January 30, 2025

Senator Wlnsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

SUBJECT: January 28 Subcommittee Questions

Dear Co-Chairs and Committee Members:

Please find below information requested by members of the Joint Ways and Means Human Services Sub-Committee at the January 28 meeting regarding the Oregon Health Authority's agency budget overview. The first four questions were directed to Patrick Heath, DAS CFO, with answers accordingly prepared in coordination with him. The final three questions were posed to OHA Director Hathi. All seven responses follow:

1. **How does the Disproportionate Share Hospital program work and who receives it?**

   OHA has two main sub-programs through which it makes Disproportionate Share Hospital payments.

   DSH 1 is for hospitals which are "deemed DSH hospitals," meaning the hospital has Medicaid utilization at least one standard deviation above the average for Medicaid-participating hospitals in the state or the hospital has a low-income inpatient utilization greater than 25 percent. OHA allocates funding among these hospitals based on percentages set in administrative rule times the relative severity of illness in patients served by the hospital. Only seven or eight hospitals qualify under this portion of the program (some hospitals may qualify

one year and not qualify the next). OHA has a budget of $3.2 million General Fund and $4.9 million Federal Funds in 2023-25 for DSH 1.

DSH 3 is for hospitals with a Medicaid utilization rate of at least one percent and at least two obstetricians who treat Medicaid enrollees. Most hospitals who receive DSH qualify under this program. OHA allocates funding among these hospitals based on their proportionate share of the amount of un- or undercompensated care multiplied by the remaining DSH allotment after DSH 1 payments are made. OHA has a budget of $23.0 million Other Funds (using hospital provider tax revenues) and $34.0 million Federal Funds for DSH 3 in 2023-25.

The size of the federal match is limited by federal allotment.

2. How did the Governor's Budget achieve such significant savings from the Healthier Oregon Program while preserving benefits and enrollment?

Here are the numbers from the Governor's Budget:

Healthier Oregon Savings	**GF Savings**
Utilization Savings	$288,875,115
Higher Utilization of Matchable Services	$120,089,947
Risk Corridor Payments for 2024	$75,000,000
Transfer to the Basic Health Plan	$42,863,403
Total	**$511,828,465**

Healthier Oregon Program Utilization Savings: OHA uses an actuarial process to set its annual rates for the CCO program, of which Healthier Oregon is a part. The rate development process looks at utilization, geography, demographic characteristics such as age and disability, and other factors to estimate the cost of serving OHP members (including Healthier Oregon) in order to make sure CCOs receive an appropriate per-member per-month rate for their members. The CCO rates adopted for Healthier Oregon in 2025 show an approximately 40% decline from the rates for 2024. This is due to the Healthier Oregon population using fewer state-only services than projected and experiencing fewer disabilities than originally projected when the program was created. The 2025 rates are the first time this decline is reflected due to the timing of the program's rollout.

Healthier Oregon Program Risk Corridor Payments for 2024: This savings is related to the above issue around rates. CCO contracts for Healthier Oregon contain a provision called a “risk corridor” which provides that any payments CCOs receive for providing Healthier Oregon services that aren’t spent on member care must be returned to the state. The Healthier Oregon rates for 2023 resulted in risk corridor payments of $125 million General Fund in 2023-25 which were described in OHA’s Fall 2024 rebalance plan. Recognizing the 2024 Healthier Oregon rates hadn’t been adjusted for actual utilization under the program, the 2025-27 Governor’s Budget contains an assumption that CCOs will also have substantial risk corridor payments for the 2024 plan year, which they will repay the state during the 2025-27 biennium. This is only an assumption, and the actual risk corridor payment could be higher or lower depending on utilization.

Healthier Oregon Higher Utilization of Matchable Services: Healthier Oregon consists of a federally matchable component called Citizenship Waived Medical (CWM) and a state-funds only component. CWM pays for a very limited set of services primarily for emergency department use and prenatal care, with state-only funds wrapping around that benefit to pay for the rest of the services members receive. OHA has worked with federal partners to increase the length of time CWM covers prenatal care to be in line with the rest of the Medicaid program, which increased from 2 months to 12 months in 2022. Separately, OHA has also found that while utilization of state-funds only services is lower (as in the above two areas), Healthier Oregon members are using more federally matchable services than previously. These two main factors contribute to the savings realized in the Governor’s Budget, which includes a $120.1 million fund shift from General Fund to Federal Funds to recognize this savings.

