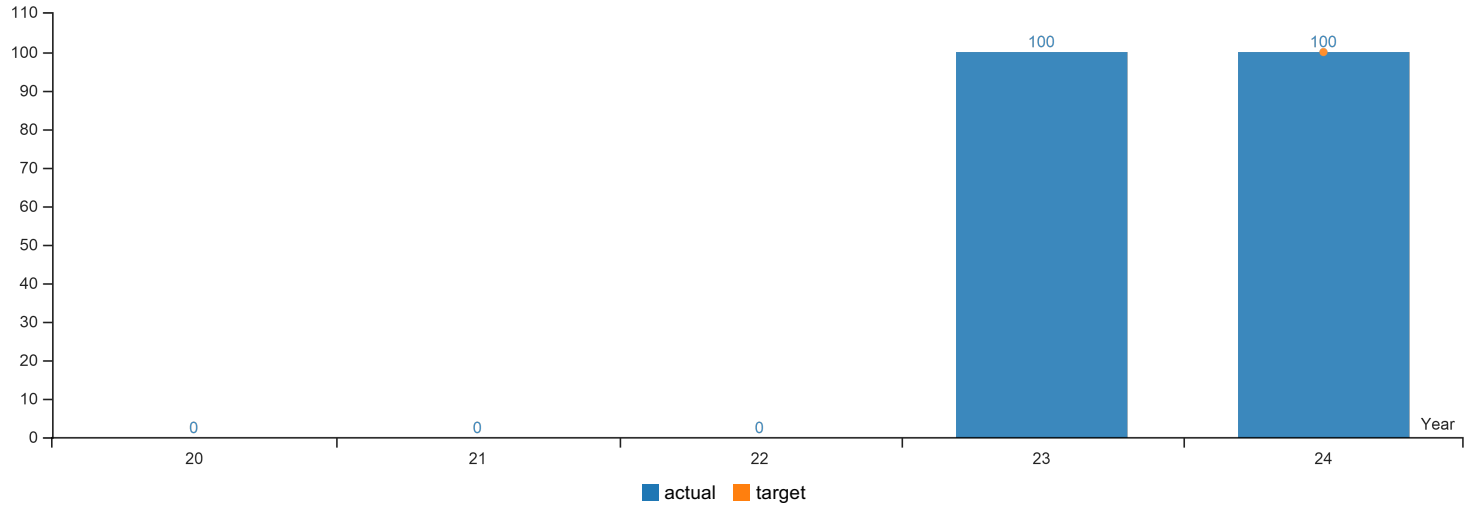
Report Year	2020	2021	2022	2023	2024
Critical events meeting the 14-calendar day timeline to provide correspondence to Tribal Leaders					
Actual				100%	100%
Target					100%

How Are We Doing

Factors Affecting Results

KPM #53	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
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



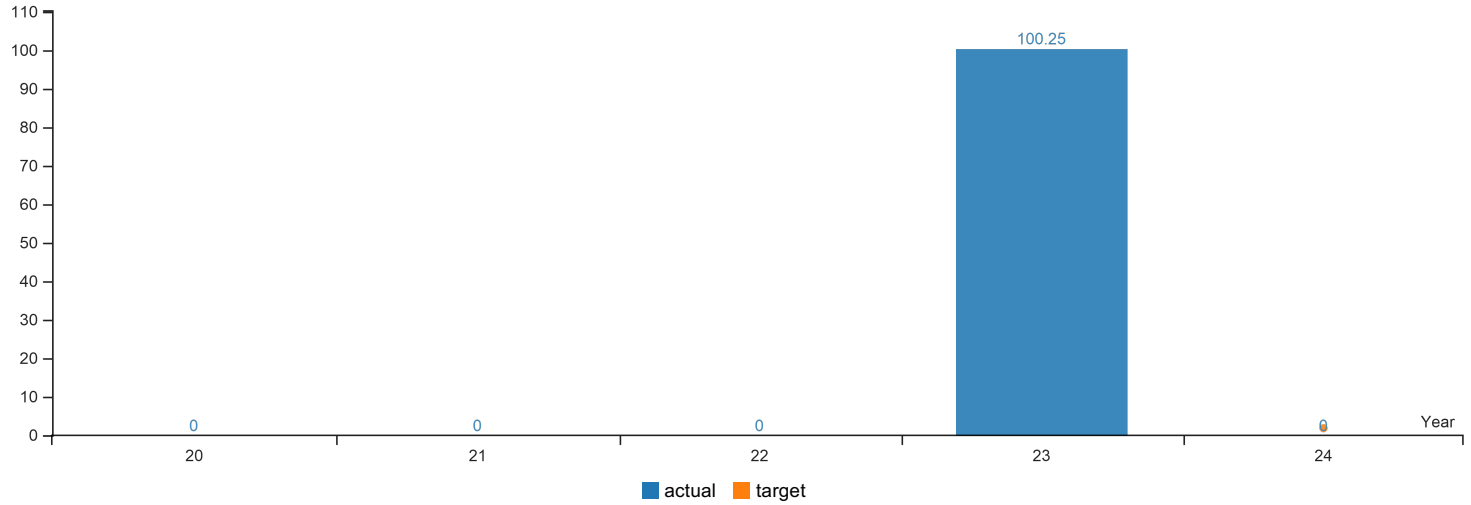
Report Year	2020	2021	2022	2023	2024
Tribal consultations meeting the 30-calendar day timeline for reporting of outcome of consultation					
Actual				100%	100%
Target					100%

