Oregon Heath Authority
2017-19 Ways and Means
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Letter from the Director

The Oregon Health Authority's core mission is to ensure health for all of 4 million Oregonians, and for individuals relying on the Oregon Health Plan/Medicaid. In collaboration with health system partners, community groups, tribes and local governments across the state, we now have improved the well-being of Oregonians by delivering better health, better care and lower costs, and we are on track to begin the modernization of Oregon's public health system. Our work has improved access to care – and held down costs for Oregon taxpayers – during a time of great change in the health care system.

Here are some of the results we've achieved for Oregonians:

- Today, 95 percent of all Oregonians – and 98 percent of children – have health coverage.
- We have held cost growth in the Oregon Health Plan to 3.4 percent, lower than the national average of health cost increases.
- We have saved $1.3 billion in avoided Medicaid costs for state and federal taxpayers since 2013.
- We have improved the quality of care and health outcomes in our Medicaid program: for example, unneeded emergency room visits dropped by 20 percent in the past five years.
- We renewed federal approval for Oregon's innovative Medicaid program, continuing our state's framework for transforming health care delivery and controlling costs.
- We made it simpler and easier for Oregon Health Plan (OHP) members to apply for or renew their health benefits through the launch of the ONE applicant portal.

We have made significant progress but there is more work to be done.

Expanding access to care and holding down costs

Access to health care is foundational to the ability of Oregonians to achieve their goals for education and employment. Good health care allows students to attend and focus on school. Effective interventions keep communities safe from disease outbreaks and address behavioral health problems that lead to preventable hospitalization and incarceration.

Preventive care and regular treatment for chronic conditions avoids millions of dollars in public and private costs for unnecessary treatment.

Expanded coverage and access

- Today, the Oregon Health Plan/Medicaid is the largest health plan in the state, providing integrated physical, oral, and behavioral health care to 1.1 million Oregonians – 28 percent of the state.
- About 38 percent of adult OHP members are employed.

Quality of care and savings

- Even as health system transformation has expanded access to care, we have improved quality and remained accountable to a promised 3.4 percent per-capita annual growth rate – saving $1.3 billion in state and federal funds from 2013 to 2016. We remain committed to maintaining the 3.4 percent annual growth limitation through 2022.
- Ninety percent of OHP members are enrolled in coordinated care organizations (CCOs), which receive incentives for improving quality and access for Oregonians.
- Outcomes have continued to improve, with reduced emergency room visits, reduced hospital readmissions, increased adolescent well-care visits, more health assessments for children in foster care, and improved member satisfaction.
- Our new online eligibility portal – ONE – improves access to care for OHP/Medicaid members and improves operational efficiency.

Protecting public health

Our public health system has continued to innovate to improve the health of those most vulnerable as well as the public's health overall.

- The rate of 2-year olds who are fully vaccinated has increased from 58 percent to 70 percent in the last two years.

- We've increased participation in school dental sealant programs for grades 6-8 from just 8 percent in the 2014-2015 school year to 65 percent in the 2015-2016 school year.
- An evidence-based campaign was recently launched to prevent marijuana use among Oregon's youth.
- We are creating health-based regulations for industrial point sources of pollution for all Oregon communities, in partnership with the Department of Environmental Quality (DEQ).
- Based on a comprehensive assessment of our existing public health system, we are modernizing to ensure that Oregon has a public health system that is accountable for the health of the community it serves regardless of whether it is rural, urban or east or west of the Cascades.

In 2016, we restructured the agency to align with the work of health system transformation – combining health-related divisions and consolidating operational units. This structure has created greater accountability and clearer expectations for all OHA staff.

Challenges for the 2017-2019 biennium

While we have made significant progress, we also face significant challenges. While we have held our overall budget growth to less than one percent, we face a large general fund budget gap due to the following factors:

- Projections for Oregonians eligible for the Oregon Health Plan are higher than originally anticipated in 2013.
- Federal Medicaid funding is decreasing.

Enrollment growth, combined with the volatility of the original one-time funding for OHP/Medicaid, challenges our ability to continue to deliver high-quality and cost-effective health care to Oregonians in need.

Despite these challenges, and the state's current fiscal constraints, the Governor's balanced budget proposal maintains eligibility and benefits for OHP members. We are committed to maintaining the level of health coverage we have achieved in Oregon and advancing our innovative, cost-saving model of health transformation.

In addition, we are committed to creating a behavioral health system that works for all Oregonians. Nearly one in six Oregonians needs behavioral health services. OHA is working with local partners, behavioral health providers, CCOs, consumers and advocates to develop recommendations to achieve better outcomes and more efficiently align resources in Oregon's behavioral health system. We want to:

- Ensure that every Oregonian has access to effective services and support in their community through partnership with community behavioral health providers, courts and public safety systems.
- Promote recovery for patients who require treatment at Oregon State Hospital.
- Accomplish the goals of Oregon's performance plan with the United States Department of Justice to provide greater access to community-based services for adults with serious and persistent mental illness.

In addition, the role of governmental public health in providing safety net services has changed over time. Growth in the volume of new and emerging health threats has exposed the need for a governmental public health system that can:

- Systematically collect and report on population health risks and health disparities.
- Implement needed policy changes to improve health and protect the population from harms.
- Leverage partnerships across the health system to ensure maximum efficiency and effectiveness of services delivered.

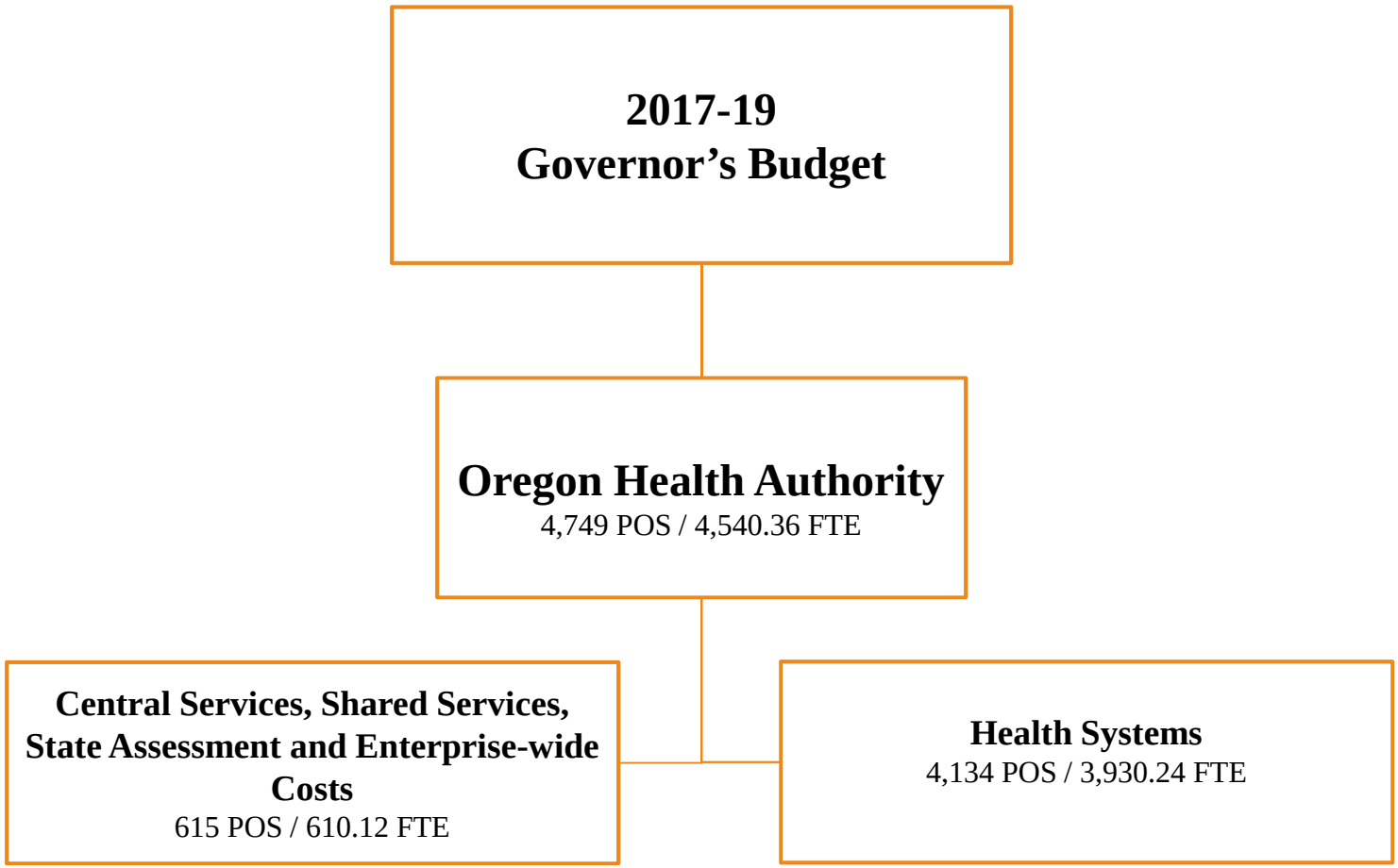
There are many recent examples of the growing complexity of community demands for governmental public health services: the response to the international Zika and Ebola virus outbreaks; meningitis outbreaks at our university campuses; community support for the Umpqua Community College tragedy and the occupation in Harney County; preparation for a possible Cascadia Subduction Zone earthquake; and the need to address environmental threats to human health. OHA remains committed to working with local public health departments, community partners, CCOs, tribes and other stakeholders to strengthen and modernize Oregon's public health system, within our available resources. While there is great uncertainty about the future direction of health policy at the national level, Oregon will continue to pursue the innovative transformations that have made our state a national leader in health reforms. We are committed to building on

the successes and cost savings we have gained over the past four years. They form a strong foundation to continue integration of physical, behavioral and oral health services and respond to the social and environmental factors that create barriers to optimum health for all Oregonians.

The Oregon Health Authority is committed to advancing the health of every Oregonian, and built its budget request with these embedded values.

Sincerely,

Lynne Saxton
Director


2017-19
Governor's Budget
Oregon Health Authority
4,749 POS / 4,540.36 FTE
Central Services, Shared Services, State Assessment and Enterprise-wide Costs
615 POS / 610.12 FTE
Health Systems
4,134 POS / 3,930.24 FTE

Oregon Health Authority

MISSION STATEMENT

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

AGENCY PRIORITIES AND INITIATIVES

With our mission in mind, OHA is focused on accelerating the transformation of Oregon's health care system. Our goals are to provide easier and wider access to care, deliver better health outcomes and contain health costs for Oregon Health Plan members. From the modernization of Oregon's public health system to the renewal of the state's Medicaid waiver, the next 18 months present both challenges and opportunities to advance these goals.

OHA's goals and priorities, detailed below, directly support and are integrally tied to Governor Brown's focus areas for safer, healthier communities and excellence in state government.

Make Oregon Health Plan member experience with Oregon's Medicaid program simpler, easier, more timely and reliable. To accomplish this goal, we will:

- Deliver accurate, timely and reliable data through enrollment and eligibility data systems.
- Improve OHA's ability to forecast future enrollment accurately.
- Implement highly functioning technology systems to support eligibility, enrollment and closures.
- Improve Oregon Health Plan member experience.

Create a behavioral health system that works for all Oregonians. To accomplish this goal, we will:

- Accelerate the development of a highly functioning behavioral health system that is patient- and family-centered, accountable and focused on outcomes (including but not limited to stable housing, transportation and employment supports).

- Implement Oregon's performance plan with the United States Department of Justice (DOJ) to expand and improve outcomes for people in Oregon who have serious and persistent mental illness.
- Improve access to behavioral health services.
- Present to the legislature recommendations developed by the Behavioral Health Collaborative to improve outcomes consumers of behavioral health services.
- Better integrate behavioral and physical health services for OHP members.

Address inequities, disparities and disproportionate impact to achieve health equity in OHA health systems. To accomplish this goal, we will:

- Reduce disparities in Oregon Health Plan (OHP) enrollment and eligibility determination among Oregon's linguistically diverse populations.
- Reduce disparities in use of behavioral health services and increase treatment completion rates for racially, ethnically and linguistically diverse populations.
- Increase colorectal cancer screening rates among racially, ethnically and linguistically diverse populations.

Accelerate health system transformation and maximize the value of Oregon's investment. To accomplish this goal we will:

- Describe a vision and create a roadmap for Oregon's Health System Transformation 2.0
- Advance the coordinated care organization system with increased focus on the social determinants of health and increase the pace of reform in components of Oregon's health system that have yet to produce intended outcomes. These areas include:
    - Addressing health system disparities in rural areas and improving workforce capacity to improve access
    - Promoting improved oral health.
    - Enhancing cross-system collaboration among health, early learning and housing.
    - Accelerating value-based payments and aligning metrics to reward better health outcomes.
    - Enhancing health system tools to support and improve care coordination.
- Increase transparency in outcomes and costs.

Advance Oregon's health system transformation through renewal of our 1115 Medicaid Demonstration Waiver. To accomplish this goal we will:

- Apply for a waiver renewal for the next five years to take our commitment to Oregon's health system transformation to the next level by:
    - Extending our Hospital Transformation Performance Program (HTTP).
    - Evolving our global budget to enhance the use of flexible services and value based purchasing.
    - Increasing behavioral health integration.
    - Improving social determinants of health through a Coordinated Health Partnership Model and health equity.
- Seek a future amendment to support needed changes in Oregon's substance use disorder delivery system.

Modernize Oregon's public health system. To accomplish this goal we will:

- Ensure all Oregonians have the opportunity to achieve optimal health.
- Ensure Oregon's public health system is highly effective, efficient, and meets performance standards.
- Ensure all Oregonians are served by a health department that provides foundational public health services that are critical for protecting the health of everyone in Oregon.
- Quantify secure and sustainable funding for state and local implementation of foundational public health services.

Address Rising Pharmaceutical Costs. New breakthrough medications coming to market are offering the chance to better treat and cure disease. However, these come at a financial cost that needs to be managed to provide sustainable delivery**.** To accomplish this goal we will:

- Collaborate with internal and external stakeholders, legislators, commercial payers and other states to develop strategies to address rising pharmacy costs.
- Establish and lead the OHA Pharmacy Cost Collaborative to coordinate efforts with the CCOs to explore creative concepts for helping to control rising pharmacy costs for the OHP population. The group is not tasked with making any formal decisions or recommendations, but it will harness the CCOs' best practices and creativity to explore specific, sustainable solutions to pharmacy-related issues such as Hepatitis C.

Implement Oregon's retail and medical marijuana laws to protect public health. To accomplish this goal, we will:

- Prevent youth marijuana use through a robust youth-oriented prevention campaign.
- Protect children and vulnerable populations from marijuana exposure.
- Educate the public about issues related to marijuana use.
- Understand and minimize the public health impacts of retail marijuana products.
- Support research of the medical properties of marijuana.
- Support the development of clinical guidelines for the use of marijuana.
- Effectively regulate medical and retail marijuana by:
    - Establishing effective registration, compliance and enforcement for dispensaries, growers and processors.
    - Providing compassionate and responsible access to medical marijuana products.
    - Developing clear and effective consumer safety labeling standards.
    - Defining robust and comprehensive laboratory accreditation and testing standards.

Maintain a fiscally sustainable budget. To accomplish this goal, we will:

- Support health system transformation for all Oregonians through a financially sustainable plan.
- Ensure that the Oregon Health Authority is operating efficiently and effectively to meet the needs of all Oregon Health Plan members by ensuring transformation occurs within the 3.4% acceptable rate of budget growth agreed upon in our waiver with the Centers for Medicare and Medicaid Services.

Empower and strengthen the skills and capabilities of OHA's employees. To accomplish this goal, we will:

- Empower the workforce to enable more people to make more decisions in their specific context (greater delegation and empowerment).
- Ensure human resource activities (recruiting, onboarding, developing retention) are robust and highly effective to support and sustain a strong, highly functioning and diversified workforce.
- Ensure all managerial and supervisory staff have training, resources and tools that are designed to lead, manage and create a positive work environment.

PROGRAM DESCRIPTIONS

OHA Central Services

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

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

The Director's Office provides leadership in achieving the agency's mission. OHA's clear direction is to innovate, improve and transform the state health care system to meet three goals:

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

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

- Health Care Finance – Providing coordination and oversight for program financing policies and collaboration for strategic finance decisions. Providing review and evaluation of coordinated care organization financial reports and data.
- Budget – Performing budget development, coordination, execution, monitoring, and management of OHA budgets within divisions and across the agency.
- Central Operations – Providing and coordinating services to support agency operations.
- Human Resources – Providing human resource services and competencies including recruitment and staffing, employee relations, organizational and employee development, risk management, and human resource regulatory compliance.
- Program Integrity – Providing coordination, oversight, and implementation for program integrity functions.
- Performance Excellence – Providing continuous improvement and quality management services.

The **Office of Equity and Inclusion (OEI)** works on behalf of the Oregon Health Authority and the broader health system in Oregon to ensure the elimination of avoidable health care gaps and to promote optimal health in Oregon for everyone. The work is carried out in three major work units:

- Equity and Policy
- Compliance and Civil Rights
- Business Support and Administration.

These units develop programs and initiatives relating to health equity policy and practice, access, diversity and inclusion, non-discrimination, the development of culturally and linguistically responsive practices and services and so forth. The division engages community partners and stakeholders, and utilizes data and best practice research to carry out its work. The policy and program initiatives of the division address social conditions and historical inequities faced predominantly by racially, ethnically, culturally and linguistically diverse populations of people so that Oregon can achieve greater health equity and a more robust and inclusive health delivery system.

The External Relations Division supports the mission of the Oregon Health Authority by providing accurate and accessible information about OHA's mission and programs, responding to requests for information from policymakers, stakeholders and the public and fostering transparent and meaningful public involvement in agency decision-making. The External Relations Division is comprised of four main work units:

- Communications
- Consumer Affairs
- Government Relations
- Ombudsman

Health Systems Division

The budget for Health Systems Division includes:

- Program Support and Administration
- Medicaid
- Non-Medicaid

Through its functional realignment, the Oregon Health Authority integrated Medical Assistance Programs (MAP) and Addictions and Mental Health (AMH) into the Health Systems Division (HSD) and structured the Oregon State Hospital as a stand-alone program unit.

The **HSD – Program Support and Administration** ensures HSD has the administrative infrastructure, and operational and technology resources, including human resources, necessary to fulfill the mission and perform HSD's legislative charge and mandates. The Health Systems Division is a newly integrated area that includes the former MAP and AMH. This area ensures systematic health care transformation in the coordinated care model occurs at the coordinated care organization level and that state operations are effective, efficient, and fiscally sustainable. HSD oversees regulatory and operational management of Oregon's health delivery system. The division manages the implementation and evaluation of multiple statewide programs and activities in support of the Medicaid program including integrating and coordinating interagency activities.

The **HSD Medicaid** 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.

The HSD Medicaid budget also includes the Qualified Medicare Beneficiaries program. This program pays the Medicare premiums, deductibles, co-insurance and co-payments for clients. To be eligible, a person must be receiving Medicare Part A (hospital insurance benefits). Income and resources must fall within certain limits. Eligibility extends up to 135 percent of the federal poverty level. For the 2015-2017 biennium, the program has a budget of $31 million and serves almost 24,000 people.

This budget includes Medicare Part A and Part B premium payments for Medicaid-eligible clients. For the 2015-2017 biennium, the budget to pay these premiums is $80 million for Medicare Part A payments for an average of 6,800 clients a month and $351 million for Medicare Part B payments for an average of 120,000 clients a month.

This budget includes Law Enforcement Medical Liability Account (LEMLA), which pays medical claims for individuals who are injured in interactions with law enforcement. Law enforcement agencies submit claims to OHA if they are unable to recover costs directly from those individuals or their insurance companies. For the 2015-2017 biennium, the LEMLA budget is $1.4 million.

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

The **HSD – Non-Medicaid** budget supports critical elements in Oregon's community behavioral health system that serve as the safety net for all Oregonians regardless of health care coverage. An important focus of this system is to respond to individual and community crises, meeting the immediate mental health needs for a defined population and geographic region. In addition, non-Medicaid funds purchase social supports for OHP members that are not included in the Medicaid benefit package, such as early outreach and engagement, peer-based recovery and housing services. These funds help fill in the gaps by supporting social and clinical activities not reimbursed by OHP or other payers. HSD works closely with OHA's Health Policy and Analytics, the Transformation Center, OHA's Office of Equity and Inclusion division and CCOs to coordinate the system of care as well as achieve better health and better care at lower costs for all Oregonians by integrating physical and behavioral health services and promoting health equity.

HSD administers contracts and agreements with local mental health authorities such as community mental health programs, 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.

Statutory Authority

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

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

Health Policy and Analytics

The budget for Health Policy and Analytics (HPA) includes the:

- Office of Health Policy (which includes the Director of Health Policy and Analytics, the State Medicaid Director, the Office of Clinical Improvement Services, and Health Policy);
- Office of Health Analytics;
- Office of Health Information Technology; and
- Office of Business Support.

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

Public Employees' Benefit Board

The Public Employees' Benefit Board (PEBB) provides high-quality insurance and other employee benefit options at a cost affordable to employees and the state. Insurance benefits are a part of employees' total compensation package and an important tool in hiring and retaining high-quality personnel.

With a staff of about 20, PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. More than 130,000 Oregonians are PEBB members. They include active employees, spouse and domestic partner dependents, child dependents up to age 26, and adult children with disabilities over age 26, from: state agencies, universities, Lottery and semi-independent agencies, and local governments and special districts. PEBB provides some bilingual and multilingual staff support and uses an interpreter service line for callers who speak languages not supported by staff.

Statutory Authority

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

Oregon Educators Benefit Board

The Oregon Educators Benefit Board (OEBB) administers medical, dental, vision and other benefit plans for Oregon's school and education service districts, and since 2013 cities, counties and special districts as well. A *Seamless System of Education* requires a stable workforce, which includes recruitment and retention. Competitive insurance benefits are a part of employees' total compensation package and an important tool in hiring and retaining quality personnel.

With a staff of 20, OEBB serves more than 150,000 members (employees and early retirees and their family members) in more than 250 publicly funded entities throughout Oregon. They include nearly all school districts, education service districts and community colleges, numerous charter schools and some counties and special districts. OEBB serves its members and entities year-round. Activity significantly increases during the annual renewal and open enrollment periods. OEBB provides some bilingual and multilingual staff support and uses an interpreter service line for callers speaking other languages not supported by staff.

OEBB works closely with its contracted carrier and vendor partners, the Public Employees' Benefit Board (PEBB), the Oregon Health Authority, Oregon Health Policy Board, the Governor's Office, participating publicly funded entities and its 150,000-plus members.

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

Public Health

The Public Health Division's mission is to promote health and prevent the leading causes of death, disease and injury in Oregon. In addition to addressing the drivers of chronic illness such as tobacco and obesity, among other services the state public health programs ensure the safety of drinking water in public water systems, investigate disease outbreaks, respond to public health emergencies, license hospitals, and provide services to prevent unintended pregnancies. These programs and services serve all people in Oregon, including its most vulnerable populations.

The vision is lifelong health for all people in Oregon. To achieve this vision, public health has identified two main goals;

- To make Oregon one of the healthiest states
- To transform the state's public health system into a national model of excellence

To make Oregon one of the healthiest states, state public health is focusing on areas where there is the potential to make significant progress to improve the health of the population. Tobacco and obesity prevention are priorities. The programs are

directly working to achieve outcomes, including supporting the achievement of 100 percent tobacco-free state properties and the establishment of a statewide nutrition policy for all state agencies, and statewide nutrition standards in procurement contracts.

Other areas of focus, all in the context of health equity, include reducing the incidence of heart disease and stroke and increasing survival of stroke patients; decreasing suicide (which kills more people than motor vehicle crashes in Oregon); preventing family violence, which causes a wide range of physical and mental health problems and also is a major factor in the development of chronic disease later in life for children exposed to violence; and increasing community resilience in public health emergencies.