Healthier Oregon Transfer to the Basic Health Plan: Healthier Oregon was established to serve those who are eligible for Medicaid but for their immigration status. This includes a subset of members who are eligible for federal Marketplace subsidies, and, by extension, for the recently established Basic Health Plan (BHP). The link here describes in greater detail the immigration statuses that are eligible. OHA estimates that around 10,000 members of Healthier Oregon are eligible for Marketplace subsidies. The Governor’s Budget for OHA includes a proposal to transfer those eligible members from Healthier Oregon to

the BHP on July 1, 2026, with the goal of uninterrupted coverage and care, as both populations are served by CCOs. There are system changes that need to be made to the Integrated Eligibility system to accommodate this shift; the Governor's Budget includes $2 million General Fund to support those system changes.

3. **What is paid for by OHA for Behavioral Rehabilitation Services? What specific set of services? What is the Medicaid connection? To what degree is there actual treatment vs. structured supervision? How is the program described in other states?**

   Currently, BRS programs serve Oregon Youth Authority (OYA) and the Oregon Department of Human Services (ODHS)-Child Welfare population. OHA, as the State Medicaid Agency, receives and passes through the federal funds for BRS to OYA and ODHS. The state match, and room and board, are paid by OYA, ODHS, and 6 county juvenile justice programs.

   OHA is in the process of expanding BRS to the entire Medicaid population under age 21. Once services are expanded, OHA will be responsible for the state share and placement-related activities including room and board for individuals not in the care or custody of OYA and ODHS.

   BRS helps children/youth experiencing behavioral symptoms acquire essential coping skills. It can be provided in a variety of settings. Currently, BRS is offered in either a proctor foster setting or a residential setting and provides the following set of services (OAR 410-170-0080):

   - Milieu therapy: Structured activities and planned interventions designed to normalize psycho-social development, promote safety, stabilize the environment, and assist youth in responding in developmentally appropriate ways. Milieu therapy occurs in concert with one of the other types of service.
   - Crisis counseling: Support provided on a 24-hour basis to stabilize the individual's behavior until the problem can be resolved or assessed and treated by a qualified mental health professional or licensed medical practitioner.

- Individual and group counseling: Face-to-face individual or group counseling sessions to the BRS individual that are designed to remediate the problem behaviors identified in the individual's service plan.
- For parent training: Planned activities or interventions (face-to-face or by telephone) to the BRS individual's family or identified aftercare resource family. Parent training is designed to assist the family in identifying the specific needs of the BRS individual, support the individual's efforts to change, and improve and strengthen parenting knowledge or skills indicated in the service plan as being necessary for the individual to return home or to another community living resource.
- Skills-training: Planned individual or group sessions using evidence-based or evidence-informed approaches or models designed to improve specific areas of functioning in the individual's daily living as identified in the service plan. Skills-training may be designed to develop appropriate social and emotional behaviors, improve peer and family relationships, improve self-care, encourage conflict resolution, reduce aggression, improve anger control, and reduce or eliminate impulse and conduct disorders.
- Placement-related activities: Activities related to the operation of the program and the care of the BRS individual as set forth in the BRS program general rules, applicable agency-specific BRS program rules, the contract or agreement with the agency or the contractor, and applicable federal and state licensing and regulatory requirements. Placement-related activities may include but are not limited to providing the individual with food, clothing, shelter, daily supervision; access to educational, cultural, and recreational activities; and case management. Room and board are not funded by Medicaid or CHIP.
- Aftercare services: Services provided to an individual for up to 180 days following discharge. Services can include but are not limited to crisis intervention, service coordination, monitoring, skills training and parent training (OAR 410-170-0070).

BRS is a Medicaid covered service. Services must receive prior authorization and must be determined to be medically necessary by a licensed health practitioner.

BRS providers that offer shelter, community step down and independent living programs are required to provide a total of six hours of services (excluding milieu and aftercare) each week. BRS providers that offer all other types of BRS programs are required to provide a total of 11 hours of services (excluding milieu and aftercare) each week.