How Are We Doing

Factors Affecting Results

KPM #54	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.
	Data Collection Period: Jan 01 - Jan 01

** Upward Trend = positive result*



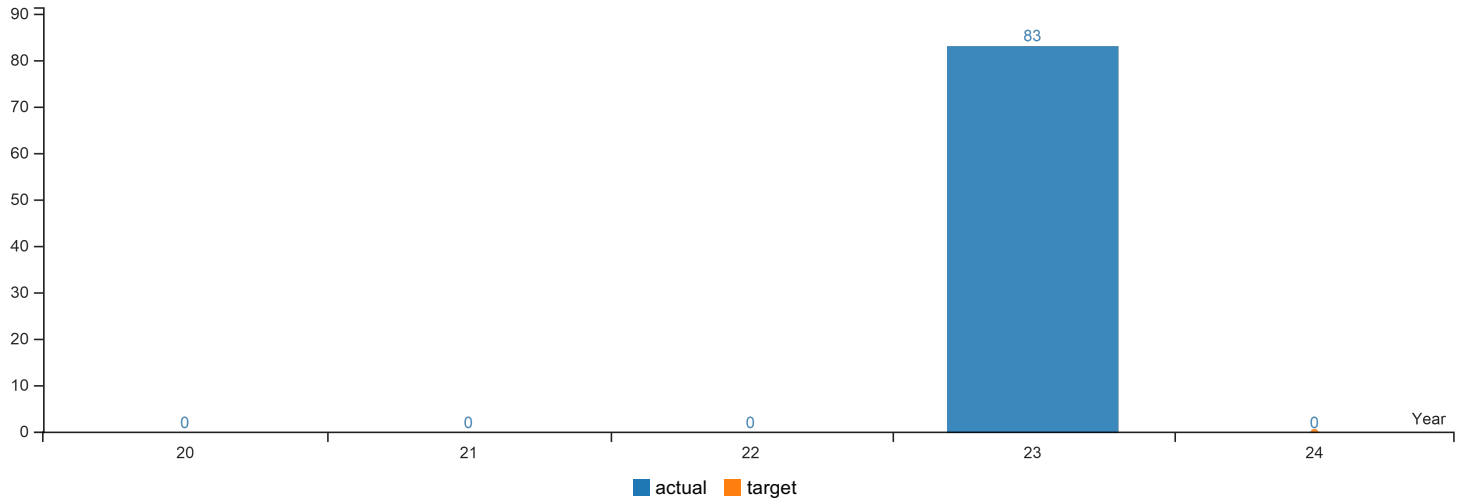
Report Year	2020	2021	2022	2023	2024
Timeliness of Translations During Emerging Public Health Events					
Actual				100.25	
Target					2

How Are We Doing

Factors Affecting Results

KPM #55	PENDING REDETERMINATION APPLICATIONS OVER 45 DAYS OLD - Total number of pending applications for redetermination that are over 45 days old.
	Data Collection Period: Jul 01 - Sep 30

** Upward Trend = positive result*



Report Year	2020	2021	2022	2023	2024
PENDING REDETERMINATION APPLICATIONS OVER 45 DAYS OLD					
Actual				83	0
Target					0

How Are We Doing

Factors Affecting Results

PROPOSED SUPERVISORY SPAN OF CONTROL REPORT

In accordance with the requirements of ORS 291.227[1], the Oregon Health Authority presents this report to the Joint Ways and Means Committee regarding the agency's Proposed Maximum Supervisory Ratio for the 2023-2025 biennium.

Actual Supervisory Ratio (ASR) Calculation[2] effective December 1, 2024

ASR Calculation for OHA:

a. Total OHA non-supervisors include all employees and vacant positions designated as nonsupervisory. (**6124**)
b. Total OHA supervisors include all employees and vacant positions designated as supervisory excluding the agency head. (**633**)
c. The calculation of the actual supervisory ratio is the total number of OHA non-supervisory employees and vacant non-supervisory positions (**6124**) in the agency divided by the total number of OHA supervisory employees and vacant supervisory positions (**633**) in the agency.