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

Oregon State Hospital

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

OSH operates two campuses with the capacity to serve up to 794 Oregonians, with 620 beds in Salem and 174 beds in Junction City. Services are provided 24 hours per day, seven days a week. OSH currently operates 578 beds on the Salem campus and 100 beds in Junction City. Commitment types include:

- **Civil commitment/voluntary by guardian** – People who are dangerous to themselves or others, or who are unable to provide for their basic needs due to their mental illness. A subset of this population includes those who have significant co-occurring medical issues, such as those with dementia, Alzheimer’s or traumatic brain injury.

- **Guilty except for insanity** – People who committed a crime related to their mental illness. Depending on the nature of their crime, patients are under the jurisdiction of the PSRB or the State Hospital Review Panel (SHRP).
- **Aid and Assist** – People who have been charged with a crime but are unable to participate in in their trial due to their mental illness. The courts refer them to OSH under Oregon Revised Statute (ORS) 161.370 for "competency restoration" which is treatment that will help them understand the criminal charges against them and assist in their own defense.

Statutory Authority
The following ORS references provide OSH its authority:

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

OHA Shared Services

Office of Information Services (OIS) is a shared service provider for DHS and OHA. It provides information technology (IT) systems and services for nearly 16,000 agency and partner staff at 350 local offices, Oregon State Hospital locations, public health laboratories and testing services for county health departments, medical and military facilities, and other locations statewide.

OIS provides support for more than 17,000 desktop computers and 2,600 printers. The Service Desk responds to more than 14,000 service requests each month.

OIS provides information systems and services to DHS 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 the Health Alert Network and emergency preparedness activities

OIS also supports partners around the state that use DHS and OHA systems. These include:

- State agencies including the Oregon Department of Justice Division of Child Support, the Oregon Employment Department and others
- Cities and counties
- District attorney's offices
- Private hospitals
- Other computer centers

Many of the IT systems used by DHS, OHA and agency partners are needed 24 hours a day, seven days a week.

Information Security and Privacy Office (ISPO) is a shared service office providing information security services for DHS and OHA. ISPO uses business risk management practices to protect confidential information assets and educate staff, volunteers and partners on how to protect this information and report incidents when they occur.

The ISPO drivers include federal and state security regulations and audit findings, contractual and grant obligations, DHS security policies and procedures, legislative mandates and the Oregon Consumer Identity Theft Protection Act.

ENVIRONMENTAL FACTORS

The OHA caseloads, cost of care, and budget are affected by the following factors:

- Economy – Poverty and unemployment
- Social issues – Untreated mental health and substance abuse, homelessness, and disparities
- State and federal policy – Health System Transformation, Medicaid match rates

Major revenue changes causing an increase in General Funds in the OHA 2017-19 Current Service Level budget include:

- Addition of $330 million from Medicaid match changes, including increased state costs to cover the Medicaid expansion population authorized under the Affordable Care Act
- Removal of a $195 million one-time investments of revenue included in the 2015-2017 budget
- Removal of $136 million because that federal investment under the Designated State Health Programs (DSHP) expires
- Reduction of $42 million in Tobacco Tax and Tobacco Master Settlement revenue

ACCOMPLISHMENTS

OHA Organizational Restructure

At the beginning of the 2015-2017 biennium, OHA streamlined the agency by completing an organizational restructure and position true-up that:

- Further integrated programs and services to better deliver services to Oregonians
- Based on functional assessments, prioritized ongoing work within existing resources
- Resolved position authority for 48 long-term double fills needing resolution
- Resolved positon authority for 48 limited duration staff performing ongoing work
- Eliminated or repurposed 31 management positions
- Ultimately resulted in OHA needing two fewer two positions in its budget

Since its organizational restructure, OHA continues to diligently manage to its position authority and ensure it effectively controls overhead costs.

Health System Transformation

- Today, nearly 95 percent of Oregonians have health coverage. The Oregon Health Plan (OHP) provides 1.1 million Oregonians access to integrated physical, oral and behavioral health care. OHP is the state's largest health plan and covers nearly 28 percent of all Oregon residents.
- Ninety percent of OHP members are enrolled in Coordinated Care Organizations (CCOs), which receive incentives for improving quality and access for Oregonians.

- Through partnerships with CCOs, OHA has contained OHP cost growth to 3.4 percent per capita, saving $1.3 billion in state and federal dollars from 2013-2016.
- Health outcomes for OHP members have continued to improve, with reduced emergency room visits, reduced hospital readmissions, increased adolescent well-care visits, increased health assessments for children in foster care, and improved member satisfaction.
- OHA submitted the state's application to renew the Oregon Health Plan Medicaid demonstration for another five years.

Behavioral Health

- OHA finalized a plan with USDOJ to transform the care and delivery of behavioral health services to adult Oregonians struggling with severe and persistent mental illness.
- Health Systems Division launched the Behavioral Health System mapping tool on June 30, 2016, to inform policy and funding discussions during the 2017 legislative session.

ONE System Implementation

- The new online eligibility portal – ONE – has made it easier for Oregonians to determine if they are eligible and apply for OHP benefits.

Public Health

- In partnership with DEQ, OHA is creating health-based regulations for industrial air emissions for all Oregon communities.
- The rate of 2-year olds who are fully vaccinated has increased from 58 percent to 70 percent in the last two years
- Participation in school dental sealant programs has increased from just 8 percent in 2014-15 school year to 65 percent in 2015-16 school year for grades 6-8.
- OHA launched a pilot evidence-based campaign to prevent marijuana use among Oregon's youth.
- OHA completed a statewide assessment of public health capabilities.
- The Public Health Division received full national accreditation from the Public Health Accreditation Board.

MAJOR INFORMATION TECHNOLOGY PROJECTS/INITIATIVES

OIS expects to have several IT projects underway during the 2017-2019 biennium. The details of these projects are outlined in the IT Related Projects/Initiatives report in the Special Reports section.

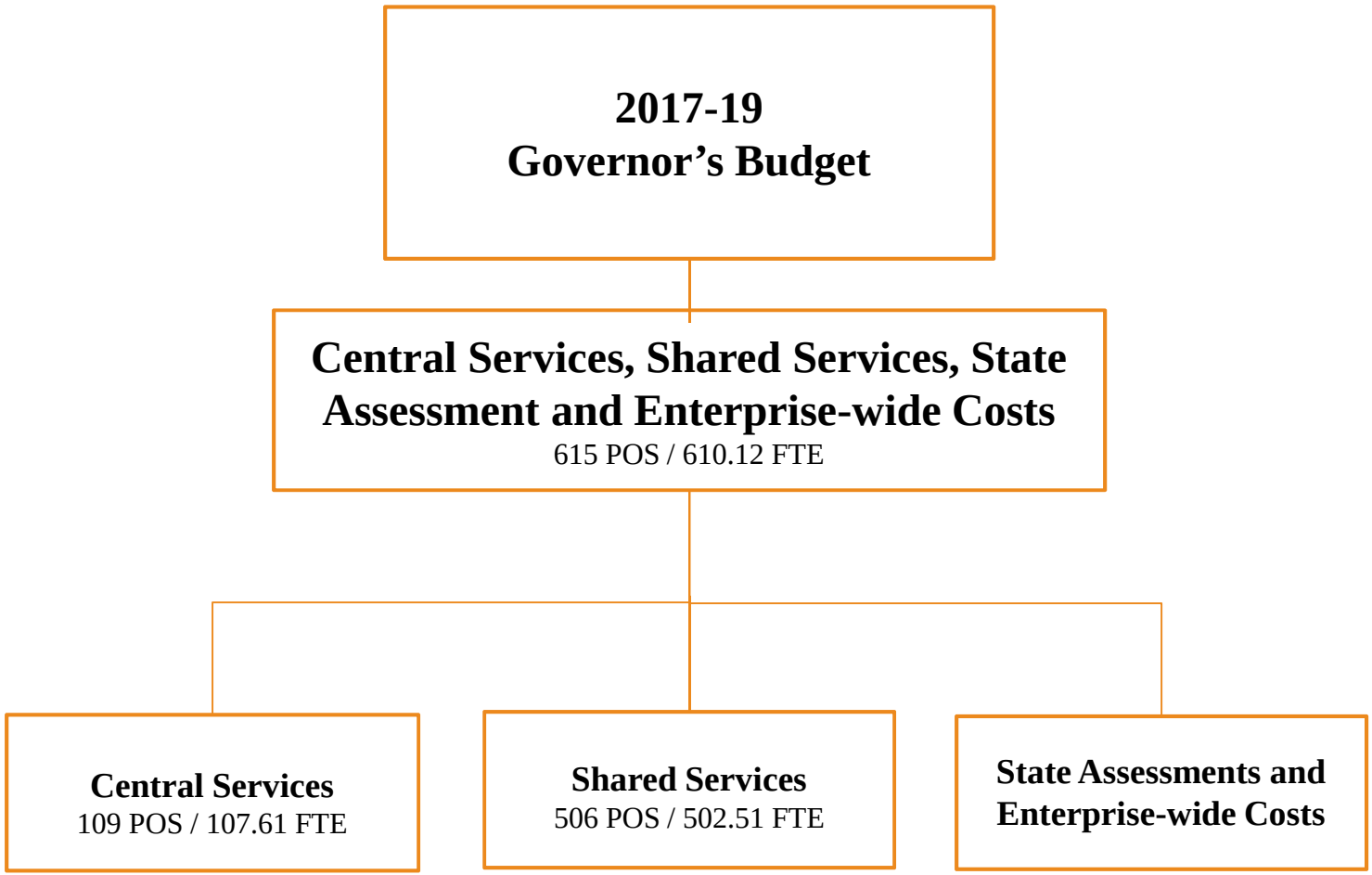
Projects that are either partially or fully aligned with Policy Option Packages (POPs) funded in the Governor's Budget include:

- **MMIS Modularization** – POP #405 funds the planning effort to modularize Oregon's Medicaid Management Information System (MMIS) to align to federal mandates. The work for the 2017-2019 biennium includes defining Oregon's Medicaid Service Delivery strategic plan, assessing other states modularization approaches, identifying options for modular solutions, defining certification requirements as required by our federal partners, and begin procurement activities to secure modular solution components.
- **ONE Enhancements and Support Services** – POP #406 funds additional system enhancements and ongoing maintenance for Oregon's Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination system, called ONE. The enhancement work includes changes required when our federal partners issue new requirements for MAGI Medicaid eligibility system, such as MARS-E 2.0 Security Compliance, as well as functionality prioritized by HSD Member Services staff and Medicaid policy staff to support process improvement.
- **Integrated Eligibility Project** – POP #201 supports the implementation effort to extend the ONE System to include eligibility determinations for Non-MAGI Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Employment Related Day Care (ERDC) programs. The Integrated ONE System will provide a web-based, self-service, applicant portal, a web-based worker portal with automated workflows, automated eligibility processing, and interfaces with OHA and DHS benefits administration and case management systems.
- **Office of Health Information Technology (OHIT) Projects** – POP#409 would allow OHIT to collect fees to support three health information technology efforts in Oregon: the Oregon Common Credentialing Program as mandated by Senate Bill 604; the statewide Provider Directory; and the CareAccord program. Other Fund authority allows OHA to collect fees and spend those funds to cover these programs' operating costs.

OIS continues the ongoing work for the following IT projects into the 2017-2019 biennium:

- **Centralized Abuse Management (CAM) System** – This ongoing Aging and Peoples with Disabilities (APD) project is developing and implementing a comprehensive multi-program centralized abuse management system for the Office of Adult Abuse Prevention and Investigations (OAAPI). The system will capture abuse allegations and investigations from intake and screening through investigation, case closure and referrals, documentation, and support abuse management oversight and inquiries. Completion of this system will provide a single repository for information and will replace the nine distinct system or data sources currently in use.
- **CAREAssist Application** – This ongoing Public Health Division project is developing a new CAREAssist web-based application system to address the current system's shortcomings, increase functionality, and improve client experience. This project will bring the state into compliance and develop a long term solution.
- **Tracking Home visiting Effectiveness in Oregon (THEO)** – This ongoing Public Health Division project is developing an interoperable and scalable home visiting data collection, case management and reporting system.
- **Provider Time Capture (PTC)** – This ongoing project is to enable DHS and OHA to capture accurate time, attendance, and travel time for home community workers and personal care workers (HCWs/PSWs) across programs. DHS and OHA are considered joint employers and their HCW/PSW programs must be modified to comply with the U.S. Department of Labor's (USDOL) Fair Labor Standards Act (FLSA). This system will enable DHS and OHA to keep the required records for each HCW/PSW who provide personal and home care assistance to older adults, people with disabilities and additions, and mental health clients.

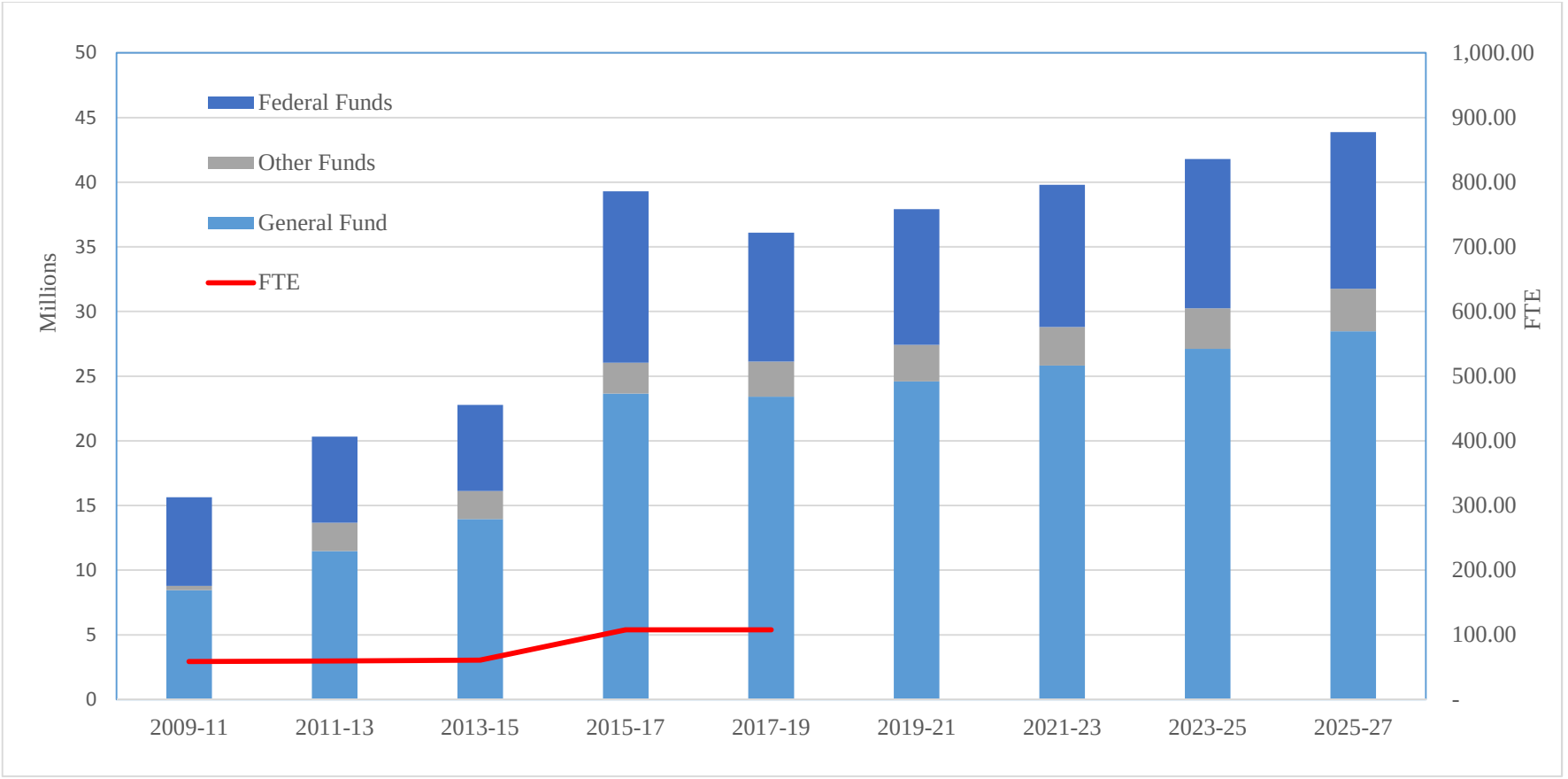
The other OIS projects on the OHA IT Related Projects/Initiatives report are in their pre-initiative stage.


2017-19
Governor's Budget
Central Services, Shared Services, State Assessment and Enterprise-wide Costs
615 POS / 610.12 FTE
Central Services
109 POS / 107.61 FTE
Shared Services
506 POS / 502.51 FTE
State Assessments and Enterprise-wide Costs

OREGON HEALTH AUTHORITY: OHA CENTRAL SERVICES

Program Unit Executive Summary

Long term focus areas: Safer, Healthier Communities; Excellence in State Government
Primary contact: Janell Evans, Budget Director
503-945-5775



Program overview

OHA Central Services supports the OHA mission by providing leadership in key policy and business areas. It includes:

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

Program funding request

For the 2017-2019 biennium, the Oregon Health Authority requests the following budget (in millions) for Central Services:

- 2017-2019 Request: $36.1 TF ($23.4 GF, $2.7 OF and $10.0 FF)

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

The Oregon Health Authority estimates the following costs (in millions) for OHA Central Services through the 2023-2025 biennium:

- 2019-2021 Projected Costs: $37.9 TF ($24.6 GF, $2.8 OF and $10.5 FF)
- 2021-2023 Projected Costs: $39.8 TF ($28.5 GF, $3.0 OF and $11.0 FF)
- 2023-2025 Projected Costs: $41.8 TF ($27.1 GF, $3.1 OF and $11.6 FF)
- 2025-2027 Projected Costs: $43.9 TF ($28.5 GF, $3.3 OF and $12.1 FF)

Program description

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

The Director's Office provides leadership in achieving the agency's mission. OHA's clear direction is to innovate, improve and transform the state health care system to meet three goals:

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

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

- Health Care Finance – Coordinating and overseeing program financing policies and collaborating for strategic finance decisions. Reviewing and evaluating coordinated care organizations' financial reports and data.
- Budget – Developing, coordinating, executing, monitoring and managing OHA budgets within divisions and across the agency.
- Central Operations – Supporting agency operations.
- Human Resources – Providing recruitment and staffing, employee relations, organization and employee development, risk management, and human resource regulatory compliance.
- Program Integrity – Coordinating, overseeing and implementing program integrity functions.
- Performance Excellence – Providing continuous improvement and quality management services.

The Office of Equity and Inclusion (OEI) works on behalf of the Oregon Health Authority and the broader health system in Oregon to ensure the elimination of avoidable health care gaps and to promote optimal health in Oregon for everyone. The work is carried out in three major work units:

- Equity and Policy
- Compliance and Civil Rights
- Business Support and Administration

These units develop programs and initiatives relating to health equity policy and practice; access; diversity and inclusion; non-discrimination; the development of culturally and linguistically responsive practices and services; etc. The division engages community partners and stakeholders, and uses data and best practice research to carry out its work. The division's policy and program initiatives address social conditions and historical inequities faced predominantly by racially, ethnically, culturally and

linguistically diverse populations of people so that Oregon can achieve greater health equity and a more robust and inclusive health delivery system.

The **External Relations Division** has three sub-divisions: Communications, Governmental Relations, and Advocacy. Together, they are responsible for building strong relationships with the public, media, Legislature, and other agencies at the state and federal levels, as well as creating a broad understanding of the many ways in which OHA contributes to the health and well-being of Oregonians.

- Governmental Relations is also responsible for the timely review and analysis of legislative concepts, and the development of strategies to engage in the legislative process.
- Under the larger umbrella of Advocacy are the Office of Consumer Activities and the OHA Ombudsperson. The Office of Consumer Activities advocates for improved behavioral health delivery and policy through consumer informed initiatives and programs while the OHA ombudsperson responds to customer calls related to all facets of OHA operations (with an emphasis on complaints related to Medicaid enrollment and eligibility) and reports to the Governor and Health Policy Board with OHP complaint trends and recommendations.
- 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, web sites and other channels for keeping the public informed.

Program justification and link to long-term outcomes

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

Program performance

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

- ***6,549*** applications for a position in which HR manually grades each to determine minimum qualifications
- ***1,056*** hires
- ***286*** promotions and ***24*** transfers

- ***58*** HR investigations and ***39*** that required corrective action
- ***106*** manager fact findings and ***95*** that required corrective action
- ***89*** managers trained on the *Essentials of HR Management*
- ***2,049*** performance appraisals
- ***136*** classification reviews

The Office of Human Resources serves as a business partner to its customers. Through this partnership, HR provides proactive, comprehensive human resource services that supports the agency in achieving its mission and goals. HR works closely with internal customers on workforce initiatives and strategies at the program and agency level. We promote a healthy workplace culture of ongoing development and feedback to ensure the workforce has the needed skills to be successful and engaged. HR is committed to assisting the agency in moving towards the vision of a Healthy Oregon.

The division also includes agency budget functions. Budget staff implement and monitor the Oregon Health Authority budget of more than $20 billion Total Funds and more than $2 billion in General Fund dollars. The staff develop and update the agency budget as it progresses through the statewide budget process, including Agency Request Budget, Governor's Balanced Budget, the Legislatively Adopted Budget, rebalance reports and various Emergency Board actions.

In 2015, the **Office of Equity and Inclusion** completed the following:

- 646 traditional health workers (THW) certified, exceeding the requirement of 300 established by the U.S. Centers for Medicare and Medicaid Services (CMS)
- 189 health care interpreters (HCI) qualified and certified, representing seven languages and exceeding the goal of 150 established by CMS
- 130 community-based organizations represented and engaged in the Regional Health Equity Coalitions (RHEC) around the state
- 70 researchers engaged in quarterly Health Equity Researchers of Oregon (HERO) meetings, focusing on THWs
- 122 community trainings by Regional Health Equity Coalitions (RHEC) around the state (six RHECS cover 10 counties and the Confederated Tribes of Warm Springs)
- Six equity and inclusion coaches provide technical assistance to CCOs and OHA

- 48 potential civil rights matters resolved or referred
- 66 civil rights cases investigated or closed
- Five formally recognized employee resource groups (ERG), with a total of more than 125 members and allies
- $3,634,830 awarded to Minority, Women and Emerging Small Business (MWESB) certified vendors from July 2014 to July 2015
- Two DHS/OHA Leadership Academy cohorts (totaling approximately 70 individuals) trained in intercultural conflict styles

The External Relations Division, according to average annual metrics, provided or completed:

- Responds to more than 1,000 media requests per year
- Issues more than 100 news releases per year.
- Produces a wide variety of publications, including messages from the OHA director and other communications, which are opened by more than 5,000 people per month.

Enabling legislation/program authorization

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

Funding streams

Funding streams support OHA Central Services 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 state and federal funding sources.