BRS is not a behavioral health treatment program. It is meant to remediate behaviors expressed by the individual through skill building and other evidence-based approaches. The State plan has been updated to reflect this, and administrative rules are currently being amended to remove language that confuses BRS with behavioral health treatment.

In Washington state, BRS settings and services are described very similarly to Oregon: Behavior rehabilitative services are health and remedial services provided to children to remediate debilitating disorders, ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice within state law, intended for the maximum reduction of mental disability and restoration of the individual to his or her best possible functional level. For more information, see here.

North Dakota has a program called Behavioral Health Rehabilitative Services described as: a range of services including assessments, intervention, counseling, and skill training and integration. Services are recommended by a physician or other licensed practitioner of the healing arts within their scope of practice according to state law for maximum reduction of physical or mental disability and restoration of an individual to their best possible functional level. Behavioral health rehabilitative services are designed to be provided on a short-term basis and in most cases, should not be considered a pattern of long-term care. For more information, see here.

Information on other states is limited. In some states, BRS programs may offer services to adult populations and/or may include different services under the name BRS.

4. **Where does funding for the Unity come from? How much of their funding, and for what services, comes from Medicaid, or from other sources?**

Medicaid is one of many funding sources for Legacy Emanuel – Unity. Specifically, OHA Medicaid paid $2.1 million for outpatient Psychiatric Emergency Services provided to Medicaid Fee For Service Open Card members in the state fiscal year 7/1/23- 6/30/24. One third of this funding was for patients who have Medicare as their primary coverage and Medicaid as secondary coverage, and two thirds was for patients with Medicaid as their primary coverage. OHA's Behavioral Health Division does not have a separate contract with Legacy Emanuel – Unity; all OHA funding flows through Medicaid.

For more information on what outpatient Psychiatric Emergency Services are, please reference this overview produced by Unity.

5. **Regarding residential behavioral health beds and the Request for Information relating to those beds, what information did OHA gain about impacts on and access for people with intellectual or developmental disabilities?**

   OHA released a Request for Information (RFI) in Fall 2024 to develop a more granular understanding of communities' behavioral health residential capacity needs. In the RFI, OHA asked a question about prioritized communities served, including disability. We received submissions from organizations that would specifically serve the following groups of people: 1) individuals with disabilities, 2) women with disabilities, 3) deaf & hard of hearing, 4) intellectual & developmental disabilities, 5) complex BH needs, and 6) women with chronic illnesses. The results of this RFI guided our 2025-2027 biennial budgetary request for additional resources to expand behavioral health residential treatment capacity and, if funded, will inform where and to which organizations we allocate those resources in 2025.

6. **How are we doing in achieving the strategic goal to eliminate health inequities by 2030? Can you share the link to your new metrics dashboard?**

   OHA continues to make progress on its 2030 goal to eliminate health inequities in Oregon. Last year, we wrote and issued a Strategic Plan to provide a roadmap for the strategies and actions we will take to achieve that 2030 goal. It details five primary goals, or "pillars" of focus, for the next 6 years: transforming

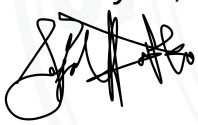
behavioral health; strengthening access to affordable care for all; fostering healthy families and environments; achieving healthy Tribal communities; and building OHA's internal capacity and commitment to eliminate health inequities. On January 30, we released an interactive dashboard depicting a set of population-health outcome measures as well as 1-, 3-, and 6-year targets for those measures that we will continually track to assess progress toward the pillars of the Strategic Plan.

7. **What do we know about how many people in Oregon are still uninsured, and about their demographics?**

   OHA's Oregon Health Insurance Survey (OHIS) Coverage dashboard is newly updated with 2023 and 2024 data. In 2024, 97.3% of respondents were insured at the time of the survey; this is the highest rate of coverage in Oregon history. To see characteristics of both insured and uninsured Oregonians at the time of the survey, click on the "Health Coverage" tab of the dashboard, then toggle demographic categories under the "View data by:" menu. We're happy to provide clarification or answer questions on dashboard interpretation if desired.

Please do not hesitate to reach out if there are any further questions.

Thank you,



Sejal Hathi, MD MBA
Director