OHA ASR = 1:9.67

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 →

[1] **ORS 291.227(e)** "Supervisory ratio" means the ratio of employees who are supervisory employees to employees who are not supervisory employees. [2017 c.285 §1; 2020 s.s.2 c.10 §3]
[2] CHRO Policy 30.000.20 (effective date 11/01/2024)

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 below)

Unions Requiring Notification_____

Date unions notified_____

Submitted by: _____ **Date** _____

Signature Line _____ **Date** _____

Signature Line _____ **Date** _____

Signature Line _____ **Date** _____

Signature Line _____ **Date** _____

FINAL Agency Span of Control as of 06/30/24 @ 11:59:59 PM

	Agency Max Supervisory ratio	Total # EEs on 06/30/24*	Total # Non-supervisory EEs on 06/30/24	÷	Total # Supervisory EEs on 06/30/24	Total # EEs not assigned a Representation on 06/30/24**	1	:	Adjusted Actual Ratio on 06/30/24	Actual ratio	Comments
Bureau of Labor and Industries	(1:7)	208	181	÷	27	0	1	:	7	6.70	
Department of Administrative Services	(1:9)	1114	998	÷	116	0	1	:	9	8.60	
Department of Agriculture	(1:8)	775	721	÷	54	0	1	:	13	13.35	
Department of Consumer & Business Services	(1:11)	1034	941	÷	93	0	1	:	10	10.12	
Department of Corrections	(1:11)	5301	4863	÷	438	1	1	:	11	11.10	
Department of Early Learning and Care	(1:9)	359	323	÷	36	0	1	:	9	8.97	
Department of Energy	(1:7)	129	114	÷	15	0	1	:	8	7.60	
Department of Environmental Quality	(1:9)	941	859	÷	82	0	1	:	10	10.48	
Department of Fish and Wildlife	(1:6)	1476	1289	÷	187	0	1	:	7	6.89	
Department of Human Services	(1:8.47)	12534	11397	÷	1137	6	1	:	10	10.02	
Department of Justice	(1:11.88)	1659	1529	÷	130	1	1	:	12	11.76	
Department of Public Safety Standards and Training	(1:17.95)	420	401	÷	19	1	1	:	21	21.11	
Department of Revenue	(1:11)	1233	1129	÷	104	0	1	:	11	10.86	
Department of State Lands	(1:8)	138	122	÷	16	0	1	:	8	7.63	
Department of the State Fire Marshal	*See Comment*	164	143	÷	21	1	1	:	7	6.81	Please provide established 23-25 ratio
Department of Transportation	(1:11)	5303	4874	÷	429	1	1	:	11	11.36	
Department of Veterans Affairs	(1:5.35)	113	98	÷	15	0	1	:	7	6.53	
Employment Department	(1:11)	2230	2051	÷	179	0	1	:	11	11.46	
Forestry Department	(1:7)	1696	1493	÷	203	0	1	:	7	7.35	
Higher Education Coordinating Commission	(1:7)	221	201	÷	20	0	1	:	10	10.05	
Oregon Business Development Department	(1:8)	214	190	÷	24	0	1	:	8	7.92	
Oregon Department of Education	(1:10)	994	912	÷	82	3	1	:	10	9.90	
Oregon Department of Emergency Management	(1:11)	153	137	÷	16	0	1	:	9	8.56	
Oregon Health Authority	(1:8.6)	6580	5959	÷	621	0	1	:	10	9.60	
Oregon Housing and Community Services	(1:7)	493	430	÷	63	0	1	:	7	6.83	
Oregon Liquor & Cannabis Commission	(1:11)	430	394	÷	36	0	1	:	11	10.94	
Oregon State Department of Police	(1:8)	1470	1330	÷	140	7	1	:	10	9.50	
Oregon Youth Authority	(1:9)	1052	949	÷	103	1	1	:	9	9.21	
Parks and Recreation Department	(1:8)	929	839	÷	90	1	1	:	9	9.32	
Public Employees Retirement System	(1:11)	445	408	÷	37	0	1	:	11	11.03	
Public Utility Commission	(1:5)	149	128	÷	21	0	1	:	6	6.10	
State of Oregon Military Department	(1:10)	525	478	÷	47	0	1	:	10	10.17	
Water Resources Department	(1:8)	264	234	÷	30	0	1	:	8	7.80	

* This total number includes positions which were flagged by Workday as NOT having a Repr code assigned. Each position was reviewed and assigned to a supervisory or non supervisory category.
** These numbers are showing up in Workday as not having a Repr code assigned. They were reallocated to a supervisory or non-supervisory category and folded into the Total on column C.

Ratio within Maximum supervisory ratio
Ratio not within Maximum supervisory ratio
No current ratio on file with CHRO