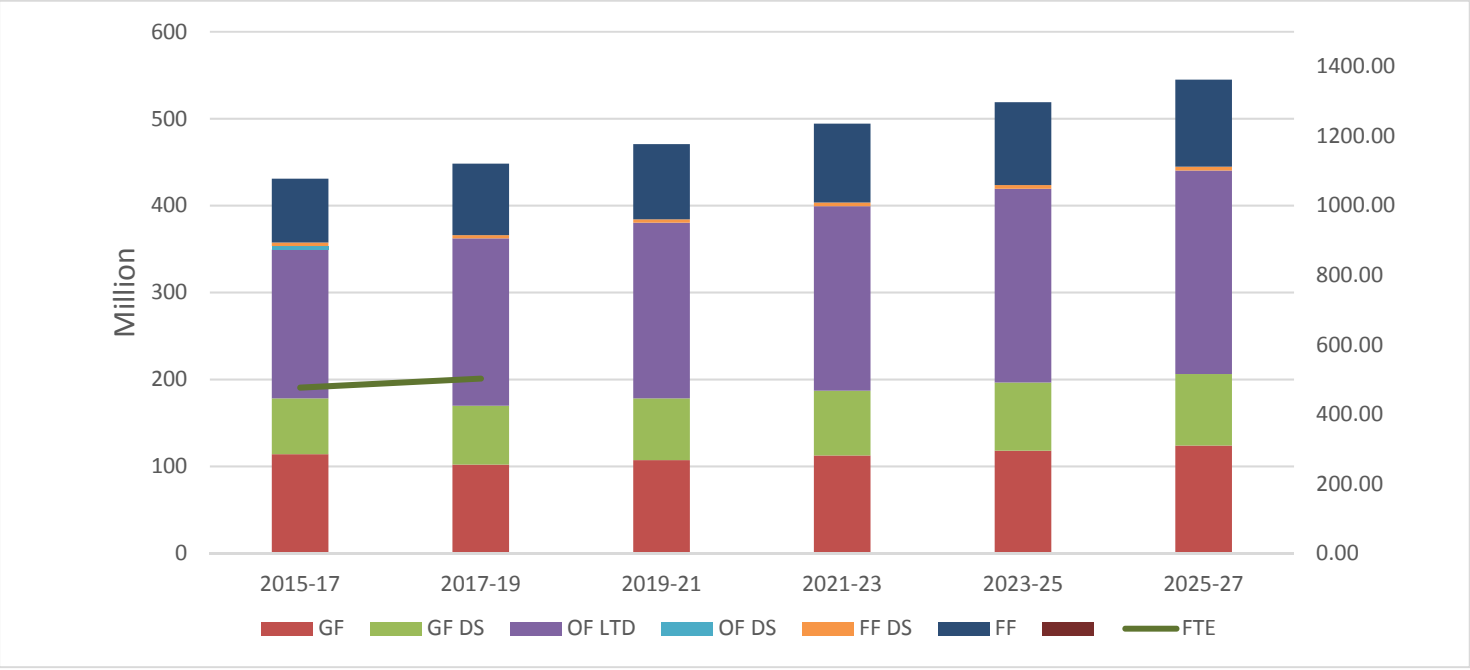
Significant proposed program changes from 2015-2017

The agency is not proposing any significant changes to OHA Central Services.

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

Program Unit Executive Summary

Long Term Focus Areas: Excellence in State Government
Program contact: Sara Singer, DHS/OHA Shared Services Budget Administrator
503-945-5629



Program overview

OHA Shared Services supports the Department of Human Services and Oregon Health Authority by providing leadership in the delivery of efficient, consistent and coordinated administrative services to all programs in both departments. OHA Shared Services contains the following programs:

- Office of Information Services
- Information Security and Privacy Office

OHA state assessments and enterprise-wide costs (SA&EC) includes the budget for costs that affect the entire agency.

State government service charges, 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 - E-Government Program
- DAS - Enterprise Security Office
- DAS - Chief Human Resources Office
- DAS – Office of the State's Chief Information Officer
- Secretary of State Audits Division
- State Controllers Division
- Enterprise Goods and Services (EGS) - procurement
- Oregon State Library
- Chief Operating Office
- 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

State Data Center (SDC), price list

The State Data Center provides and manages a common computing and network infrastructure for state agencies and local governments. The SDC provides services in the following service areas:

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

Telecom, price list

Telecommunications provides access to data and technology necessary to do business.

Facilities

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

- Rent or lease work space 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 to OHA vs. DHS, and the revenue distribution by General Fund, Other Fund or Federal Fund.

Debt service

Debt service is the obligation to repay principal and interest on funds borrowed through the sale of certificates of participation (COPs) and bonds. The state uses proceeds of COPs and bonds to build and improve correctional 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 six to 26 years depending on the nature and value of the project. The Department of Administrative Services Capital Investment Section provides schedules of debt service obligations for each sale; these are the values used to develop the budget. Occasionally, the Capital Investment Section is able to 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 Funds) funding. Note: for the Governor’s Budget, this budget continues to be decentralized to conform to statewide processes.

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.

Treasury

This budget component was established to capture the Other Fund loan limitation for the loan interest payment for each agency sometime during the second year of the biennium. Loan and interest estimates are provided by Financial Services Cash Management Accountant.

Program funding requests

Shared Services	GF	OF	FF	TF
Personal Services	$ -	$ 126,156,711	$ -	$ 126,156,711
Services and Supplies	$ -	$ 36,402,350	$ -	$ 36,402,350
Capital Outlay	$ -	$ -	$ -	$ -
Special Payments	$ -	$ 523,509	$ -	$ 523,509
Agency Requested Budget 2017-19	$ -	$ 163,082,570	$ -	$ 163,082,570

SA&EC	GF	OF	FF	TF
Personal Services	$ 473,919	$ 84,301	$ 118,150	$ 676,370
Services and Supplies	$ 52,147,356	$ 13,264,574	$ 50,384,437	$ 115,796,467
Capital Outlay	$ -	$ -	$ -	$ -
Special Payments	$ 49,387,245	$ 16,113,969	$ 31,789,745	$ 97,290,797
Debt Services	$ 67,710,170	$ -	$ 3,719,310	$ 71,429,480
Agency Requested Budget 2017-19	$ 169,718,690	$ 29,462,864	$ 86,011,742	$ 285,193,296

Program description

Office of Information Services (OIS) is a shared service provider for DHS and OHA. It provides information technology (IT systems and services for nearly 16,000 agency and partner staff at 350 local offices, Oregon State Hospital locations, public health laboratories and testing services for county health departments, medical and military facilities, and other locations statewide.

OIS provides support for more than 17,000 desktop computers and 2,600 printers. The Service Desk responds to more than 14,000 service requests each month.

OIS provides information systems and services to DHS 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 the Health Alert Network and emergency preparedness activities

OIS also supports partners around the state that use DHS and OHA systems. These include:

- State agencies including the Oregon Department of Justice Division of Child Support, the Oregon Employment Department and others
- Cities and counties
- District attorney's offices
- Private hospitals

- Other computer centers

Many of the IT systems used by DHS, OHA and agency partners are needed 24 hours a day, seven days a week.

Information Security and Privacy Office (ISPO) is a shared service office providing information security services for DHS and OHA. ISPO uses business risk management practices to protect confidential information assets and educate staff, volunteers and partners on how to protect this information and report incidents when they occur.

The ISPO drivers include federal and state security regulations and audit findings, contractual and grant obligations, DHS security policies and procedures, legislative mandates and the Oregon Consumer Identity Theft Protection Act.

Program justification and link to 10-year outcome

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

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

Control over major costs. OHA centrally manages many major costs. Some, such as many DAS charges, are essentially fixed to the agency. Others, such as facility rents, are managed centrally to control the costs. OHA Shared Services supports both DHS and OHA by providing leadership in the delivery of efficient, consistent and coordinated administrative services to all programs within both departments.

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

DHS 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
- Managed staff within the shared services deliver services in a rational way
- Begun implementing more integrated systems to support the performance of all our employees

Program performance

OIS and ISPO 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. The following table provides an overview of OIS and ISPO customer measures.

Measure Name	RANGE Red	Yellow	Green	STATUS
Customer Service and Support				
Customer ticket 1st contact response: Customer tickets resolved in first contact with the Service Desk.	<35%	35 - 60%	≥60%	64%
Customer ticket resolution: Average time to resolve Service Desk ticket.	<7	3 - 7	< 3	2.8 days
IT acquisition/purchase request response: Respond to IT acquisition/purchase requests within one (1) business week (five (5) working days), pending parts and availability.	<80%	80 - 89%	≥90%	90%
DHS/OHA network availability: The DHS/OHA network is available.	<98%	98 - 99.8%	>99.8%	99.87%
Systems Applications Maintenance and Support				
System Availability - Email: Percent of time e-mail is available for our customers.	<98%	98 - 99.8%	>99.8%	99.9%
System Availability - Mainframe Environment: Percent of time mainframe environment is available for our customers.	<98%	98 - 99.8%	>99.8%	99.85%
System Availability - Medicaid Management Information System (MMIS): Percent of time MMIS application is available for our customers (contractual).	<99.6%	99.6 - 99.89%	>99.9%	99.9%
System Availability - OR-Kids System: Percent of time OR-Kids application is available for our customers.	<98%	98 - 99.8%	>99.8%	99.98%
System Availability - Avatar System: Percent of time OR-Kids application is available for our customers (contractual).	<99.6%	99.6 - 99.89%	>99.9%	99.99%
Information Security and Privacy				
Agreement Process Timeliness: Percent of Information Exchange agreements processed within 8 weeks.	<70%	70 - 85%	>85%	74%
Employee Required Training	<70%	70 - 89%	≥90%	95% - Info Security 93% - General Privacy

Enabling legislation/program authorization

HB 2009 created the Oregon Health Authority in 2009.

Funding streams

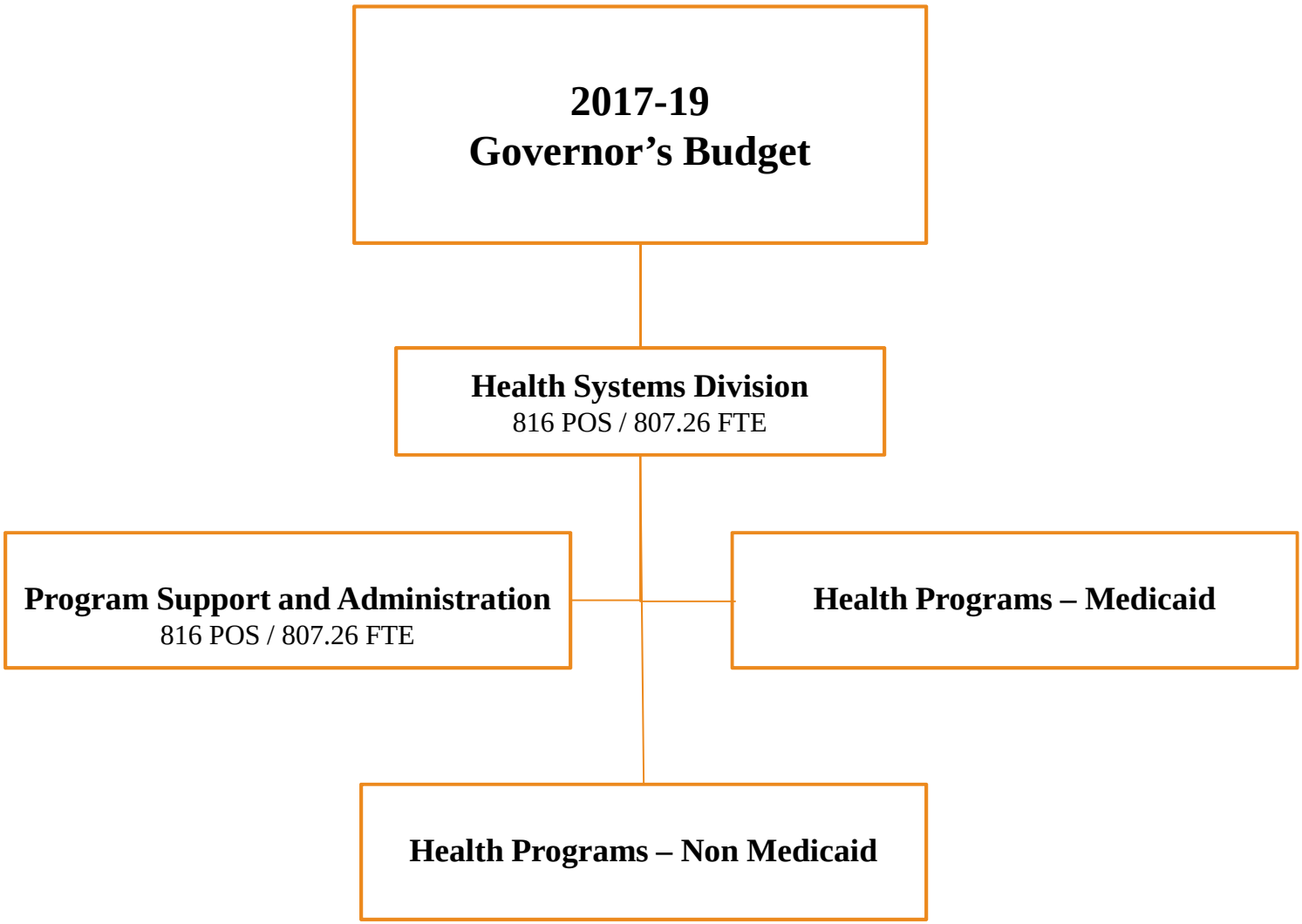
Funding streams in support of Shared Services are billed to through a federally approved cost allocation plan. The model contains a billing allocation module and a grant allocation module.

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 on a monthly basis as outlined in the federally approved plan.

Significant proposed program changes from 2015-2017

None.

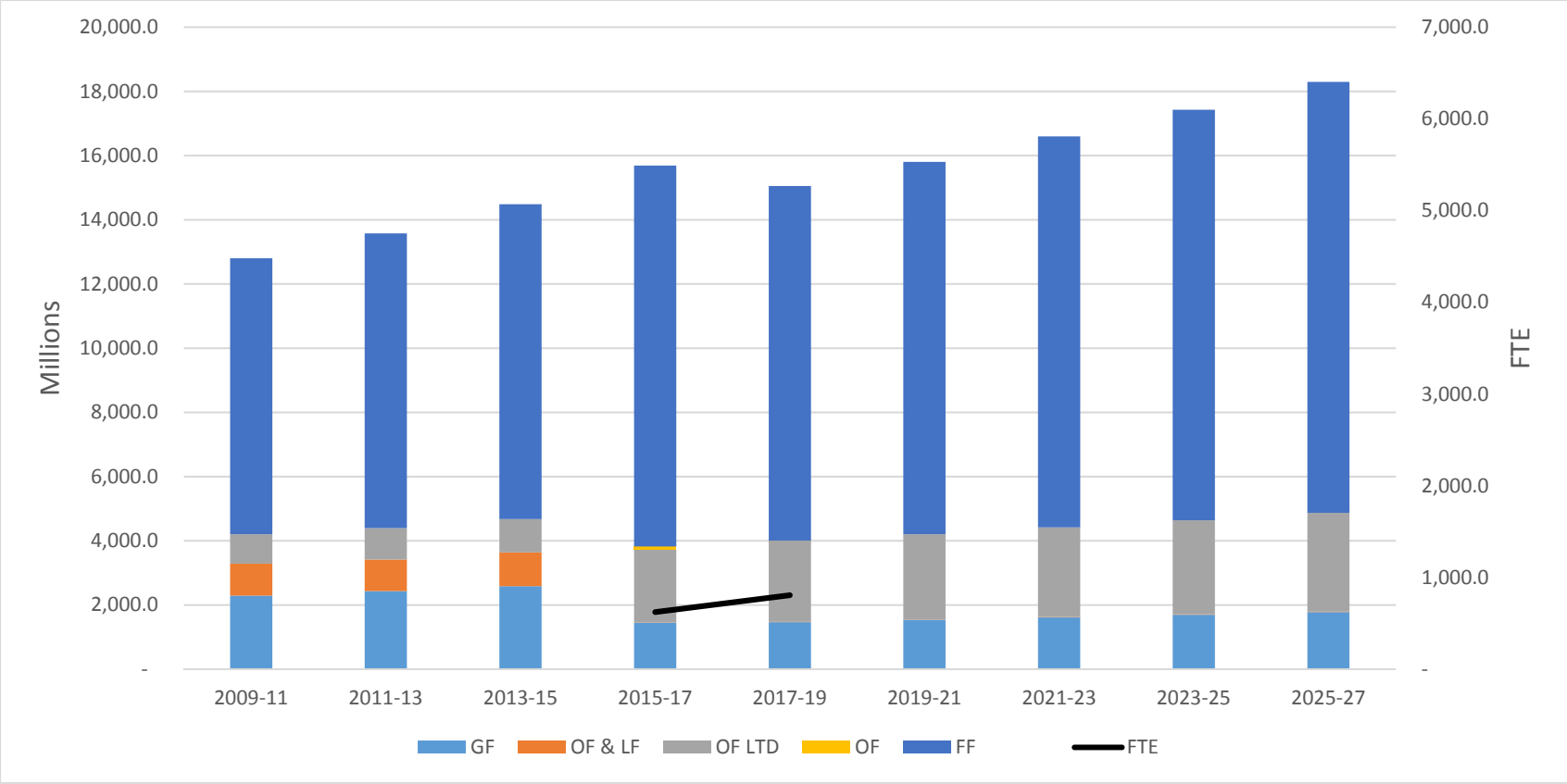

2017-19
Governor's Budget
Health Systems Division
816 POS / 807.26 FTE
Program Support and Administration
816 POS / 807.26 FTE
Health Programs – Medicaid
Health Programs – Non Medicaid

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Executive Summary

Long term focus areas: Excellence in State Government, Safer, Healthier Communities

Primary contact: Varsha Chauhan, Chief Health Systems Officer
503-947-2659



Program overview

The budget for Health Systems Division includes:

- Program Support and Administration
- Medicaid
- Non-Medicaid

Through its functional realignment, the Oregon Health Authority integrated Medical Assistance Programs (MAP) and Addictions and Mental Health (AMH) into the Health Systems Division (HSD) and structured the Oregon State Hospital as a stand-alone program unit.

Program funding request

For the 2017-2019 biennium, the Oregon Health Authority requests the following budget (in millions) for Health Systems Division:

- 2017-2019 request: $15,051.9 TF ($1,463.6 GF, $2,543.5 OF, and $11,044.9 FF)

The Oregon Health Authority estimates the following costs for Health Systems Division through the 2025-2027 biennium:

- 2019-2021 projected costs: $15,804.5 TF ($1,536.7 GF, $2,670.6 OF, and $11,567.1 FF)
- 2021-2023 projected costs: $16,594.7 TF ($1,613.6 GF, $2,804.2 OF, and $12,177.0 FF)
- 2023-2025 projected costs: $17,424.5 TF ($1,694.5 GF, $2,944.4 OF, and $12,785.8 FF)
- 2025-2027 projected costs: $18,295.7 TF ($1,779.0 GF, $3,091.6 OF, and $13,425.1 FF)

Health Systems Division is projected to provide health care coverage for approximately:

- 1,068,667 Oregonians on average per month for the 2017-2019 biennium
- 1,084,252 Oregonians on average per month for the 2019-21 biennium

Program Description

The Health Systems Division budget includes:

HSD – Program Support and Administration

HSD program support ensures HSD has the administrative infrastructure, and operational and technology resources, including human resources, necessary to fulfill the mission and perform HSD's legislative charge and mandates. The Health Systems Division is a newly integrated area that includes the former MAP and AMH. This area ensures systematic health care transformation in the coordinated care model occurs at the coordinated care organization level and that state operations are effective, efficient, and fiscally sustainable. HSD oversees regulatory and operational management of Oregon's health delivery system. The division manages the implementation and evaluation of multiple statewide programs and activities in support of the Medicaid program including integrating and coordinating interagency activities.

- Central Administration comprises the Chief Health Systems Officer and staff teams providing office management including overseeing the hiring process and paperwork, facility moves, paying administrative invoices and oversight of the administrative and program budgets and expenditures.
- The Integrated Health Programs section comprises three teams focused on both Medicaid- and non-Medicaid-funded physical, dental and behavioral health program development, operations policy, and special projects.
- The Compliance and Regulation section of the Health Systems Division is responsible for four functions: Contracts, Complaints, Regulation, and Quality Management. Contracts initiates and oversees all Health Systems contracts and grants, including but not limited to; coordinated care organization (CCO) contracts, intergovernmental agreements with local mental health authorities (LMHAs) and community mental health programs (CMHPs), direct contracts with tribes and tribal organizations, and all other physical, dental, and behavioral health contracts administered by the Oregon Health Authority.
- The Provider Services section comprises delivery system support, provider support and enrollment, provider services training, provider clinical support, and service data reporting. Within the delivery system support function, staff teams are direct the coordinated care support program by developing and implementing policies, procedures, and program priorities. In addition, staff provide legislative analysis and administrative rule input.
- The Member Services section is responsible for implementing Oregon's Medicaid program. This includes policy interpretation and compliance, eligibility evaluation and processing, and customer service for the estimated 1.1 million Oregonians receiving the program's benefits.
- The Business Systems section includes business-related functions and expenditures for information technology to support Health Systems. Its functions include Medicaid Management Information System (MMIS), the ONE system, COMPASS, Special Projects, and Business Systems Training.

- The Office of Program Integrity detects, prevents and investigates Medicaid and non-Medicaid fraud and abuse. This work is pivotal to ensuring public resources maximize the health care benefits delivered to Oregonians. This is why the Governor's Budget invests $7.3 million, of which $1.6 million is General Fund, to enhance OHA's Office of Program Integrity. This investment will enable OHA to improve its program for investigating Medicaid and non-Medicaid fraud; provide better oversight of how the state's health care partners spend public resources; and comply with federal program integrity requirements. The return on investment of this initiative cannot be understated, which is why the Governor's Budget also recognizes a General Fund savings of $15 million to reflect the benefit of increasing the state's program integrity capabilities.

HSD – Medicaid

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.

- As provided under the Affordable Care Act (ACA), the Legislature approved a budget to expand Medicaid coverage to all adults under 138 percent of the federal poverty level. This expansion is entirely federally funded through 2016. Starting in 2017, Medicaid match is phased down to 90 percent by 2020.
- During 2014 the Oregon Health Plan caseload increased by approximately 400,000 clients, primarily driven by the expansion of Medicaid coverage. The program now provides medical coverage for more than one million Oregonians.
- For approximately 90 percent of those on the Oregon Health Plan, care is provided by one of 16 CCOs designed to bring better health, better care and lower costs.

This budget includes the Citizen/Alien-Waived Emergency Medical (CAWEM) program. This is a mandatory Medicaid program. People who are ineligible for Medicaid solely because they do not meet the Medicaid citizenship or immigration status requirements are eligible for limited medical assistance under CAWEM. The program provides emergency medical services including labor and delivery services for pregnant women. Most expenditures are for labor and delivery. Clients receive services from medical providers who accept Medicaid fee-for-service payments. For the 2015-2017 biennium, the program has a budget of $41 million and serves more than 55,000 clients.

This budget includes payments to the federal government for Medicare Part D coverage for people who are eligible for both Medicaid and Medicare ("dual-eligible"). The Medicare Modernization Act of 2005 created Medicare Part D under which Medicare beneficiaries became eligible for Medicare prescription drug benefits beginning Jan. 1, 2006. This was a change for dual-eligible clients, who previously received their prescription drug coverage under Medicaid. The 2005 law requires states to pay the federal government for a large portion of the cost that the state would have paid as the state share for drug costs for dual-eligible clients. When states started paying in 2006, they paid 90 percent of the cost. For the 2015-2017 biennium, the program has a budget of $191 million based on an average monthly caseload of 77,000 dual-eligible clients.

This budget includes the Qualified Medicare Beneficiaries program. This program pays the Medicare premiums, deductibles, co-insurance and co-payments for clients. To be eligible, a person must be receiving Medicare Part A (hospital insurance benefits). Income and resources must fall within certain limits. Eligibility extends up to 135 percent of the federal poverty level. For the 2015-2017 biennium, the program has a budget of $31 million and serves almost 24,000 people.

This budget includes Medicare Part A and Part B premium payments for Medicaid-eligible clients. For the 2015-2017 biennium, the budget to pay these premiums is $80 million for Medicare Part A payments for an average of 6,800 clients a month and $351 million for Medicare Part B payments for an average of 120,000 clients a month.

This budget includes Law Enforcement Medical Liability Account (LEMLA), which pays medical claims for individuals who are injured in interactions with law enforcement. Law enforcement agencies submit claims to OHA if they are unable to recover costs directly from those individuals or their insurance companies. For the 2015-2017 biennium, the LEMLA budget is $1.4 million.

The 2017-19 Governor's Budget includes the following initiatives in the HSD Medicaid budget:

- Reducing Unintended Pregnancies – Approximately 50 percent of pregnancies in Oregon are unintended. The Governor and OHA continue to place a high priority on improving women's health and reducing unintended pregnancies by implementing pregnancy intention screenings and providing effective contraceptives to women who do not wish to become pregnant. The Governor's Budget recognizes the state and federal Medicaid savings expected to be achieved through reducing the rate of unintended pregnancies across the state.

- Cover All Kids - The Governor's Budget not only maintains the state's robust health care coverage for low-income Oregonians and their families, it also expands access to all low-income children in Oregon. This initiative is supported with $55 million General Fund and will provide OHP coverage to children who do not qualify for Medicaid solely because they do not meet federal citizenship and immigration status requirements. The Governor's initiative reflects the return on investment achieved when children have health insurance coverage – they have fewer emergency room visits, have improved social and emotional functioning, do better in school, miss fewer school days, and are more likely to graduate school and go to college.
- Hepatitis C Treatment Expansion – New breakthrough therapies to treat Hepatitis C with high rates of success became available in the past few years, although at a steep cost per patient. OHP has been providing treatment to Hepatitis C patients with higher stages of the disease; however, these treatments have presented a challenge for the state to stay within budgetary thresholds. The Governor's Budget recognizes the challenge of these increasing costs and invests in expanding treatment to patients at earlier stages. Hepatitis C disproportionately affects minority communities and the Governor's initiative will help put the state on the path of decreasing the number of infections and halting the spread of the disease.

HSD – Non-Medicaid

This budget supports critical elements in Oregon's community behavioral health system that serve as the safety net for all Oregonians regardless of health care coverage. An important focus of this system is to respond to individual and community crises, meeting the immediate mental health needs for a defined population and geographic region. In addition, non-Medicaid funds purchase social supports for OHP members that are not included in the Medicaid benefit package, such as early outreach and engagement, peer-based recovery and housing services. These funds help fill in the gaps by supporting social and clinical activities not reimbursed by OHP or other payers. HSD works closely with OHA's Health Policy and Analytics, the Transformation Center, OHA's Office of Equity and Inclusion division and CCOs to coordinate the system of care as well as achieve better health and better care at lower costs for all Oregonians by integrating physical and behavioral health services and promoting health equity.

HSD administers contracts and agreements with local mental health authorities such as community mental health programs, 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.

The services available include:

- Early intervention
- Mental health promotion and prevention
- Outpatient treatment
- Day treatment and residential treatment
- Acute psychiatric treatment in local hospital specialty units
- Medications and medication management
- Case management
- Housing and supports
- Peer supports and peer-delivered services
- Employment and education supports
- Psychiatric residential treatment
- Psychiatric day treatment
- Care coordination
- Crisis services
- Skills training
- Intensive community-based treatment services
- Longer term, hospital-level care to adults with mental illness who otherwise cannot be treated safely or successfully in community settings

Program justification and link to long-term outcomes

OHP is key for advancing Oregon's coordinated care model. The coordinated care organizations provide services using evidence-based practices to manage and coordinate care. Locally integrated services use patient-centered primary care homes that provide team-based care.

Looking toward the 2017-2019 biennium, OHA is applying to the federal government for a five-year extension to the Oregon Health Plan Medicaid demonstration. With that application, the agency seeks to build on the coordinated care model's success to:

- Build on health care transformation with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance-driven system with the goal of improving health outcomes;
- Improve the social determinants of health and health equity across all low-income, vulnerable Oregonians with the goal of improving population health outcomes;
- Commit to an ongoing sustainable rate of growth for health care costs and promote increased spending on health-related services and the use of value-based payments; and
- Establish supportive partnerships with the federal government to expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual eligible members.

HSD non-Medicaid programs ensure access to safety net behavioral health services and care for all Oregonians who are at risk of developing or who have been diagnosed with any behavioral health disorder, including problem gambling disorder and severe and persistent mental illness regardless of payer. This care is delivered in the least restrictive and most integrated setting possible by a diverse, locally administered and designed provider. Programs deliver evidence-based services that help restore individuals and their families to a level of function that is optimal for them.

These services are aligned with two of the Governor's Long Term Focus Areas: A Thriving Oregon Economy and Safer, Healthier Communities and help to reduce per capita cost, improve patient experience, and reduce chronic disease costs, while increasing the life expectancy and success of people who receive substance abuse and mental health treatment.

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) plans to reduce the impact of substance abuse and mental illness on America's communities. In a 2012 study, SAMSHA found that the annual total estimated societal cost of

substance abuse in the United States is $510.8 billion, and that by the year 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.

Program performance

OHP has helped transform the health care delivery system to one of coordinated care with 16 CCOs delivering the vast majority of physical, oral and behavioral health services to Oregon Health Plan members.

- Over one million Oregonians, about 25 percent of Oregon's population, receive health care under this new health care delivery model
- Approximately 90 percent of members are enrolled in a coordinated care organization, covering the entire state geographically
- With nearly 95 percent of Oregonians now enrolled in health care coverage, Oregon has one of the lowest uninsured rates in the nation
- OHP has bent the per-member-per-month cost curve by staying within the 3.4 percent annual sustainable rate of growth, two percentage points below the President's 2012 budget projection of 5.4 percent
- Developed a successful, robust measurement and public reporting process to align incentive metrics, so that 5 percent of CCO budgets are now paid based on meeting incentive targets
- Health outcomes improved:
    - Emergency department visits for coordinated care enrollees decreased 23 percent since 2011
    - Hospital admissions decreased for short-term complications from diabetes
    - Hospital admissions decreased for chronic obstructive pulmonary disease

Non-Medicaid investments support a safety-net system for people who are experiencing urgent behavioral health needs and people who need social supports to maintain recovery goals. These services work cooperatively with Medicaid funded services to support individuals and families in achieving improved social and health status.

OHA and the United States Department of Justice (USDOJ) have a shared interest in the state's health system transformation and its impact on improving health outcomes for individuals with severe and persistent mental illness. OHA and USDOJ have agreed to collect data on specific metrics to better understand the system and to engage in discussions regarding services and outcomes. The

metrics are defined in Oregon's Performance Plan, which was finalized in late July 2016 and will be actively monitored for three years by USDOJ.

Enabling legislation/program authorization

The Oregon Health Plan is supported by Medicaid and the Children's Health Insurance Program (CHIP). Title XIX and Title XXI of the Social Security Act, respectively, provide the federal authorization. Oregon administers the program under the authority of the federally approved Medicaid State Plan, CHIP State Plan, and Oregon Health Plan Medicaid demonstration. The Legislature authorizes the Oregon Health Plan, including coordinated care organizations, under Oregon Revised Statutes 414.018 through 414.760.

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

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

Funding streams

HSD – Medicaid

Federal matching funds (Medicaid and CHIP) are the primary funding streams supporting OHP. Oregon qualifies for these federal dollars under its federally approved Medicaid and CHIP State Plans and the Oregon Health Plan Medicaid demonstration. The federal match rate for Medicaid program expenditures and for CHIP program expenditures changes each fiscal year. Oregon funds the state's share of the program with General Fund dollars and a variety of Other Fund sources, (e.g., hospital assessment, tobacco tax, tobacco settlement payments, drug rebates,) and leveraged funds from a variety of sources such as counties and Oregon Health & Science University.

The Legislature established the hospital assessment in 2003 (Chapter 736, Oregon Laws 2003) to fund the OHP Standard program and enhanced hospital reimbursement. In 2011, the Legislature expanded the use of the assessment to support reimbursement rates for other providers, not just hospitals. In 2013, the Legislature extended the assessment two more years (with the passage of HB 2216) to provide continued support for OHP and to fund a hospital transformation performance program. OHA, in consultation with hospital representatives, sets the assessment rate by administrative rule (OAR 410-050-0861) to generate the projected revenue needed to meet budget and program objectives. As of April 1, 2016, the assessment rate is 5.3 percent.

HSD – Non-Medicaid
State General Fund: legislative appropriation for treatment services.

Other Funds: Beer and wine taxes – statutorily dedicated by ORS 430.345 to 430.380, requires local maintenance of effort and local expenditure of dedicated taxes for state-approved services. Intoxicated Driver Program Fund – statutorily dedicated by ORS 813.270, does not require any matching or maintenance of effort. Miscellaneous – contract settlements, state match from Multnomah County/DePaul and OHA, and sponsored travel reimbursements. Community Housing Trust Funds – this trust fund was established with the sale of the Dammasch hospital property (ORS 413.101). Interest from the fund is dedicated for new housing and facility maintenance to benefit people with mental illness.

Tobacco tax: During the 2013 Special Session the Legislature approved a 13 percent tobacco tax, a portion of which is dedicated to community mental health services.

Tobacco Master Settlement Agreement funds have been used in Oregon over the past several years to cover costs of health care, including those associated with tobacco-related illnesses. In building 2015-2017 budget, a portion of these funds was earmarked for non-Medicaid expenditures, in lieu of General Funds. These revenues recently began to decline, under the terms of the Master Settlement Agreement. As these funds continue to decline, additional reductions to programs or alternative sources of revenues can be expected.

Marijuana revenue: In the 2015-2017 budget build, the Department of Administrative Services estimated almost $2 million as OHA’s portion of the recreational marijuana fee-based charges. This funding was set to assist with addiction and recovery services. However, when these revenues were estimated, all of the administrative rules, and other technicalities were not yet in

place. Now that we are part way into the 2015-2017 biennium, the Department of Revenue has a better idea of what mechanisms need to be in place to allocate this funding at the beginning of the 2017-2019 biennium.

Federal Funds: Substance Abuse Prevention Treatment grant (SAPT) requirements are: 20 percent of the grant must be spent on prevention (transferred to the Public Health Division) and service levels must be maintained for specified populations such as women and women with children. The one qualifying factor for this grant is that the state must expend a minimum of state and local revenues on SAPT-related services to meet the maintenance-of-effort requirement. Access to Recovery grant (ATR), which expires Sept. 29, 2018, includes several unique requirements: nontraditional client-driven services and supports, administration of a voucher system for clients to purchase services, and free and independent choice in the selection of recovery and treatment services, including faith-based options. This grant does not require any matching or maintenance of effort. Temporary Assistance for Needy Families grant (TANF) requires maintenance of effort. Medicaid (Title XIX) has a matching requirement. Center for Mental Health Services block grant (CMHS) – at least 35 percent of each grant's service funding must be expended for mental health services for children. The grant has a maintenance of effort (MOE) requirement. PATH – Projects for Assistance in Transition from Homelessness.

Lottery Funds: Oregon Revised Statute (ORS) 461.549, dedicates 1 percent of Lottery revenue for prevention and treatment of problem gambling and does not require any matching or maintenance of effort. In spite of this, these funds are frequently reduced in times of economic decline.

A&D 66 Intoxicated Driver Prevention Fund (IDPF)/Driving Under the Influence of Intoxicants (DUII) funds provide funding to counties for intoxicated driver services, as well as contracting with Guardian Interlock to provide breathalyzer machines for IDPF clients.

Significant proposed program changes from 2015-2017:

HSD is proposing to remove the clause that allows youth to be placed in the state's Secure Adolescent Inpatient Program (SAIP) solely for a fitness to proceed evaluation. This change would allow youth to receive services to improve their mental health and fitness to proceed in the least restrictive setting. This change would provide better care as services will more often be provided in the youth's own community and improve mental health outcomes by using the natural continuity of care system aligned with the youth's mental health needs.

In light of the one-time revenue no longer available to support OHP, as well as the decreased availability of federal funding, the Governor's Budget reforms how OHP is funded in the following key ways:

- Hospital Assessments – The budget revises the Hospital Assessment structure to make it a true tax and discontinues the Hospital Transformation Performance Program, thereby redirecting the program's funding to support OHP benefits.
- Insurance and Managed Care – The budget reinstates the insurance and managed care tax that expired in 2013.
- Coordinated Care Organizations - The budget does not fund 18 months of inflationary costs for CCOs, previously capped at 3.4 percent per member per year and reduces the allowed CCO administrative rate.
- Fee-for-Service – The budget does not provide a full inflationary increase for fee-for-service rates.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Program Support and Administration

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 135.1	$ 19.1	$ 247.7	$ 402.0	623	610.47
Governor's Budget 17-19	$ 129.6	$ 17.7	$ 249.9	$ 397.3	816	807.3
Difference	$ (5.5)	$ (1.4)	$ 2.2	$ (4.7)	193	196.79
Percent Change	-4%	-7%	1%	-1%	31%	32%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

HSD program support ensures HSD has the administrative infrastructure, and operational and technology resources, including human resources, necessary to fulfill the mission and perform HSD's legislative charge and mandates. The Health Systems Division is a newly integrated area that includes the former MAP and AMH. This area ensures systematic health care transformation in the coordinated care model occurs at the coordinated care organization level and that state operations are effective, efficient, and fiscally sustainable. HSD oversees regulatory and operational management of Oregon's health delivery system. The division manages the implementation and evaluation of multiple statewide programs and activities in support of the Medicaid program including integrating and coordinating interagency activities.

Central Administration: Central Administration comprises the Chief Health Systems Officer and office management staff. They oversee the hiring process and paperwork, facility moves, pay administrative invoices and oversee the administrative and program budgets and expenditures.

- The Business and Portfolio Management team provides project management resources to critical path projects across the division. In addition, the team develops and offers a set of standardized project management tools to staff working in other units within HSD, serving as project managers for various special projects. Team members are versed in Lean and serve as process improvement consultants to other units across the division.
- The business office and financial coding team coordinates business continuity planning, disaster and emergency management planning, establishes project communications and coordination tools. Staff also ensure accurate coding for contract invoices, calculate and issue settlements and payments.

Integrated Health Programs: The Integrated Health Programs section comprises three teams focused on both Medicaid-funded and non-Medicaid-funded physical, dental and behavioral health program development, operations policy, and special projects.

- Medical and dental operations policy staff are design, develop, implement, monitor, and maintain Medicaid medical and dental service programs to comply with state and federal regulations.
- Adult and Child and Family Behavioral Health teams provide oversight, contract administration, and direction in the areas of child, adolescent, adult and older adult behavioral health service elements. This encompasses substance use disorder, mental health, and problem gambling services including screening and early intervention, community-based outpatient, residential, inpatient, crisis stabilization, emergency services, housing and recovery supports. Many of these services are tailored to specific populations such as juvenile and adult forensic populations, civilly committed individuals, children and families who are involved in multiple systems, young adults in transition, and older adults. In addition, staff provide legislative analysis and coordinate the administrative rule process.
- Working with internal and external multi-sector partners, the Integrated Health Programs section performs analysis that helps management make decisions about the implementation and operation of the division's health care programs. The research and analysis are focused on translating strategic policy direction into programs and services that are ready for providers to implement and members to access.

Compliance and Regulation: The Health Systems Division Compliance and Regulation section has four functions: contracts, complaints, regulation, and quality management. Contracts initiates and oversees all Health Systems contracts and grants, including CCO contracts; intergovernmental agreements with local mental health authorities (LMHAs) and community mental health programs (CMHPs); direct contracts with tribes and tribal organizations; and all other physical, dental, and behavioral health contracts administered by the Oregon Health Authority. Complaints receives, manages and resolves complaints and grievances submitted by OHP members, providers, contractors, families, advocates, and others. Its functions include:

- Complaint management
- Hearings (including support and consultation)
- Fee for service (FFS) and managed care complaint and grievance review and monitoring
- Processing of hearing requests for OHP coverage denials

The Regulatory team licenses, certifies and approves mental health and addiction service providers statewide. It evaluates programs to ensure services are provided to individuals in a safe and therapeutic manner in compliance with all applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OARs). This includes:

- Certification of child and adolescent treatment programs
- Civil commitment
- CMHPs
- Outpatient behavioral health programs (mental health, substance use disorder and problem gambling)
- Residential licensing

The Quality Management (QM) team is responsible for the Compliance and Regulation's quality control, quality assurance, quality planning and quality action initiatives for improvement. Its four main components are quality control, quality assurance (QA), quality planning and quality action initiatives for improvement.

Provider Services: The Provider Services section's functions include delivery system support, provider support and enrollment, provider services training, provider clinical support, and service data reporting.

- Delivery system support develops and implements policies, procedures, and program priorities for the coordinated care support program. This includes providing services to the CCOs and associated organizations and individuals. In addition, staff provide legislative analysis and administrative rule input.
- Provider support and enrollment enrolls providers, answers their questions and provides them with customer service. Staff also resolve complex problems, and develop, implement and monitor procedures. This unit also identifies and reports any adverse actions taken against providers by licensing and enforcement agencies.
- Provider services training develops and provides training for individual providers and coordinated care organizations. It is also ensures that program clinical and operational strategies employed by Oregon and out-of-state providers to OHA clients comply with state and federal rules. Its staff also support a system of integration of behavioral health, oral health, and physical health for FFS members.
- Service data reporting manages electronic encounter data, ensures MMIS fee for service claims and managed care encounters are processed appropriately according to state plan and associated OARs, and manages program monitoring and data analysis.

Member Services: The Member Services section operates Oregon's Medicaid program. This includes policy interpretation and compliance, eligibility evaluation and processing, and customer service for the estimated 1.1 million Oregonians receiving the program's benefits.

- The Customer Service team is to respond to client inquiries about their OHP applications and coverage. They are OHP's primary ambassadors, providing clients' primary resource by telephone. Members typically call for information about their application status, benefits, and care coordination. They also call to make changes in their personal information that may affect their eligibility. Another team serves our community partners, the trained in-person application assisters located around the state.
- The Member Services Eligibility team includes several teams with detailed eligibility expertise. Factors that can affect eligibility include Medicare, pregnancy, children's medical, tribal members, corrections, and much more. This unit

handles eligibility determinations, renewals, requests for additional information, demographic changes, case closures and other eligibility-related tasks and issues.

- The Policy team of medical eligibility policy analysts oversees rule evaluation and establishment, audits and audit-required activities, and responds to legislative inquiries. They support system design, testing, and implementation. They provide ongoing review of procedures and system enhancements for policy compliance. The medical eligibility policy team also works directly with and for CMS on all matters of federal program compliance, reporting, and problem-solving.

Business Systems: Business Systems includes business-related functions and expenditures for information technology to support Health Systems. Its functions include Medicaid Management Information System (MMIS), the ONE system, COMPASS, Special Projects, and Business Systems Training. In 2015, OHA began a phased-in approach to launch the Oregon Eligibility (ONE) system for Medicaid eligibility and enrollment. The Governor's Budget builds on the system's progress and trajectory by supporting system enhancements to ensure it achieves its goal of automating and streamlining the eligibility and enrollment process for OHP applicants and caseload specialists.

Program Integrity and Fraud Prevention: The Office of Program Integrity detects, prevents and investigates Medicaid and non-Medicaid fraud and abuse. This work is pivotal to ensuring public resources maximize the health care benefits delivered to Oregonians. This work is pivotal to ensuring public resources maximize the health care benefits delivered to Oregonians. This is why the Governor's Budget invests $7.3 million, of which $1.6 million is General Fund, to enhance OHA's Office of Program Integrity. This investment will enable OHA to improve its program for investigating Medicaid and non-Medicaid fraud; provide better oversight of how the state's health care partners spend public resources; and comply with federal program integrity requirements. The return on investment of this initiative cannot be understated, which is why the Governor's Budget also recognizes a General Fund savings of $15 million to reflect the benefit of increasing the state's program integrity capabilities.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Mental Health: An agreement with the United States Department of Justice (USDOJ) related to adults with serious and persistent mental illness in Oregon was pending at the time this was written. It addresses several behavioral health care issues. In order to implement this agreement, OHA staff provide oversight, technical assistance, evaluation, and monitor and ensure compliance with the agreement and related rules and statutes.

Addiction Services: In order to address the multiple issues related to opioid use and misuse, several initiatives are underway, led by OHA Health Systems and the Public Health Division, in coordination with our multiple stakeholders and partners. The Oregon Opioid Initiative is an internal workgroup focusing on opioid related topics such as prescribing guidelines, opioids and the Medicaid population, and expanding access to medication-assisted treatment and naloxone. The goal is to help create a more accessible statewide system for patients to access office-based opioid treatment options, especially in underserved, rural and frontier areas of our state. The Naloxone Workgroup made up of state, county and other public health, treatment, and law enforcement groups is addressing the issues of access to naloxone in Oregon, including payment issues, expanding use in social services agency settings, and co-prescribing for those on high dosage opioid prescriptions.

Contracting: The administrative work of the contracting unit has increased as HSD received legislative direction to fund the behavioral health system outside of our current community mental health program contracts. The contracting unit does not have a robust technology solution that would relieve staff from manually performing tasks associated with procuring, executing and managing the contracting process. HSD administers and manages more than 280 contracts and anticipates growth in the volume of contracts and more administrative complexity in all areas associated with operations and contracting. The unit will require additional resources and a more robust technology solution to manage this growth.

Medicaid Eligibility and Enrollment: The introduction of new eligibility systems did not reduce net processing time. This led to a deficit of capacity to process the significant increase in caseload. Since the implementation of the Affordable Care Act (ACA) the

Medicaid caseload has increased by 51 percent, from 626,000 to nearly 1.1 million individuals. The introduction of new determination systems has not reduced the time it takes to set up and manage a Medicaid case. Prior to the ACA, the average time to set up a case in OHA legacy systems was approximately 8 minutes. Processing time in Cover Oregon system was approximately 18 minutes and processing time in the new Oregon Eligibility System is currently averaging approximately 45 minutes. Processing time is estimated to be approximately 8 minutes once the first year of renewals, which require manual data entry, are complete.

Business Systems: The ONE System was implemented in December 2015. HSD will need staff dedicated to train workers on the system. Health Systems will also need dedicated call center staff to assist applicants. OIS and HSD will need to respectively provide technical support, including Help Desk services, and business support (e.g., business analysts, testers, trainers) for ongoing operations and maintenance.

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

State General Funds: Appropriated for behavioral health treatment services, administration and supports.

Other Funds:

- Limited amount of licensing revenue and small contracts for data reporting to the federal government and educating the system relative to the Olmstead Supreme Court decision
- A portion of court fines, fees and assessments support administrative activities related to Driving Under the influence of Intoxicants (DUII) program

Lottery Funds: A portion of the 1 percent to support problem gambling treatment programs.

Beer and Wine & Marijuana Tax Revenues: HSD receives a monthly allotment from the Mental Health Alcoholism Services Account. This revenue is appropriated for substance use disorder treatment and recovery services according to statutory requirements. A portion of this revenue also supports administration.

Federal Funds: Medicaid administrative match, small amounts of the federal block grants to meet administrative requirements, and other federal grants to fulfill the grant obligations.

Proposed new laws that apply to the program unit

None.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Medicaid

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$1,011.5	$ 2,166.8	$11,441.2	$ 4,619.5	0	0.0
Governor's Budget 17-19	$1,057.5	$ 2,394.6	$10,745.2	$ 14,197.3	0	0.0
Difference	$ 46.1	$ 227.8	$ (695.9)	$ (422.1)	0	0.0
Percent Change	5%	11%	-6%	-3%	0%	0%

Health Systems Division – Medicaid has no dedicated positions or full-time equivalents. All positions that are dedicated to doing the work are in Health Systems Division Program Support and Administration budget.

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

The Oregon Health Plan (OHA) Medicaid demonstration is often referred to as the OHP "waiver" because it is an agreement with the federal government to waive specific regulations to allow Oregon to administer a state-designed Medicaid program. The OHP budget is largely driven by the demonstration agreement, which requires the state to hold OHP per-member-per-month health care expenditures to no more than 3.4 percent annual growth during the 2015-2017 biennium. The current five-year demonstration expires June 30, 2017. During the five years, the federal government invested $1.9 billion in additional Federal Funds (approximately $380 million in the 2015-2017 biennium) to support Oregon's health care system transformation by allowing the

state to receive Medicaid match on expenditures not traditionally allowed for matching funds under a Designated State Health Programs (DSHP) provision.

OHA has submitted the state's application to extend the OHP Medicaid demonstration another five years. Based on the success and program savings to both the state and federal government, Oregon is requesting continued additional federal investment to support and further Oregon's health care system transformation. With that continued support, the state also is proposing to hold annual per-member-month expenditures to 3.4 percent, but with breakthrough pharmacy therapies excluded. The application includes the continuation of the Hospital Transformation Performance Program. Hospital assessment revenue would continue to fund the state share for those incentive payments. The Oregon Health Authority is requesting the federal government to approve the demonstration extension by fall 2016.

The OHP budget is based on caseload forecasts and cost estimates projected for the coming two years. Because of the size of the budget, even the slightest variance from the original caseload forecast can result in a significant budget shortfall or savings. The caseload forecast used for the 2017-2019 OHP budget is especially risky because of data issues associated with transitioning to a new eligibility system while catching up on redetermining eligibility during the transition. Capitation rates for coordinated care organizations are also a significant budget driver. The agency does not set the capitation rates. For each calendar year, an independent actuary certifies the capitation rates and the federal government approves for actuarial soundness according to federal managed care regulations.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

The budget for Citizen/Alien Waived Emergency Medical (CAWEM) program is driven by the caseload forecast. The caseload forecast used for the 2017-2019 budget is especially risky because of data issues associated with transitioning to a new eligibility system while catching up on redetermining eligibility during the transition.

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

The Medicaid budget has two primary Federal Fund revenue sources: Medicaid and the Children's Health Insurance Program (CHIP). The Medicaid match rate used for the 2015-2017 biennial budget is approximately 64 percent for most services. (The rate generally is 50 percent for Medicaid staffing and administrative expenditures, but the agency is able to claim 75 percent on administrative activities directly related to eligibility determinations and enrollment.) The CHIP match rate changed significantly during the 2015-2017 biennium. The CHIP match rate for the first quarter of the biennium was approximately 74 percent. Effective October 1, 2015, the Affordable Care Act (ACA) increases the CHIP match rate by 23 percentage points to about 97 percent federal funding. For 2017-2019, the CHIP rate is projected to remain at about 97 percent.

The hospital assessment provides a major portion of state funding for the Health System Division – Medicaid budget. During the 2015 regular session, the Legislature extended the hospital assessment four more years with the passage of House Bill 2395. The assessment expires September 30, 2019.

The major unknown with the Health Systems Division – Medicaid 2017-2019 budget is whether and to what extent the federal government will continue to provide additional investment in Oregon's health care system transformation with the extension of the OHP demonstration. The Governor's Budget assumes the federal investment (currently under the Designated Health Programs provision of the demonstration) does not continue into the 2017-2019 budget.

In light of the one-time revenue no longer available to support OHP, as well as the decreased availability of federal funding, the Governor's Budget reforms how OHP is funded in the following key ways:

- Hospital Assessments – The budget revises the Hospital Assessment structure to make it a true tax and discontinues the Hospital Transformation Performance Program, thereby redirecting the program's funding to support OHP benefits.
- Insurance and Managed Care – The budget reinstates the insurance and managed care tax that expired in 2013.
- Coordinated Care Organizations - The budget does not fund 18 months of inflationary costs for CCOs, previously capped at 3.4 percent per member per year and reduces the allowed CCO administrative rate.
- Fee-for-Service – The budget does not provide a full inflationary increase for fee-for-service rates.

Proposed new laws that apply to the program unit

HSD is proposing to make mental health drugs subject to the preferred drug list and remove the carve-out of mental health drugs from the coordinated care organizations' contract and capitation rates, allowing coordinated care organizations to better coordinate integrated care.

OREGON HEALTH AUTHORITY: HEALTH SYSTEMS DIVISION

Program Unit Narrative: Non Medicaid

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 303.8	$ 187.7	$ 174.4	$ 665.9	0	0.0
Governor's Budget 17-19	$ 276.4	$ 131.2	$ 49.7	$ 457.3	0	0.0
Difference	$ (27.4)	$ (56.5)	$ (124.7)	$ (208.6)	0	0.0
Percent Change	-9%	-30%	-72%	-31%	0%	0%

The Governor's Budget continues funding for the Non-Medicaid Mental Health, Intervention and Prevention Services programs at the current service level for 2017-2019. The Substance Use Disorder Prevention services formerly overseen by Health Systems Division have been transferred to the Public Health Division.

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

It is widely understood that people with mental health and co-occurring substance use disorders die an average of 25 years earlier than their counterparts and experience other associated health risks and social consequences. These include infectious diseases, obesity, liver diseases, criminal involvement and lost productivity. In addition, people with untreated mental health and substance use disorders, particularly people from underserved communities, experience poor health and societal outcomes that create economic costs throughout state and local systems.

In partnership with legislators, other state agencies, and a broad set of diverse community stakeholders, OHA conducted large-scale qualitative and quantitative analyses in preparation for the 2017 legislative session. The Behavioral Health Mapping Tool, in

combination with the Behavioral Health Town Hall report and other associated special studies, formed the foundation of knowledge to help inform policy and funding discussions during 2017.

Oregon communities experienced a number of high-profile stressful and psychologically traumatic events in the past 18-24 months. Most notably, the mass shooting incident at Umpqua Community College and the armed militia occupation in Harney County. Unfortunately, many communities also experienced the loss of life due to suicide. Oregon's behavioral health system was able to respond to community needs due to the Non-Medicaid funding supporting this infrastructure.

- Community Health Alliance (CHA), the community mental health program (CMHP) in Douglas County, served as the hub of crisis response operations, a function essential to bringing a sense of calm and order to a community working with other first responders from state, federal and local entities. HSD deployed three staff members to help respond to the behavioral health needs at Umpqua Community College and the broader community after the tragedy. Staff spent between three and 12 weeks on the ground as part of the coordination and response effort.
- Harney County, through agreement with Symmetry Care, provided for the escalated mental health needs in the community through collaboration, enhanced case management and outreach to many partners and stakeholders. OHA and HSD deployed staff to assess and respond to the behavioral health needs in this community.
- The Burns Paiute Tribe worked to meet the emotional support needs in that tribal community through traditions and healing ceremonies after the disturbance of sacred cultural artifacts at the Malheur Wildlife Sanctuary. HSD coordinated closely with the tribe to evaluate the immediate behavioral health support needs and responded with additional resources after a plan was developed and approved.
- Clatsop Behavioral Health (CBH) partnered with school leaders to direct an effort to reduce concerns about suicide risk among multiple middle school students. At the request of CBH, Greater Oregon Behavioral Health, Inc. (GOBHI) and OHA mobilized to provide school staff education, youth awareness, a parent meeting, onsite youth peer support, and family support services. Family support services continue to assist CBH providers in engaging families of high-risk youth and to train local parents to become long-term family support specialists for the community.

Efforts worth noting that are supported by Non-Medicaid funding administered by HSD include:

Community mental health programs
Mental health services improve the daily lives for Oregonians of all ages with severe mental health disorders such as bipolar, major depression, post-traumatic stress and schizophrenia. Persons experiencing a mental health crisis receive brief treatment consisting of medication, counseling and, if necessary, temporary respite housing or local hospitalization. Mental health assessments determine the need for further treatment and whether other supportive services will be provided. These ongoing supports and services improve a person's ability to be successful with their family, education, employment and in their community. This often reduces public safety problems and negative health-related consequences.

Children with mental health issues are served in their local communities and are linked with other child and family serving systems. Each child can be screened and served within the integrated service array for their mental health service and support needs. Services are child- and family-driven and team-based with a clear focus on providing a broad array of services and supports across a coordinated continuum of types and intensity of care.

Services and supports include those delivered by peers, such as help establishing personal relationships, obtaining employment or education; independent living skills training such as cooking, recreation and cultural activities, shopping and money management; residential treatment services or adult foster care; and supervision of people who live in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB). Services are provided in many settings including local mental health clinics, doctor offices and clinics, schools, drop-in centers and homes. The Oregon Health Plan covers mental health services for eligible persons with conditions funded under the Health Evidence Review Commission Prioritized List for all Medicaid and SCHIP clients. The state General Fund pays for services and individuals not covered by OHP.

Highlights
System of Care and Wrap-Around Initiative: HSD contracts with Portland State University and Oregon Family Support Network to provide technical support in the ongoing development of the state, county and local infrastructure needed to provide intensive care coordination for children, youth and young adults with emotional and behavioral disorders being served across multiple systems. In 2017, wrap around services will be available in all counties with governance structures in place to ensure adequate support for providers and consumers in effective implementation of wrap around services.

Parent Child Interactive Therapy (PCIT): This funding covers the cost of infrastructure needed to implement this evidence-based practice, co-located in childhood settings. A total of 783 parent-child pairs received PCIT in 2015. In Quarter 4 of 2015, families completed an average of 12 sessions, and 79 percent showed improvement. Of those who completed treatment, 83 percent had behaviors within normal range at the end of treatment.

Oregon Psychiatric Access Line about Kids (OPAL-K): OPAL-K makes psychiatric consultation for children up to age 18 available to primary care providers. This consultation service increases the primary care provider's ability to manage complex cases, improves effective use of medications, and facilitates connections with additional mental health treatment when necessary. OPAL-K also will provide for tele-psychiatry appointments for children who are in the foster care system and have been prescribed complex psychiatric medications. This will greatly improve access to timely psychiatric services and oversight for this vulnerable population. In June of 2016, OPAL-K has reached 1,000 calls since its startup date.

Aid and Assist and Jail Diversion: The 2015 session authorized funding for counties with the greatest number of "Aid and Assist" referrals to Oregon State Hospital. The funds allow the counties to provide the evaluations and restoration services in the communities rather than at the state hospital. Jail diversion funding is available throughout Oregon to provide resources to divert people with mental illness from incarceration and into treatment services and supports.

Crisis Services: This funding supports services for persons with mental illness in crisis. It provides a range of interventions including transportation, assessment, de-escalation, and referral to treatment. Crisis services in the community reduce the need for a higher level of care and can reduce negative impacts of a crisis in order to reduce the time a higher level service is needed.

Rental assistance and supportive housing

Rental assistance for people with serious mental illness:

The rental assistance program supports individuals with a serious mental illness to secure affordable rental housing so they can live independently. Eligible individuals receive move-in assistance funds and monthly rent subsidies. Each program employs a residential housing specialist and a peer support specialist to assist participants in becoming rent-ready, locating, making application, securing and maintaining a rental unit. These supportive services are available but are not required.

As of February 2016, 21 rental assistance programs were in operation offering 972 housing units across all counties. Beginning in October 2016 an additional seven rental assistance programs for veterans and young adults will begin operation offering an additional 152 housing units. This latest addition bring the total to 1,124 housing slots of affordable housing throughout the state, for a total investment of over $20 million per biennium.

Rental assistance for people with substance use disorders:
This rental assistance program supplies housing coordination and rental assistance so individuals in recovery from a substance use disorder can live independently. Housing coordination services include helping individuals locate and access alcohol- and drug-free housing, case management services and referrals to other services. Rental assistance helps individuals cover a portion of their monthly rent for up to two years. As of March 2016, 11 programs throughout Oregon serve 750 individuals with housing coordination services and 315 with rental assistance, for a total investment of $1.9 million per biennium.

Supported Housing Development:
HSD funds the development of new supported housing units for individuals with a serious mental illness or substance use disorder, using state General Fund dollars and the Community Mental Health Housing Trust Fund. This biennium HSD awarded $643,616 for the development of eight units in three projects for individuals with a serious mental illness and $800,000 for the development of 18 units in four projects for individuals with a substance use disorder.

Substance use disorder services
Substance use disorders are complex problems that affect people from all ethnic groups and walks of life. Dependence on alcohol or drugs is a chronic, progressive illness like asthma, hypertension or diabetes. Addiction contributes directly to other diseases and chronic conditions. Heavy drinking, for example, contributes to illness in each of the top three causes of death: heart disease, cancer and stroke. Each year, nearly 1,230 Oregonians die as a result of diseases caused by alcohol and drug use.[1] Hundreds more die from alcohol- and drug-related accidents and injuries, suicides and overdoses. Addiction complicates chronic illnesses and is strongly correlated with difficulty in treating other diseases and illnesses.

[1] Oregon Vital Statistics Annual Report for 2012, Volume 2, Table 6-17

Substance use disorder treatment and recovery services help people develop the lifelong skills and abilities needed to manage these chronic health conditions. Effective substance use treatment results in decreased criminal activity and recidivism for individuals completing treatment.

Non-Medicaid funded services and supports fill gaps in the service continuum for individuals who are not eligible for OHP and those who have no resources to pay for clinical supports. The purpose of this full continuum of care is to build upon resilience, help individuals make healthier lifestyle choices and promote recovery from substance use disorders. Services include outreach (case finding), early identification and screening, assessment and diagnosis, initiation and engagement, therapeutic interventions, continuity of care, recovery management, and interim services, which are delivered in outpatient, residential, and community settings. These are evidence-based, culturally specific, or promising practices that are individualized to help people achieve and maintain recovery. Outpatient services include specialized programs that use synthetic medications such as methadone, buprenorphine, and injectable Vivitrol as an alternative to chronic heroin and prescription opioid addiction. Education and treatment are available for people convicted of driving under the influence of intoxicants (DUII).

The 2015 Legislature made additional investments in addiction services supporting increased infrastructure for peer-delivered services, sobering facilities, and rate increases for both Medicaid and non-Medicaid funded residential treatment.

Problem gambling services

Gambling disorder is a public health problem that affects relationships, families, businesses and communities. Gamblers suffer from a variety of financial hardships and associated physical and emotional problems. Depression and other mental health concerns also are prevalent among problem gamblers. National studies show that problem gamblers have a higher rate of suicide than those with any other addictive disorder. It is important to know the risks involved with gambling, because anyone who gambles can develop a problem.

Problem gambling treatment and prevention programs are delivered in all 36 counties through CMHPs and by for-profit and non-profit providers. The state also has one residential treatment program. They employ evidence-based prevention strategies to decrease the probability that young people will begin gambling at young ages and to ensure that adults of all ages will be aware of the addictive nature of gambling. They also help people make smarter life choices and reduce risk factors associated with gambling. Treatment programs include outpatient individual and group therapies, intensive therapies, and statewide access to residential

treatment for those who are at risk because of pathological gambling. Problem gambling treatment services consistently show effective and cost-effective, outcomes.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Prevalence of suicide

Suicide intervention and prevention: In response to SB 4124, a five-year plan was created with the input of more than 100 diverse stakeholders across Oregon. Implementation is scheduled to begin in 2016 and will continue until 2020. There are currently no funds designated to implement this mandatory plan. Oregon continues to see an alarming and unprecedented increase in suicide rates for young people aged 10 to 24. Preliminary results indicate that in 2015 there were again at least 12 youth suicides per 100,000 in Oregon.

Opioid misuse, abuse and addiction

Results from the 2013-2014 National Survey on Drug Use Health (NSDUH) rank Oregon in fourth place among all states in non-medical use of prescription pain relievers by individuals over age 12. Multnomah County, Oregon's largest metropolitan area, had the fourth highest rate of nonmedical prescription pain reliever use (7.52 percent) among all 383 regions. OHA estimates that the rate of nonmedical use is twice as high (15 percent) when measuring only persons ages 18-25. In 2013, 3.6 million prescriptions for opioid painkillers were dispensed in Oregon, enough for 925 opioid prescriptions for every 1,000 residents. A significant risk of prescription opioid misuse is escalation to heroin. Poorly controlled opioid prescribing is a key driver of opioid deaths and hospitalizations. The need for opiate addiction treatment continues to grow. Diagnosis of opioid use disorder among Oregonians has increased more than 400 percent since 2005.

Aid and Assist

When people who are accused of a crime are unable to assist in their own defense due to a mental disease or defect, the court may issue an order under Oregon Revised Statutes (ORS) 161.370 for restoration services – that is, to restore the individual to a condition in which they can assist in their defense. These are also known as "Aid and Assist" or "370" services. Restoration

services can be provided in the community or at OSH depending several factors: the person's mental health acuity, public safety risk factors, time available for services to be rendered, and availability of services and supports in the community. The OSH aid and assist census was significantly over budgeted capacity and steadily climbing, which was a significant burden to General Fund dollars. The budgeted number of beds is 184, and the maximum aid and assist census was 228 in March 2016. Due to increased funds from the Legislature during the 2015-2017 biennium, more resources are available for community restoration services. Increased resources in the community along with outreach and coordination via a new position from OHA, have contributed to a drop in OSH aid and assist census (194 as of June 2016). HSD will continue working with its community partners to address this significant cost driver.

One way for HSD to improve this and other metrics in partnership with its provider community is to implement new data systems. These systems will make data available in a more timely manner and allow a better understanding of how to improve the quality of services. Behavioral Health Mapping is a critical piece of this work.

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

State General Fund: Legislative appropriation for treatment services.

Other Funds:

- Beer and wine – statutorily dedicated by ORS 430.345 to 430.380, requires local maintenance of effort and local expenditure of dedicated taxes for state-approved services
- Intoxicated Driver Program Fund – statutorily dedicated by ORS 813.270, does not require any matching or maintenance of effort
- Miscellaneous – contract settlements, state match from Multnomah County/DePaul and the Oregon Youth Authority, and sponsored travel reimbursements
- Community Housing Trust Funds – this trust fund was established with the sale of the Dammasch hospital property (ORS 413.101). Interest from the fund is dedicated for new housing and facility maintenance to benefit people with mental illness.

Tobacco Tax: During the 2013 Special Session the Legislature approved a 13 percent tobacco tax, a portion of which is dedicated to community mental health services.

Tobacco Master Settlement Agreement funds have been used in Oregon over the past several years to cover costs of health care, including those associated with tobacco-related illnesses. In the 2015-2017 budget build, a portion of these funds was also earmarked for non-Medicaid expenditures, in lieu of General Funds. There has been a recent decline in these revenues, which are paying back a Master Settlement Agreement. It is expected that as these funds continue to decline, there will be additional reductions to programs or alternative sources of revenues needed to continue to support programs.

Marijuana revenue: In the 2015-2017 budget build, almost $2 million was estimated by Department of Administrative Services, as OHA's portion of the recreational marijuana fee-based charges. This funding was set to assist with addiction and recovery services. However, when these revenues were estimated, all of the administrative rules and other technicalities were not yet in place. Now that we are part way into the 2015-2017 biennium, the Department of Revenue has a better idea of what mechanisms need to be in place to allocate this funding at the beginning of the 2017-2019 biennium.

Federal Funds:

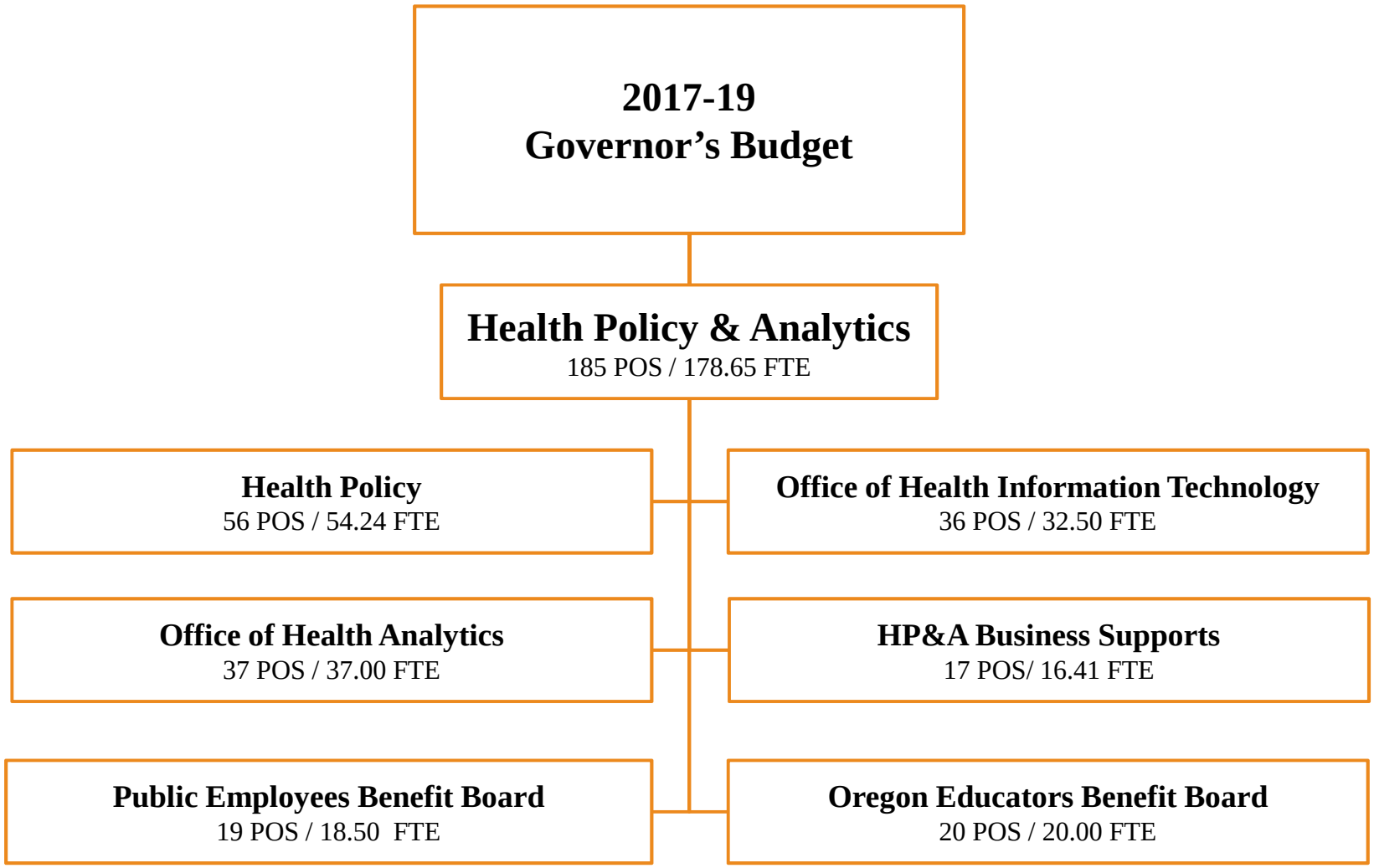
- Substance Abuse Prevention Treatment grant (SAPT) requirements are: 20 percent of the grant must be spent on prevention (transferred to the Public Health Division) and service levels must be maintained for specified populations such as women and women with children. The one qualifying factor for this grant is that the state must expend a minimum of state and local revenues on SAPT-related services to meet the maintenance-of-effort requirement.
- Access to Recovery grant (ATR), which expires September 29, 2018, includes several unique requirements: nontraditional client-driven services and supports, administration of a voucher system for clients to purchase services, and free and independent choice in the selection of recovery and treatment services, including faith-based options. This grant does not require any matching or maintenance of effort.
- Temporary Assistance for Needy Families grant (TANF) requires maintenance of effort. Medicaid (Title XIX) has a matching requirement. Center for Mental Health Services block grant (CMHS) – at least 35 percent of each grant's service funding must be expended for mental health services for children. The grant has a maintenance of effort (MOE) requirement. PATH – Projects for Assistance in Transition from Homelessness.

Lottery Funds: Oregon Revised Statute (ORS) 461.549, dedicates 1 percent of Lottery revenue for prevention and treatment of problem gambling and does not require any matching or maintenance of effort. In spite of this, these funds are frequently reduced in times of economic decline.

A&D 66 Intoxicated Driver Prevention Fund (IDPF) and Driving Under the Influence of Intoxicants (DUII) funds provide funding to counties for intoxicated driver services, as well as contracting with Guardian Interlock to provide breathalyzer machines for IDPF clients.

Proposed new laws that apply to the program unit

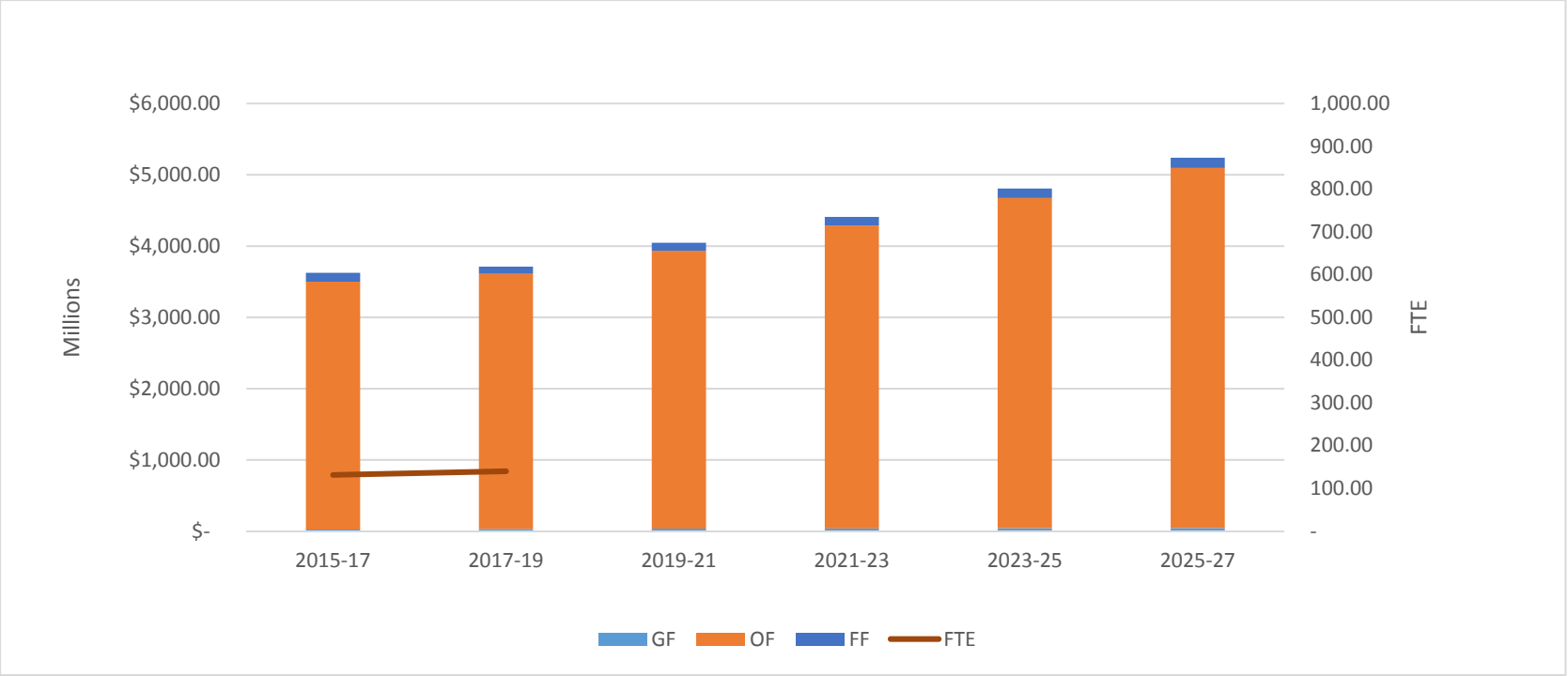
HSD is proposing to remove the clause that allows youth to be placed in the state's Secure Adolescent Inpatient Program (SAIP) solely for a fitness to proceed evaluation. This change would allow youth to receive services to improve their mental health and fitness to proceed in the least restrictive setting. This change would provide better care as services will more often be provided in the youth's own community and improve mental health outcomes by using the natural continuity of care system aligned with the youth's mental health needs.


2017-19
Governor's Budget
Health Policy & Analytics
185 POS / 178.65 FTE
Health Policy
56 POS / 54.24 FTE
Office of Health Information Technology
36 POS / 32.50 FTE
Office of Health Analytics
37 POS / 37.00 FTE
HP&A Business Supports
17 POS/ 16.41 FTE
Public Employees Benefit Board
19 POS / 18.50 FTE
Oregon Educators Benefit Board
20 POS / 20.00 FTE

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Executive Summary

Long-term focus areas: Safer, Healthier Communities and Excellence in State Government
Primary Contact: Leslie Clement, Chief of Policy
(503) 945-9718



- Prior to 2015 HP&A included the office of Equity and Inclusion, which is now part of Central Services.

Program overview

The Health Policy and Analytics Division develops and implements innovative approaches to lowering health care costs, achieving better health and better health care. This is accomplished through seven main functions:

- The Office of Health Policy
- The Office of Clinical Improvement Services
- The Office of Health Analytics
- The State Medicaid Director
- The Office of Health Information Technology
- The Public Employees Benefit Board and the Oregon Educators Benefit Board
- The Office of Business Support

Program funding request

For the 2017-2019 biennium, the Oregon Health Authority requests the following budget (in millions) for Health Policy and Analytics :

- 2017-2019 request: $3,710.9 TF ($31.2 GF, $3,578.6 OF, and $101.1 FF)

Program description

The budget for Health Policy and Analytics (HPA) includes the:

- Office of Health Policy (which includes the Director of Health Policy and Analytics, the State Medicaid Director, the Office of Clinical Improvement Services, and Health Policy);
- Office of Health Analytics;

- Office of Health Information Technology; and
- Office of Business Support.

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

The division **Director of Health Policy and Analytics** coordinates with the Governor's Office, the Legislature, other state and federal agencies, partners and stakeholders, local governments, advocacy and client groups, and the private sector to achieve the triple aim of better health, better care, and lower costs.

The **Office of Clinical Services Improvement** (CSI) supports the implementation of the coordinated care model in all provider and payer organizations, including the health authority, by aligning and integrating clinical resources and policies. The chief medical officer oversees the Transformation Center, Patient Centered Primary Care Home program, the Health Evidence Review Commission, Behavioral Health Integration, Oral Health Integration, the Oregon Prescription Drug Program and the Quality Council implementation of clinical services.

The **Office of Health Policy** supports the Oregon Health Policy Board, the Medicaid Advisory Council, OHA programs, and other stakeholders engaged in the design of Oregon's health system transformation. Its services include policy analysis, development, and evaluation. The Office of Health Policy provides technical assistance on topics such as primary care workforce development, resource leveraging, and grant development for health system transformation projects.

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

- Evaluate OHA program performance
- Provide data to support health system and program planning and implementation

- Analyze trends across all payers and claims data

The **Office of Health Information Technology** is provides coordination across programs, departments, and agencies to develop policies and procedures that:

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

The **Office of Business Supports** is responsible for all of the division's operational functions. The office partners with other Shared Services offices and acts as liaison to internal and external stakeholders related to operational functions. These operational functions include but are not limited to:

- Program contracts management
- Program staffing
- Program grants management
- Operational and project budget management
- Facilities management
- Program policy and rule making management
- Administrative and executive support
- Program technical support

Program justification and link to long-term outcomes

All Health Policy and Analytics programs directly support the Healthy People and Health Equity long-term outcomes. Together, the offices help to establish the common vision, define the outcomes, measure fiscal accountability, measure the effects of

investment in various health care strategies, and inform all aspects of Oregon's health care decision- and policy-making efforts. In essence, these offices recommend the policy direction, measure the results, and suggest strategies for improving all Healthy People outcomes. Recent focus has been on tracking:

- Reducing per capita costs
- Reducing the number of uninsured Oregonians
- Improving specific health measures tracked by the CCOs

Program performance

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

Enabling legislation/program authorization

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

Funding streams

Health Policy and Analytics is supported primarily by General Funds, matched with Medicaid Administrative Federal Funds. The match rates vary depending on the type of work being performed. The office also receives 100 percent Federal Funds from the Health Resources and Services Administration (HRSA) Primary Care grant, the Office of National Coordinator for HIT (ONC) grant, and Health Information Technology Electronic Health Record funds. It receives Other Funds from various grants (Northwest Health Foundation), fees (workforce, inpatient data, ambulatory surgical data, All Payer All Claim [APAC], and J1 Visa), and loan repayment programs (Primary Care Provider Loan).

The Federal Funds ended during 2015-2017 from the following grants: CMS Children's Health Insurance Program Reauthorization Act (CHIPRA) grant; Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model grant; CMS Adult Medicaid Quality (AMQ) grant; and the Certified Community Behavioral Health Clinics (CCBHC) grant.

Significant proposed program changes from 2015-2017

None.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: Health Policy

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 12.0	$ 4.3	$ 32.8	$ 49.2	61	54.44
Governor's Budget 17-19	$ 20.3	$ 5.2	$ 13.6	$ 39.1	54	52.24
Difference	$ 8.4	$ 0.8	$ (19.3)	$ (10.1)	-7	-2.2
Percent Change	70%	19%	-59%	-21%	-11%	-4%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

The vision set forth by the Governor, the Oregon Health Policy Board and the Legislature is of one integrated, statewide health system that achieves better health, better care, and lower health care costs for all Oregonians. Moving toward achievement of this vision has resulted in a policy framework that requires the current delivery system to focus on:

- Improving care coordination
- Integrating behavioral, physical, and oral health care
- Incorporating community-based and public health resources toward improved population health
- Use of alternative payments to provide incentive for health outcomes the
- Managing within a fixed rate of growth
- Spreading evidence-based best practices and innovations

Health Policy coordinates with the Governor's Office, the Legislature, other state and federal agencies, partners and stakeholders, local governments, advocacy and client groups, and the private sector to achieve the triple aim of better health, better care, and lower costs. Health Policy includes the Health Policy and Analytics Division director, the state Medicaid director, the Office of Clinical Improvement Services (led by the chief medical officer), and the Office of Health Policy.

The Office of Clinical Improvement Services

In 2015, OHA has shifted existing clinical staff, programs and resources into a new unit under the direction of the chief medical officer (CMO). The purpose of this shift is to better align medical management practices and coordinate clinical policies across the coordinated care organizations, the fee-for-service population, other plans and payers, and all OHA departments.

The goals of the chief medical officer and Clinical Services Improvements Office are to:

- Integrate clinical policies and resources to support the coordinated care model
- Align and coordinate health care delivery strategies and systems throughout the Oregon Health Authority
- Pursue further integration of behavioral, physical and oral health care
- Establish and maintain effective working relationships with Oregon's providers and health care delivery system representatives
- Coordinate quality improvement efforts across OHA, PEBB- and OEBB-contracted plans, the CCOs, and other entities involved in quality improvement

One goal of the CMO is to focus the agency's clinical knowledge and expertise on achieving performance, quality, and cost containment goals. It will accomplish this in part by assuming direct supervision of several existing positions within OHA that have historically reported through a variety of chains of command. These include:

- OHA Medicaid medical director
- OHA behavioral health director
- OHA dental director
- Transformation Center's director of systems innovation
- Health Evidence Review Commission (HERC) clinical directors

- OHA quality improvement director
- Pharmacy and Therapeutics Committee contracted clinical resources
- Oregon Prescription Drug Program
- Patient Centered Primary Care Program

This unit will coordinate with the Public Health and Health Systems divisions to align OHA's clinical policies and program strategies.

The Office of Health Policy

The health policy office analyzes and develops policy options, facilitates stakeholder discussions, coordinates strategic and implementation planning efforts, and conducts health services research and policy evaluation for the Governor's Office, the Legislature, the Oregon Health Policy Board (OHPB), OHA, and other participants in Oregon's health system transformation work. These services help Oregon identify opportunities, articulate program options, implement policy, and assess its progress toward achieving the triple aim of better health, better care, and lower costs. Focused areas of work include:

- Oversight of Oregon's Medicaid policies, including the State Plan, which defines all Medicaid eligibility, benefits and reimbursement policies, the 1115 waiver, home and community-based waivers and serving as the single point of contact for the Centers for Medicare and Medicaid
- Staffing the Medicaid Advisory Committee
- Staffing the OHPB and its committee and work groups
- Developing and analyzing policy as legislatively directed on priority topics such as the key elements of health system transformation, rural health care initiatives, health care financing and others
- Engaging stakeholders, working with contractors, initiating and administrating grants to implement delivery system transformation policies, primary care workforce development, strategic plans, etc.
- Analyzing emerging health policy issues and regulations, and working with national and other state experts to bring best practices and new ideas to Oregon

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

The CMO also oversees the Health Evidence Review Commission (HERC). Among other responsibilities, 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 based on clinical evidence
- Maintains the Oregon Health Plan's Prioritized List of Health Services
- Disseminates information on the cost and effectiveness of medical treatments and technologies

A key strategy for the Office of Clinical Services staff is applying HERC research to advance policy development, implementation, and evaluation for OHA, the CCOs, and PEBB/OEBB contracted plans.

The Office of Clinical Improvement Services has a key role in developing and staffing OHA's internal, cross-agency Quality Council. The Quality Council brings together OHA leadership to coordinate and lead quality improvement efforts for the agency. It provides the structure for: (1) OHA's leaders in clinical, behavioral, and population health to analyze clinical trends in quality, compliance, and system performance; and, (2) the development of integrated strategies to improve quality. The Office of Clinical Improvement Services ensures that the Quality Council's work is integrated and shared with the CCO medical directors, PEBB/OEBB boards and their contracted plans, and other OHA programs.

The Office of Clinical Improvement Services also sponsors performance improvement projects and oversees the Transformation Center to coordinate and support quality efforts based on the Quality Council's recommendations. It identifies valuable information such as key health care trends to share with our partner agencies, the Department of Human Services, the Department of Consumer and Business Services Insurance Division, the Governor's Office, and the Legislature.

The chief medical officer oversees the Pharmacy and Therapeutics committee and Oregon Prescription Drug Program. This includes evaluating and monitoring pharmacy benefits across Medicaid populations, both those in CCOs and in traditional fee-for-service coverage. Additionally, the CMO leads development of strategies for fiscally sustainable administration of pharmacy benefits.

The Office of Health Policy

The Office of Health Policy facilitated Oregon's application and approval for two new federal programs:

- Oregon was one of 24 states selected by the Substance Abuse and Mental Health Services Administration (SAMHSA) to receive grants to plan and develop certified community behavioral health clinics. SAMHSA will select up to eight of these states to participate in a two-year CCBHC demonstration program.
- Oregon was selected as one of eight states by the Center for Medicare and Medicaid Innovation (CMMI) to participate in an Innovation Accelerator Program on Medicaid-State Housing Agency Partnerships.

During 2015-2017, the Office of Health Policy also provided extensive analysis, planning and coordination to implement significant changes required by new federal rules and guidance on Home and Community Based setting requirements, mental health parity, Medicaid managed care regulations, and monitoring access to Medicaid services.

Enabling legislation

The Office of Clinical Services Improvement supports the following state mandates:

- Health Evidence Review Commission (HERC) (ORS 414.688-704)
- Pain Management Commission (PMC) (ORS 413.570-599)
- Patient Centered Primary Care Home Program (ORS 442.210, 414.655) and 414.655 adds CCOs under PCPCH program

Revenue sources and proposed revenue changes.

Health Policy leverages Medicaid administrative match for eligible programs and activities including Medicaid-related health system transformation, the Medicaid Advisory Committee, research and evaluation, and staffing.

The office receives Federal Funds from the Centers for Medicare and Medicaid Innovation (SIM grant), the Health Resources and Services Administration (HRSA) Primary Care grant and Other Fund grant awards from the Northwest Health Foundation and others to fund efforts that fit within the strategic vision of health care reform in Oregon.

The Other Funds include a fee-supported program for the Conrad J-1 Visa Program (HB 2151; ORS 409.745), a loan repayment program (Primary Care Provider Loan; ORS 413.127) and the Health Care Provider Incentives Fund taking effect January 2018 (HB 3396).

Proposed new laws that apply to the program unit.

None.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program Unit Narrative: Office of Health Information Technology

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 3.1	$ 1.0	$ 82.7	$ 86.8	19	19.00
Governor's Budget 17-19	$ 2.5	$ 13.0	$ 80.8	$ 96.3	36	32.50
Difference	$ (0.6)	$ 13.0	$ (1.9)	$ 9.5	17	13.50
Percent Change	-19%	1291%	-2%	11%	89%	71%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

The Office of Health Information Technology develops and supports effective health information technology (HIT) policies, programs, and partnerships that enable improved health for all Oregonians. Health information technology is computerized storage, retrieval and sharing of health information and data. A good example is electronic health records used by hospitals and health care providers. Health information exchange (HIE) is the electronic sharing of health information between health care providers, patients, or other users of HIT systems, which can include finding (query); sharing (send), and exchanging (receive) patient information. Health information exchange also sometimes refers to an organization that provides health information exchange technology services.

OHIT is working with Oregon's health care community to improve health by making it possible to securely share patient information within the state and nationally. An electronic health information network connecting providers, health plans and individuals will make care more efficient and effective.

OHIT also has significant HIT and HIE programs in place and new projects in development:

- More than half of OHIT's budget is Federal Funds that pay for Oregon's Medicaid Electronic Health Record Incentive Program. These funds pay 100 percent of incentives to Oregon providers and hospitals that adopt and use certified electronic health records in a meaningful way. It began in 2011 and will end in 2021.
- OHIT partnered with stakeholders to launch the Emergency Department Information Exchange (EDIE) and PreManage, which bring real-time hospital event information to providers, CCOs, health plans and emergency departments across the state, making a real difference in getting people to the right care, in the right place, at the right time.
- CareAccord, Oregon's statewide health information exchange program, supports care coordination and sharing health information via Direct secure messaging for health care organizations and state agency programs across the state. Direct is a national encryption standard for securely exchanging clinical healthcare data via the Internet.
- OHIT launched a new technical assistance program to support providers who serve Medicaid members in effectively adopting and using certified electronic health records.
- OHIT is implementing HIT services for Oregon health care stakeholders, such as state agency programs, providers, health plans, CCOs, and hospitals. This is the next step in using health information technology to transform Oregon's health care system. This effort includes a mandated common credentialing database and program, a state-level provider directory, and a registry of clinical quality metrics data.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

To be effective, Oregon's transformed health care system increasingly relies on access to patient information and the health information technology infrastructure to share and analyze data. HIT affects nearly every aspect of coordinated care including care coordination; population health management; integration of physical, behavioral, and oral health; accountability, quality improvement and metrics; alternative payment methodologies; and patient engagement. New tools are needed to share information, aggregate data effectively, support telehealth, and provide patients with tools and data.

Oregon is in the top tier of states for providers receiving federal incentive payments (either from Medicare or Medicaid) for electronic health records, with more than $430 million coming to all Oregon hospitals and more than 7,300 Oregon providers. As of December 2016, Oregon's Medicaid Electronic Health Record Incentive Program has disbursed more than $151 million in federal incentive payments to hospitals and health care providers since its inception in 2011.

In the past biennium, OHIT made significant progress in supporting Oregon's triple aim of improved health care, lower costs, and better patient outcomes through HIT and health information exchange efforts.

- In 2015, OHA established the Oregon Health Information Technology Program to connect and support community and organizational HIT efforts where they exist, fill gaps where these efforts do not exist, and ensure all providers on a care team have the means to participate in basic sharing of information needed to coordinate care.
- OHIT partnered with the Oregon Health Leadership Council to launch one such service – the Emergency Department Information Exchange, connecting all Oregon hospitals and providing emergency rooms with critical, concise information about patients who are high utilizers of emergency department services. Participating CCOs, health plans, and providers subscribe to receive real-time information when their patient or member has a hospital event in any hospital in Oregon or Washington. All of Oregon's eligible hospitals have made their ED and inpatient data available in EDIE, adding Oregon's data to the data from Washington hospitals. As of November 2016, nine of the 16 CCOs have

subscribed to PreManage and are extending their license to their key clinical practices. About 150 clinic sites in Oregon are live.

- CareAccord serves more than 1,300 providers and other health care-related users in Oregon through its Health Information Service Provider (HISP) services for Direct secure message exchange, including many Oregon safety-net clinics through integration with OCHIN's EHR. CareAccord also administers the Flat File Directory, which is Oregon's address book of participating organizations' Direct secure messaging addresses. The directory allows its participants throughout Oregon to find or "discover" Direct addresses outside their own organizations so they can exchange patient health care information across disparate settings. As of December 2016, the Flat File Directory represents 552 Oregon health care organizations (primary care, hospital, behavioral health, dentistry, etc.), totaling more than 8,389 Direct addresses. Plans called for Washington Direct secure messaging addresses to be added in early 2017.
- In 2016 OHIT launched the Oregon Medicaid Meaningful Use Technical Assistance Program to help providers effectively use their EHR technology and realize the benefits of their investments. It also will help support CCO efforts in care coordination, quality improvement, and metrics and data reporting required for the CCO quality incentive program. OHA has contracted with OCHIN to provide these technical assistance services. The Technical Assistance program will run through May 2018 and aims to serve more than 1,200 Medicaid providers.
- OHIT has three new HIT services in development in 2016, to support efficient and effective care coordination, analytics, population management and health care operations. These projects are subject to rigorous oversight by DAS Office of the State CIO, the Legislative Fiscal Office, a third-party quality assurance vendor, and CMS oversight for Provider Directory and the Metrics Registry. The projects include:
    - A common credentialing program and database that streamlines access to information necessary to credential or re-credential all health care practitioners in the state
    - A statewide provider directory, critical to supporting health information exchange, analytics and population management, accountability efforts, and operational efficiencies
    - A registry to capture clinical quality metrics from electronic health records, with an initial focus on required CCO quality metric reporting and Medicaid EHR Incentive Program reporting in 2018

Enabling legislation

In the 2009 regular session, House Bill 2009 established the Health Information Technology Oversight Council (HITOC), which coordinates Oregon's public and private statewide efforts in electronic health record adoption, HIT and health information exchange. Since its creation, HITOC has created strategic and operational plans for the development of a statewide system for electronic health information exchange. HITOC also helps Oregon meet the federal requirements for providers to become eligible to receive EHR incentive payments available under the ARRA/HITECH Act.

In the same session, House Bill 3650, which defined health care transformation in Oregon, included significant health information technology requirements, including that coordinated care organizations use health information technology for care coordination. It also requires OHA to ensure the appropriate use of electronic health information by CCOs to improve health and health care.

In the 2013 regular session, Senate Bill 604 required OHA to establish a common credentialing database and program. The program will provide a common credentialing solution that will streamline the process for applying for and maintaining credentialing information for Oregon practitioners. Today practitioners must complete credentialing applications and provide supporting documentation for each credentialing organization. SB 604 requires OHA to establish fees for the sustainability of the program. Senate Bill 594 (2015) updated that legislation by allowing OHA to establish the program start date by rule.

In 2015, Oregon passed legislation to align HIT efforts with health system transformation goals, formalize and support OHA's health IT efforts, and improve OHA's ability to advance the necessary health IT to support CCOs and the spread of the coordinated care model. HB 2294 (2015) updates the original HITOC components of HB 2009 (2009) to account for changes since 2009. It has three major components:

- Establishing the Oregon HIT Program within OHA, allowing the agency to offer services beyond Medicaid to the private sector. Participation is voluntary and OHA may charge user fees for such services to cover costs and ensure sustainability. OHA is required to report at least annually to the Legislature on the status of the Oregon HIT Program.

- Providing OHA greater flexibility in working with stakeholders and partners. It gives OHA the opportunity to enter into partnerships or collaboratives when other entities in Oregon are establishing statewide HIT infrastructure tools.
- Moving HITOC under the Oregon Health Policy Board to ensure statewide HIT efforts align with and support health system transformation.

Revenue sources and proposed revenue changes

The Office of Health Information Technology is funded through state General Funds along with federal HITECH and Medicaid Management Information System (MMIS) matching dollars. More than half of OHIT's budget is derived from 100 percent federal HITECH Act funding to provide federal incentive payments to Oregon hospitals and providers under Oregon's Medicaid Electronic Health Record Incentive Program. OHIT's General Fund dollars are used as a match to acquire HITECH and MMIS funds at mostly 90:10 (FF to GF) matching rate; OHIT has additional funding at 75:25 (FF to GF) and 50:50 (FF to GF). The funding percentage depends on several factors including whether the money is spent on planning, implementation or operations. This means that for every state dollar invested, five to nine matching dollars are drawn into the Oregon economy.

In 2015, OHA and sub-recipient Jefferson Health Information Exchange (Jefferson HIE) were awarded a two-year, $1.6 million cooperative agreement from the Office of the National Coordinator for Health Information Technology aimed at advancing the adoption and expansion of health information technology infrastructure and interoperability. Through the project, Jefferson HIE aims to address barriers to information sharing and care coordination across settings, particularly for behavioral health data. Funding ends in July 2017. In September 2016, ONC awarded the OHA and JHIE $625,000 supplemental funds under this cooperative agreement to expand multistate Admit Discharge Transfer (ADT) notifications. The project supports the routing of EDIE ADT messages through Jefferson HIE to facilitate more actionable data across care teams, through encounter notifications and provider directory lookup, which improves patient outcomes and keeps users within their workflows.

OHIT intends to charge fees starting in 2017-2019 for common credentialing, provider directory. Fee amounts and fee structure will be included for legislative approval in OHA's fee policy option package, as well as Other Fund budget limitation.

Proposed new laws that apply to the program unit.

None.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS DIVISION

Program Unit Narrative: The Office of Health Analytics

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 5.8	$ 1.9	$ 6.2	$ 13.8	37	38.14
Governor's Budget 17-19	$ 6.9	$ 1.0	$ 5.3	$ 13.2	37	37.00
Difference	$ 1.2	$ (0.8)	$ (0.9)	$ (0.6)	0	-1.14
Percent Change	20%	-46%	-15%	-4%	0%	-3%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

The Office of Health Analytics coordinates and produces financial, quality, and performance data, and analyzes these data for the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB). The office supports OHA's and OHPB's management and budget decisions and evaluates the impact of those decisions.

The office collects and analyzes data on the performance of Oregon's health care system. Examples include hospital utilization, quality and costs; health care workforce capacity; and rate of insurance coverage. It also collects and analyzes OHA program performance data, including behavioral health services evaluation (the Behavioral Health Map) and coordinated care organization incentive metrics). Among the data the office collects and analyzes is the All Payer All Claims Database, which is used to make policies and decisions that are based on solid research and data.

The Office of Health Analytics is organized into four program units serving complimentary functions:

The Metrics Program facilitates metrics related committees and publishes multiple metrics reports. These include:

- An annual CCO metrics report on performance
- Hospital metrics reports for the Hospital Committee and the Hospital Technical Advisory group
- Health Plan quality metrics driven by Senate Bill 440
- Reports from the Clinical Quality Metrics Registry
- Evaluations, including the State Innovation Model grant and the Oregon Health Plan Medicaid demonstration waiver

The Research and Data Program supplies data and analytics services mainly to OHA's external partners. Some of these services include:

- The All Payer All Claims database – data collection, compilation and reporting
- Physician workforce data such as licensing
- Health insurance coverage and access to care
- Health care financing and costs including those related to Medicaid expansion
- Hospital and facilities inpatient and outpatient data, hospital finances and expenses, price transparency and capital projects

The Program Analysis and Measurement Program collects, measures and reports data to other OHA programs. These services include:

- Oregon Health Plan and Medicaid Support data reporting, dashboards and analysis
- Analysis and data support for the Office of Equity and Inclusion
- Behavioral Health data analysis, dashboards, and USDOJ and Block Grant reporting
- Survey services (including physician workforce survey, student wellness survey, Consumer Assessment of Health Providers and Systems Survey (CAHPS)
- Internal program performance metrics

The Data Integration Program provides technology, system and infrastructure support for the Office of Health Analytics and its programs. The support includes:

- Data governance, privacy and security
- Data request tracking and data access requests
- Cross-agency data strategy, integration and coordination
- Data systems and infrastructure – data warehousing, server management, data documentation and business intelligence

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

None.

Revenue sources and proposed revenue changes.

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

The office receives Other Funds fees for health care workforce data collection and reporting, all-payer all-claims and health care data reporting.

Proposed new laws that apply to the program unit.

None.

OREGON HEALTH AUTHORITY: HEALTH POLICY AND ANALYTICS

Program unit narrative: The Office of Business Support

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 1.6	$ 0.1	$ 1.8	$ 3.5	20	19.91
Governor's Budget 17-19	$ 1.4	$ 0.2	$ 1.4	$ 3.1	17	16.41
Difference	$ (0.1)	$ 0.1	$ (0.4)	$ (0.4)	0	0.00
Percent Change	-9%	66%	-21%	-12%	0%	0%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

The Office of Business Support develops and maintains operational processes and procedures on behalf of the Health Policy and Analytics division.

The operational services are organized into three program units: Contracts and Grants Management, Budget and Technology Management, and Staffing and Administrative Support. The Office of Business Support works closely with and acts as liaison with other operational areas of the agency including: other business support offices in other divisions, Central Services, the Director's Office, and the Shared Services offices.

The Contracts and Grants Management program unit includes the following functions:

- Manage the operations of the State Innovation Model (SIM) grant
- Manage the division's contract portfolio
- Administer contract initiation, amendments and renewal including the use of interagency agreements and memos of understanding
- Maintain grant documentation and version control, grant carry-over process, grant operational setup and maintenance and grant closeout

The Budget and Technology Management program unit includes the following functions:

- Lead the initial biennial budget building and projection process at the division level and for each office in the division
- Provide rebalance and reshoot budget tracking for the division budget
- Build and maintain active operating budgets for each division program area
- Build, monitor and maintain project budgets for the division's higher-level projects
- Provide all accounts payable and accounts receivable services for the division
- Provide and maintain the division's technology support including: SharePoint, Web development, deskside support, asset management, etc.
- Provide the division's rule making and policy writing services and track legislation during the sessions

The Staffing and Administrative Support program unit includes the following functions:

- Manage the hiring process for the human resources in the division including: assisting agency Human Resources with recruitments, maintain a recruitment tracker, provide onboarding services, assist with trial service issues, ensure recruitment diversity, and write position descriptions and process personnel actions
- Manage human resource disciplinary issues
- Establish and maintain a workforce strategy and succession plan for the division, aligning with the agency diversity recruitment policy
- Provide administrative support to the division's programs and executive support for the directors of each office

- Manage and support all inter-office moves in all buildings where the division is located

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

In the first year of its existence the Office of Business Support's focus has been to consolidate, identify, document and maintain operational processes for the division as a whole. Going forward the office will begin identifying meaningful metrics for each process, benchmark the current state of the measures for those processes and set goals for improvements. The focus will be on incremental improvements through the use of a maturity model and focusing on the processes that the division collectively deems to be most important.

Revenue sources and proposed revenue changes.

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

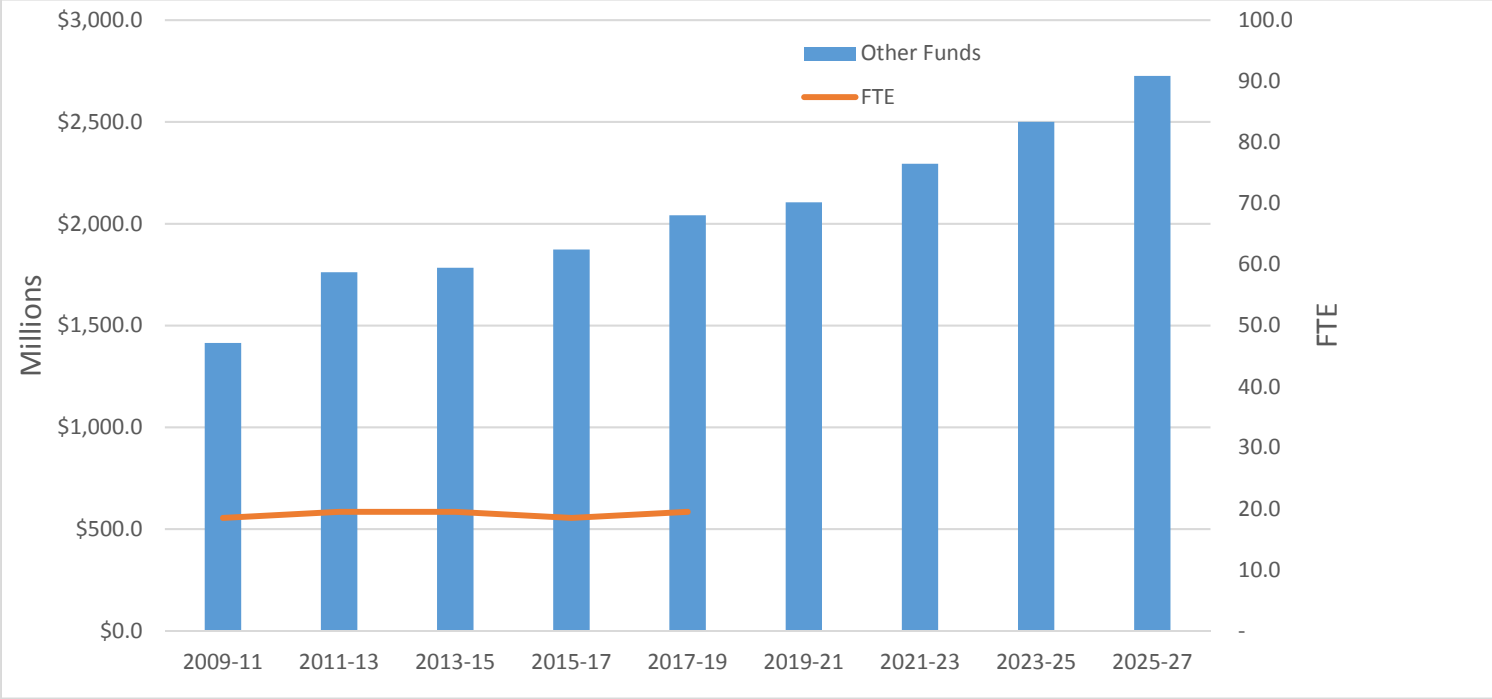
Proposed new laws that apply to the program unit

None.

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Program Unit Executive Summary

Long Term Focus Areas: Safer, Healthier Communities, Excellence in State Government
Primary contact: Kathy Loretz, Director,
503-373-0800

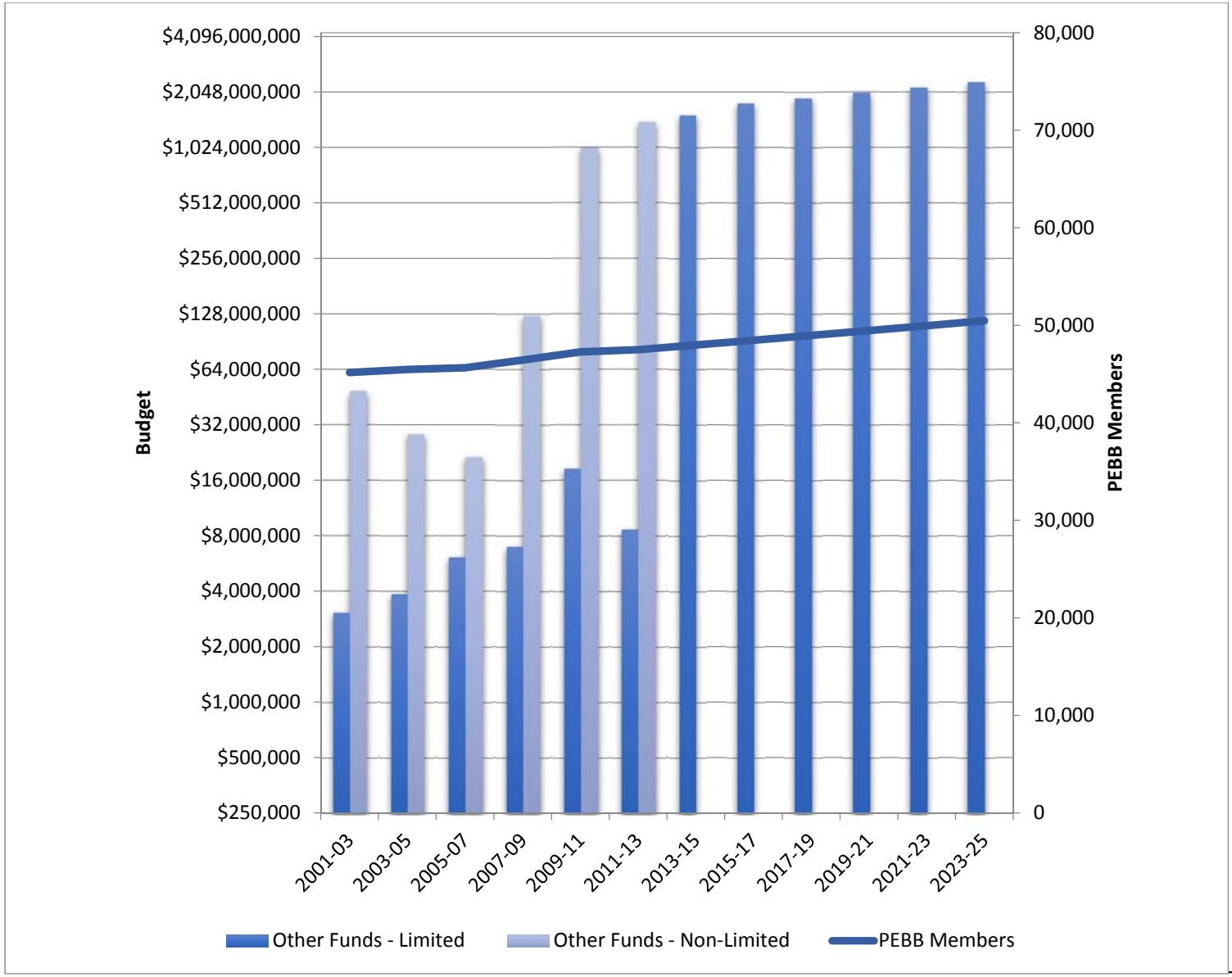


Program overview

The Public Employees' Benefit Board (PEBB) provides high-quality insurance and other employee benefit options at a cost affordable to employees and the state. Insurance benefits are a part of employees' total compensation package and an important tool in hiring and retaining high-quality personnel.

Program funding request

The 2017-2019 PEBB Governor's Budget includes the Stabilization Fund budget for expenditures related to PEBB's self-insured and fully insured plans as well as PEBB's Operating budget. All PEBB expenditures are categorized as Other Funds Limited. PEBB's Stabilization Fund budget expenditure growth is capped at 3.4 percent annually by the Legislature on a per employee-per-month (PEPM) basis. PEBB has managed to stay within the 3.4 percent PEPM budget through the first three plan years. PEBB exceeded its limitation budget in the 2013-2015 biennium due to significantly higher enrollment volume than was anticipated during budget development. The 2017-2019 Governor's Budget also is built on a PEPM basis. The limitation will be determined with assumptions on enrollment volume. More enrollees means more money for PEBB's budget. The PEBB Board receives quarterly updates on PEBB's budget status.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$500,000
$250,000
Budget
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
PEBB Members
2001-03
2003-05
2005-07
2007-09
2009-11
2011-13
2013-15
2015-17
2017-19
2019-21
2021-23
2023-25
Other Funds - Limited
Other Funds - Non-Limited
PEBB Members

Program description

With a working staff of 20, PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. More than 130,000 Oregonians are PEBB members. They include active employees, spouse and domestic partner dependents, child dependents up to age 26, and adult children with disabilities over age 26, from: state agencies, universities, Lottery and semi-independent agencies, and local governments and special districts. PEBB provides some bilingual and multilingual staff support and uses an interpreter service line for callers who speak languages not supported by staff.

PEBB offers core benefits including: Medical, Dental, Vision and basic Life Insurance

Optional Benefits include: Life Insurance, Accidental Death & Dismemberment, Long Term Disability, Short Term Disability, and Long Term Care

PEBB's benefit package also includes: flexible spending accounts (health care, dependent care), commuter accounts, continuing coverage for early retirees, and COBRA.

Program justification and link to long term outcomes

Oregon Health Authority's vision of a healthy Oregon and Improving Member Health

PEBB supports the Oregon Health Authority's goal to transform the health care system in Oregon and to fundamentally improve how care is paid for and delivered. This transformation process focuses on health and preventive care for everyone and reducing waste in the health care system. In 2012 PEBB adopted the triple aim as one of the program's guiding principles. The triple aim includes three clearly established goals of providing better health and better care at an affordable cost.

PEBB believes the coordinated care model (CCM) is essential for achieving success in these goals. As a result, in 2013 PEBB conducted a Request for Proposal (RFP) for comprehensive medical and pharmacy services. PEBB sought to:

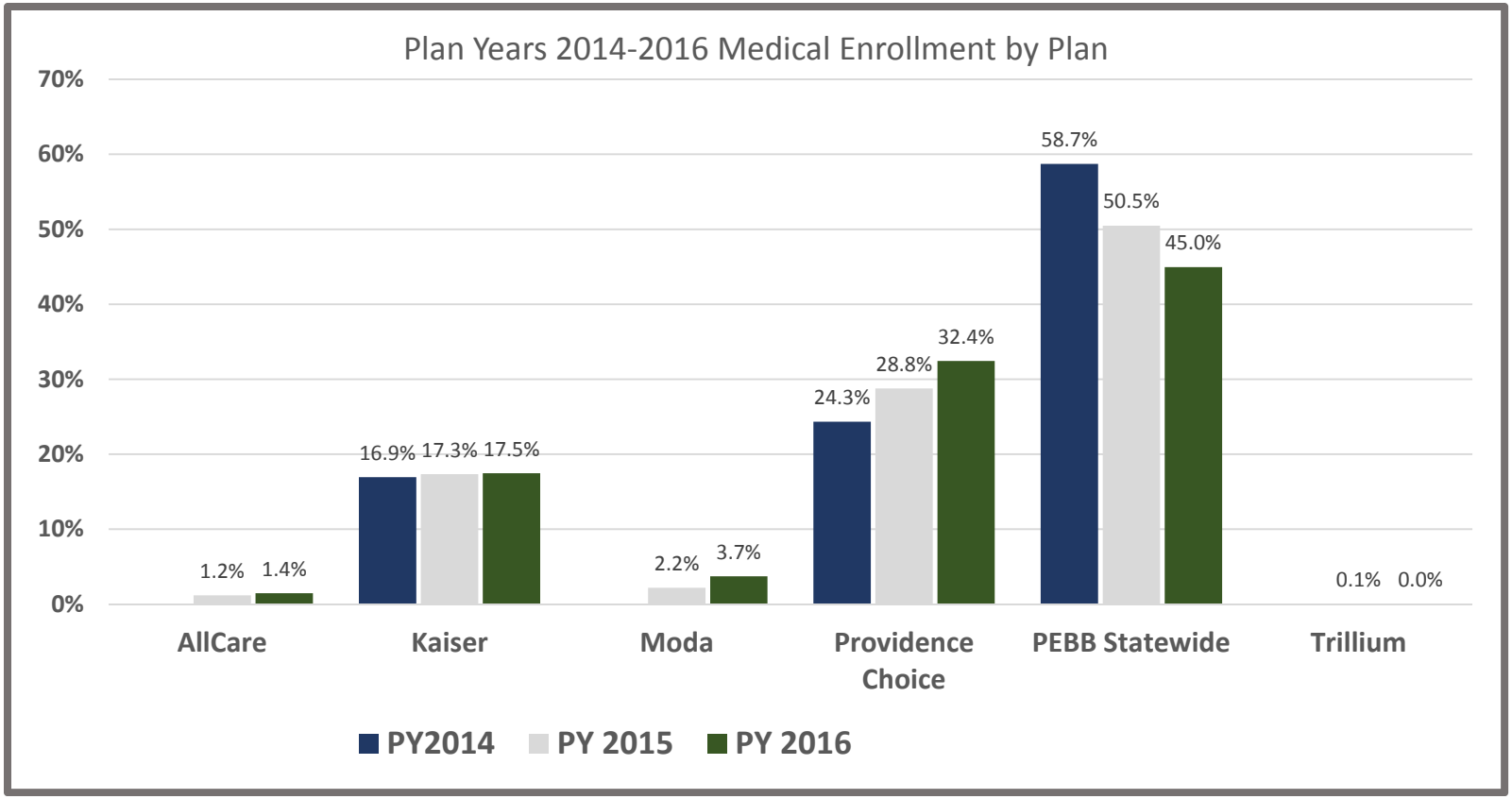
- Transform the delivery system in a new way for better efficiency, value and health outcomes, placing employees and their families at the center of their care

- Ensure that members' care is coordinated across the continuum and that quality and financial incentives are more aligned throughout the delivery system
- Advance the patient-centered primary care home structure by finding health care partners to help us achieve better health outcomes and offer patient-centered programs with demonstrated success
- Support health equity, diversity and inclusion through our health care partners

In 2015, PEBB expanded its regional "systems of care" throughout the state which provide members improved, more integrated care at an affordable cost. Regional "systems of care" focus on primary care and prevention and encourage members to share in the responsibility for their own health outcomes.

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

- Better Choices Better Health helps people living with a chronic condition to live healthier lives
- Employee Assistance Program (EAP) provides emotional, social and financial health services
- Healthy Team Healthy U offers members a foundation of knowledge and skills to help members live a healthier lifestyle
- MoodHelper online tool helps members overcome depression
- Tobacco Cessation helps members overcome tobacco use
- Weight Watchers is designed to help members achieve their weight loss goals and maintain them


Plan Years 2014-2016 Medical Enrollment by Plan
70%
60%
50%
40%
30%
20%
10%
0%
1.2%
1.4%
16.9%
17.3%
17.5%
2.2%
3.7%
24.3%
28.8%
32.4%
58.7%
50.5%
45.0%
0.1%
0.0%
AllCare
Kaiser
Moda
Providence Choice
PEBB Statewide
Trillium
PY2014
PY 2015
PY 2016

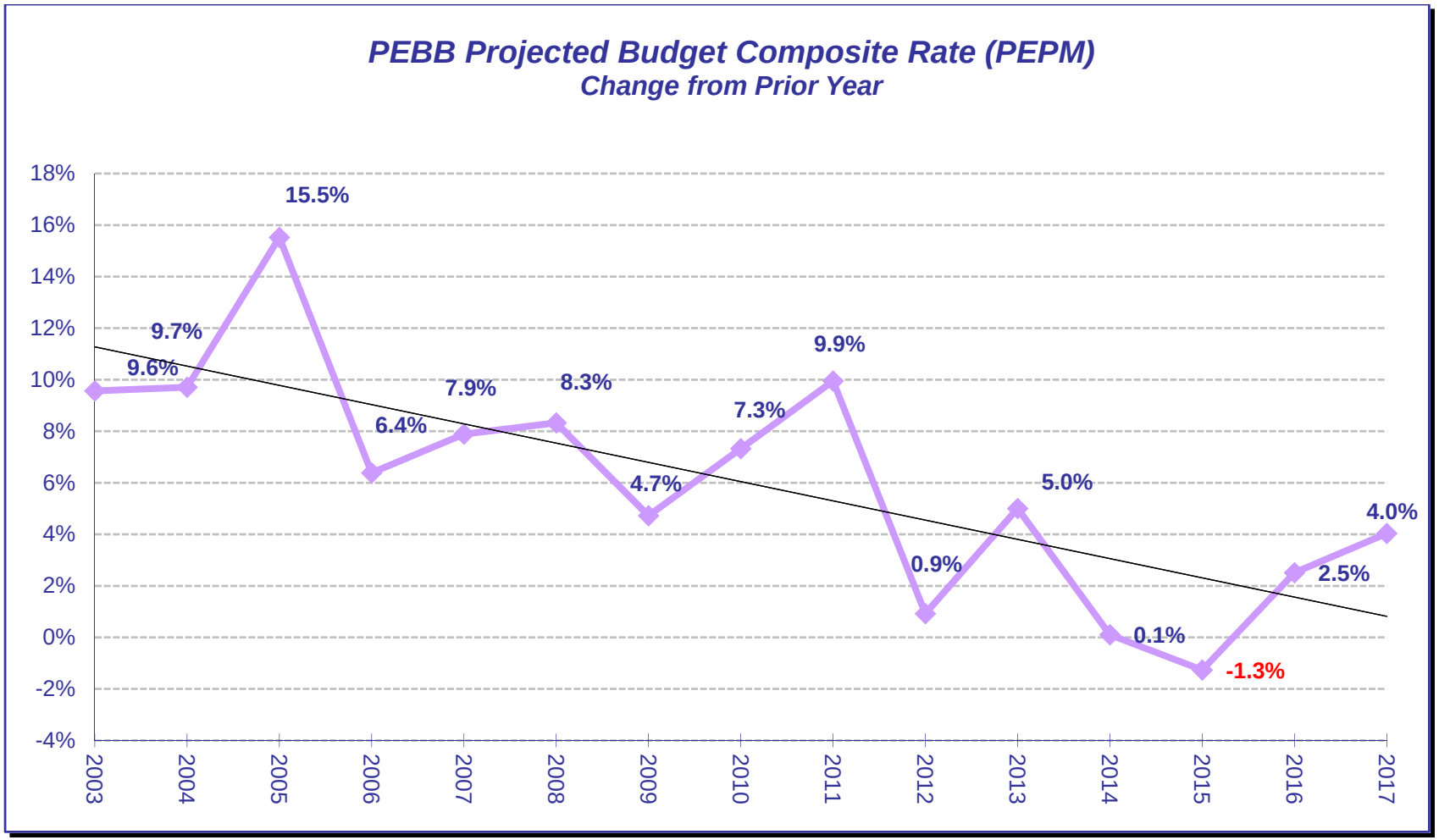
Program performance

- PEBB offers members in all 36 Oregon counties choice between the statewide Preferred Provider Organization (PPO) plan and at least one or more regional "system of care" plan
- Most plan choices are available at a lower cost to both members and the state
- Plans are required to meet and report high quality measures of care by:
    - Prioritizing health and prevention services
    - Managing costs by cutting waste and requiring health plans and providers to be efficient, coordinated and focused on the patient
    - Emphasizing behavioral health in addition to physical health

The PEBB 2017 medical plans:

- Offer the first four visits to primary care, with no deductible
- Cover the full cost of certain chronic condition and substance abuse visits, with no deductible, copayment or coinsurance
- Cover nationally recommended preventive services
- Cover no cost outpatient mental health services when provided in-network
- Limit out-of-pocket costs:
    - $ 600 per person, up to $1,200 per family – Kaiser
    - $1,500 per person, up to $4,500 per family – all other plans

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, naturopathic and spinal manipulation services.


PEBB Projected Budget Composite Rate (PEPM)
Change from Prior Year
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
-2%
-4%
9.6%
9.7%
15.5%
6.4%
7.9%
8.3%
4.7%
7.3%
9.9%
0.9%
5.0%
0.1%
-1.3%
2.5%
4.0%
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017

Addressing health care inflation and implementing cost containment measures: The escalating cost of care drives industry trend affecting PEBB premium costs. PEBB's move to self-insurance has alleviated the impact of the rapid rise of market trend and resulted in containing costs by:

- Increasing PEBB membership in patient-centered primary care homes
- Provide incentives for providing the right care at the right time to keep members healthy; such as implementing value-based plan designs that include additional cost tiers for preference-sensitive services and low or no cost prescription drugs
- Implementing benefit design changes aimed at reducing barriers to care for members with chronic diseases
- Employing cost-effective, sustainable technologies
- Achieving better cost and quality controls through direct contracting
- Maintaining a leadership role in value-based health care as a purchaser of commercial medical plans

Enabling legislation/program authorization

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

Funding streams

Since 2013, all premiums paid for PEBB benefit plans flow through PEBB before passing through to vendors. PEBB receives Other Fund dollars from agencies, universities and self-pay members to directly cover the costs of self-insured plan members. PEBB self-insures 76 percent of members for medical coverage. These moneys are used dollar for dollar to pay member medical, vision and dental claims, for insurance carriers' administrative fees, and other federal and state fees. In 2016, the average administrative fee paid to PEBB's self-funded plan administrators was less than 5 percent of premium. The "administrative services only" (ASO) fee PEBB pays for medical plans was reduced in 2016 after being held steady for more than five years.

By statute, PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs. In 2011 PEBB reduced the assessment from 0.6 to 0.4 percent and maintained this rate until 2015 when the PEBB Board

voted to reduce the administrative fee to 0.37 percent. In 2016 the PEBB Board voted to further reduce its administrative fee from 0.37 percent to 0.35 percent.

Significant proposed program changes from 2015-2017

The following legislative concepts are being proposed:

- Treat long-term care insurance as all other optional benefits. PEBB would have the ability to offer the plan if they chose to do so, but it would not be mandated. Employees currently pay 100 percent of cost.
- Add the same proposal confidentiality provision to PEBB statutes that is already included in the public contracting code. This would put PEBB on equal footing with most other agencies and programs.
- Removes the authority of the Department of Consumer and Business Services to enforce specified health benefit plan coverage requirements applicable to PEBB

OREGON HEALTH AUTHORITY: PUBLIC EMPLOYEES' BENEFIT BOARD

Program Unit Narrative: Public Employees' Benefit Board

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ -	$ 1,872.8	$ -	$ 1,872.8	19	18.50
Governor's Budget 17-19	$ -	$ 1,895.8	$ -	$ 1,895.8	19	18.50
Difference	$ -	$ 23.0	$ -	$ 23.0	0	0.00
Percent Change	0%	1%	0%	1%	0%	0%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

The Public Employees' Benefit Board (PEBB) supports the Oregon Health Authority's (OHA) goal to transform the health care system in Oregon and to fundamentally improve how care is paid for and delivered. This transformation process focuses on health and preventive care for Oregonians and reducing waste in the health care system. Critical steps to successful transformation include:

Member engagement and education:

- Helping members understand the value of better care coordination
- Providing culturally and linguistically appropriate outreach and target messaging related to specific health conditions and traditionally underserved populations
- Encouraging members to fully utilize available health and wellness programs to improve their health and reduce health risks

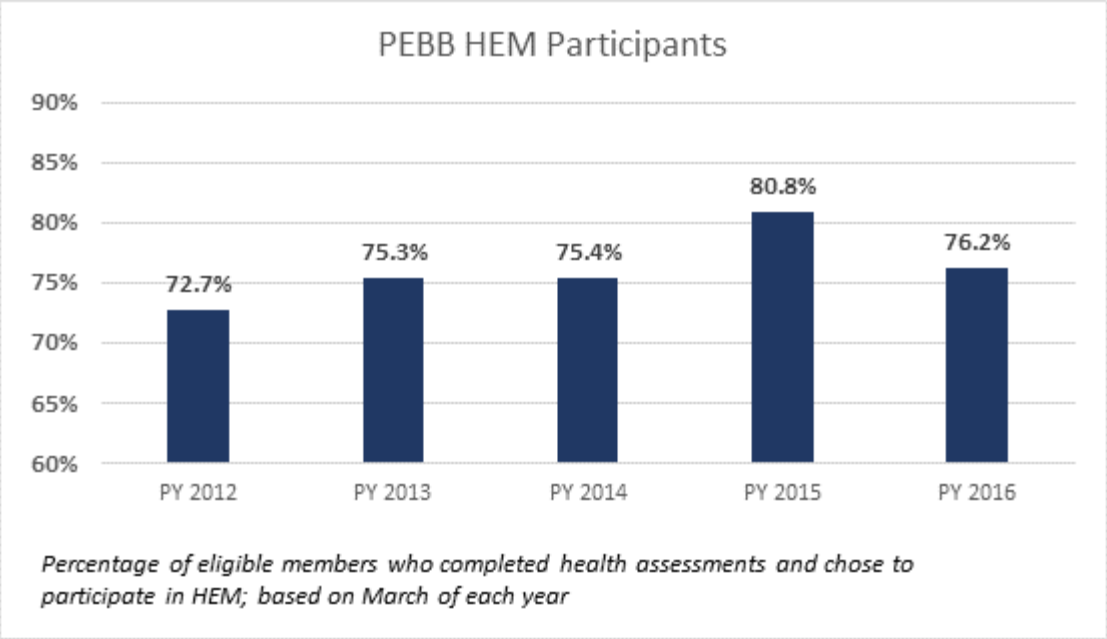
Promoting member health and using health care resources wisely and in a culturally and linguistically responsive manner by:

- Reducing barriers, including those experienced by traditionally underserved populations, for certain chronic condition and substance abuse care
- Promoting chronic care self-management
- Providing no-cost preventive care on all medical plans
- Working with local, regional and national purchasers on value-based benefit designs

Offering members opportunities to improve their health and contain costs through participation in the Health Engagement Model (HEM) program.

- HEM allows program participants the opportunity to learn more about their own personal health risks and how to reduce them
- Participants earn financial incentives by annually completing:
    - A private health assessment on their carrier's secure website, and
    - Two health-related activities
- Ideally, once the participant completes the assessment and identifies personal health risks, the assessment serves as an important tool to help members have a conversation with their health care provider that will lead the member down their own personal road to wellness
- PEBB offers an exemption to members who indicate they are not able to complete the health assessment

PEBB is working with carriers to improve the health assessment tool to include "transgender" as a demographic selection option to be more inclusive to this population. More work is needed to make the tool truly useful in identifying health risks for members identifying as transgender.



Alignment with the Oregon Health Authority and modifying carrier and vendor contracts to implement:

- Provider quality measures reporting
- Simplified claims billing and payment administration
- Meaningful use of electronic medical records
- C-section delivery rate reduction
- Contracting with health systems accountable for performance
- Carrier accountability for promoting the delivery of culturally competent health care and health equity
- Enhanced accessibility for members
- Increased use of decision support tools
- Best practices to manage and coordinate care

- Sharing responsibility for health
- Measuring performance
- Paying for outcomes and health
- Sustainable rate of growth

Implementing value-based benefits:

- Low or no member cost for effective treatments with lower risk or lower cost:
  - no or lowered cost for chronic-care visits
  - no cost for in-network substance abuse services
  - no or lowered cost for value-based drugs
- Higher member cost for less-effective treatments with higher risk or higher cost:
  - additional copay for advanced imaging technologies, sleep studies and upper endoscopies
  - additional copay for spinal and total joint replacement surgery

Maintain programs designed to address risks related to:

- Tobacco use – the percentage of PEBB members who smoke continues to be well below the statewide level
- Obesity
- Diabetes
- Depression and anxiety
- Other chronic conditions

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Major program challenges:

Controlling premium costs

Premium costs are affected by external drivers, such as:

- Inflation in health care costs, including large increases in the costs of prescription drugs
- Aging populations
- About 10 percent of population with chronic conditions
- Most PEBB members have sedentary occupations
- PEBB members continue to migrate to coordinated care model plans year over year; however, 45 percent are still enrolled in the statewide preferred provider organization, the plan that offers least amount of coordinated care

Process improvement efforts:

Shared operational functions serving PEBB and OEBB

In an effort to address staffing issues, provide program cross-training and support, and streamline business processes, PEBB and the Oregon Educators Benefit Board (OEBB) have implemented a shared services strategy in the areas of:

- Budget
- Accounting
- Contracts
- Communications

ACA administration and support

Federal law (26 U.S. Code Section 6056) mandates that certain employers report on health insurance coverage. Employers that offer employer-sponsored self-insured coverage use Form 1095-C to report information to the IRS and to employees about

individuals who meet the individual shared-responsibility mandate by having minimum essential coverage under the employer plan.

For self-insured plans, PEBB successfully partnered with state and university payrolls to meet their ACA health insurance coverage reporting mandate by:

- Collecting Social Security numbers from members, spouses, domestic partners and child dependents
- Contracting with a third party vendor for software and mailing services
- Facilitating the form printing
- Completing and mailing the 1095-C forms in 2016
- Assisting OSPS meet their ACA reporting mandates

2017-2019 planning and program priorities:

Implement new premium tier structure

With additional aspects of the Affordable Care Act set to go into effect in 2020, PEBB is implementing changes to its premium tier structure to avoid exposure to the Excise Tax.

Pharmacy plan design assessment

Beginning in late 2016, the PEBB Board will begin to reassess all pharmacy plan designs to ensure PEBB offers high-quality coverage at a cost affordable to both the employer and employees. By the end of 2016, the board will:

- Develop culturally and linguistically responsive strategies and tactics for the assessment and redesign process
- Provide education; subject matter expert testimony to board
- Assess the specific impact of explosive cost increases of specialty medications
- Collect public comment, ensuring a diverse cross-section and community engagement
- Initiate board evaluation of pharmacy plan designs
- Select and vote on pharmacy plan design changes for 2018 renewal

In 2017 the board will work with carriers to negotiate the board-approved plan design changes and by June will finalize the new plan designs for the 2018 renewal.

HEM strategies

The PEBB Member Advisory Committee (PMAC) is beginning to evaluate and explore opportunities to update the program, improve health outcomes and increase member participation. Throughout this process PEBB and PMAC will:

- Evaluate vendor health assessments and develop strategies to address assessment and risk criteria for people who identify as transgender and other traditionally underserved populations such as ethnically and linguistically diverse populations
- Engage members in evaluating the program; consider program changes and enhancements based on feedback
- Engage the board in program improvement strategies
- Identify outcome goals and develop performance measures
- Develop a communication plan and design communications that promote member involvement in achieving health outcome goals

* Note: In 2017 spouses and domestic partners are no longer eligible to participate in the HEM due to IRS regulations

Metrics and outcome reporting implementation

PEBB staff will:

- Continue working with carriers to refine contractual performance metrics reporting and analysis
- Develop and implement appropriate outcome measures and reporting
- Continue to collect data on race and ethnicity and evaluate timeline by which to add language and disability demographic data elements to PEBB.Benefits, the PEBB benefit management system

Additional budget drivers

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

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

Other Funds revenue pays for PEBB administration through an administrative assessment added to medical and dental insurance premiums and premium equivalents. By statute (ORS 243.185), PEBB can collect an amount that equals up to 2 percent of total premiums to meet administrative and operational costs. In 2011, PEBB reduced the assessment from 0.6 to 0.4 percent and maintained this rate until 2015 when the PEBB Board voted to reduce the administrative fee to 0.37%. In 2016, the PEBB Board voted to further reduce its administrative fee from 0.37 percent to 0.35 percent.

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.

Proposed new laws that apply to the program unit

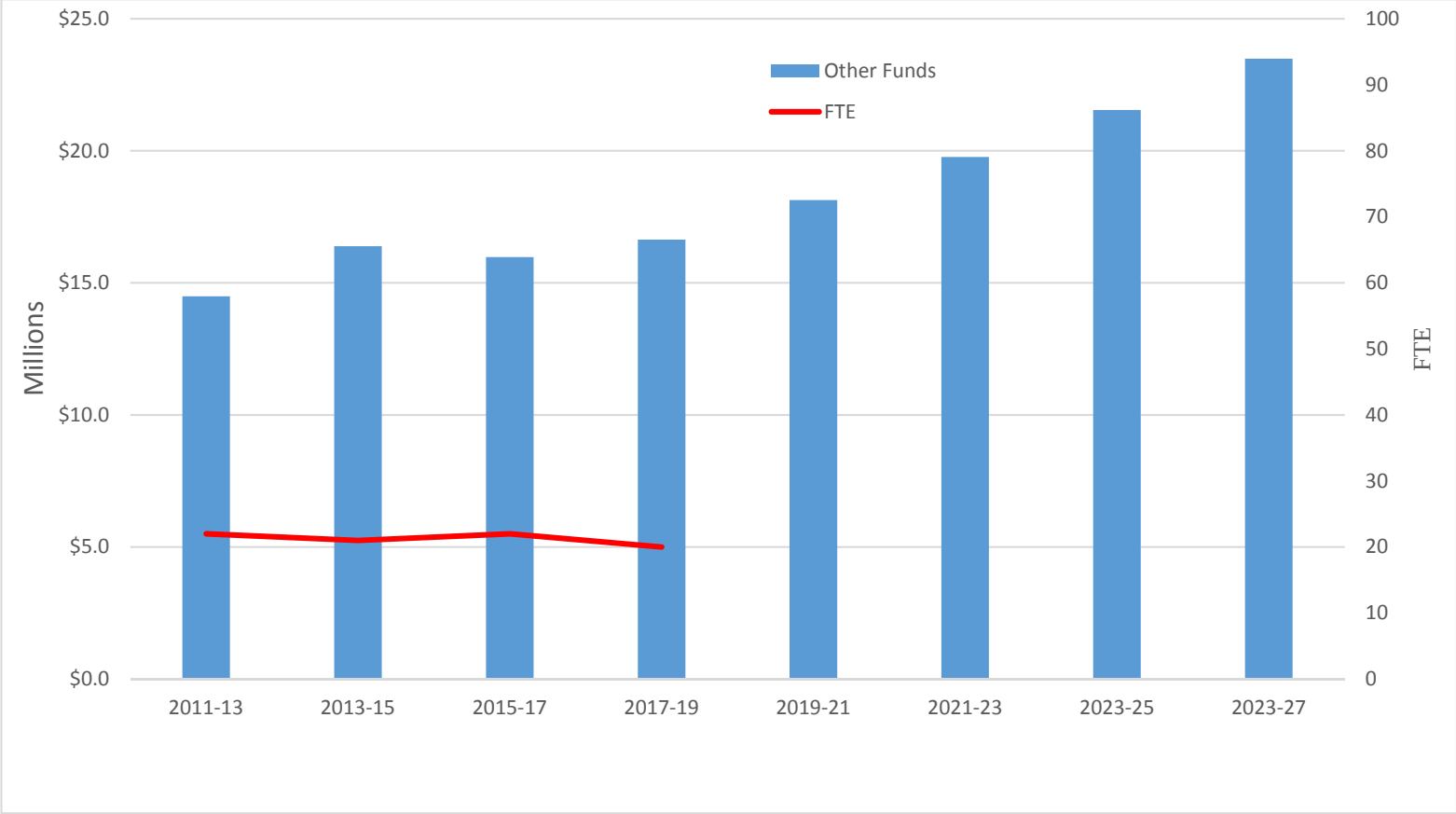
The following legislative concepts are being proposed:

- Treat long-term care insurance as all other optional benefits. PEBB would have the ability to offer the plan if they chose to do so, but it would not be mandated. Employees currently pay 100 percent of cost.
- Add the same proposal confidentiality provision to PEBB statutes that is already included in the public contracting code. This would put PEBB on equal footing with most other agencies and programs.
- Removes the authority of the Department of Consumer and Business Services to enforce specified health benefit plan coverage requirements applicable to PEBB.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Program Unit Executive Summary

Long Term Focus Areas: Safer, Healthier Communities, A Seamless System of Education, Excellence in State Government
Primary contact: Kathy Loretz, Acting Director



Program overview:

The Oregon Educators Benefit Board (OEBB) administers medical, dental, vision and other benefit plans for Oregon's school and education service districts, and since 2013 cities, counties and special districts as well. A *Seamless System of Education* requires a stable workforce, which includes recruitment and retention. Competitive insurance benefits are a part of employees' total compensation package and an important tool in hiring and retaining quality personnel.

OEBB's Mission is to:

- Work collaboratively to improve members' health and well-being through affordable health care with optimum results and service

Program funding request

OEBB's proposal requests funding at the 2015-2017 biennium level plus allowed inflation factors and cost growth for OEBB medical premiums at 3.4 percent for the 2016-2017 plan year and 3.4 percent for the 2017-2019 plan year. This will allow the program to continue to achieve the goals set forth in the guiding principles adopted by the OEBB Board, and continue to promote and advance health care transformation in Oregon. The program goals are described in the program description section. Estimated costs through the 2023-2025 biennium are trended forward using the inflation factors prescribed by Oregon Health Authority Office of Budget, Planning and Analysis. OEBB anticipates this funding level will allow it to continue to provide its current members a high level of customer service and continued access to reliable, high-quality and lower-cost health care through use of providers certified by OHA as patient centered primary care homes (PCPCHs) and recognized providers under coordinated care model health plans. The requested funding level also will allow OEBB to continue to promote ongoing improvement in the health of its more than 150,000 members enrolled in at least one OEBB benefit plan, making a major contribution to the overall health of Oregonians.

Program description

With a staff of 20, OEBB serves more than 150,000 members (employees and early retirees and their family members) in more than 250 publicly funded entities throughout Oregon. They include nearly all school districts, education service districts and

community colleges, numerous charter schools and some counties and special districts. OEBB serves its members and entities year-round. Activity significantly increases during the annual renewal and open enrollment periods. OEBB provides some bilingual and multilingual staff support and uses an interpreter service line for callers speaking other languages not supported by staff.

OEBB designs and maintains a full range of benefit plans for eligible and participating publicly funded entities to offer to their employees and early retirees. Plans include medical, dental, vision, life, disability, accidental death and dismemberment, long term care, an employee assistance program, a health savings account and flexible spending accounts. OEBB also maintains an online benefit enrollment system (MyOEBB), and carries out the wide range of duties required of a program that coordinates insurance coverage and other benefits for a large, statewide pool of public employees.

OEBB works closely with its contracted carrier and vendor partners, the Public Employees' Benefit Board (PEBB), the Oregon Health Authority, Oregon Health Policy Board, the Governor's Office, participating publicly funded entities and its 150,000-plus members.

Program Justification and Link to Long Term Outcomes:

Oregon Health Authority's vision of a healthy Oregon and Improving Member Health by:

OEBB has one major cost driver – rising health care costs. OEBB believes the coordinated care model is essential for achieving success in addressing health care costs. As a result, OEBB is conducting a Request for Proposal for comprehensive medical, pharmacy and vision services for the 2017-2018 plan year. OEBB also continues to work closely with its carrier partners to develop and pilot alternative delivery and payment methods that align with OEBB goals and the triple aim of better health, better care, and lower cost.

OEBB continues to expand access to patient centered primary care homes (PCPCHs) and provide an incentive (in the form of reduced out-of-pocket costs for office visits) to encourage members in OEBB's traditional preferred provider organization (PPO) medical plans to use a PCPCH as their primary care provider.

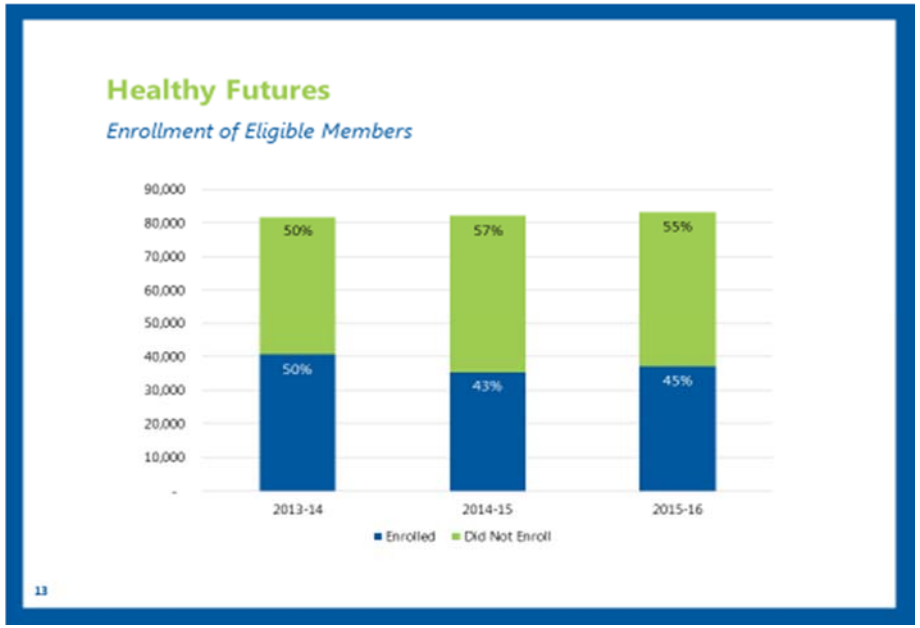
OEBB has implemented alternative payment models to help reduce costs. These included reference-based pricing programs for several major surgeries and certain oral appliances and better coordination of health care for some members with costly multiple chronic conditions.

OEBB offers non-traditional and culturally responsive benefits and services, e.g., acupuncture, naturopaths, the use of doulas and other traditional health workers, etc. The program also pays for services provided in non-traditional settings to increase access for members. Examples include payment for home birth, tele-medicine, mail order pharmacy, some home lab testing, and ambulatory surgical centers.

Beginning with the 2013-2014 plan year, OEBB implemented the Healthy Futures program. This program encourages members to learn more about their own health and health risks and to take action to reduce or eliminate those risks. Participants receive a $100 deductible credit on their PPO model medical plans, or the equivalent in copayment credits if they are in a health maintenance organization (HMO) model medical plan.

For the 2015-2016 plan year, the OEBB Board authorized:

- An online program to help people dealing with chronic conditions, Better Choices, Better Health
- A new diabetes prevention program effective October 2016
- Changes to the Health Futures program in order to improve member participation



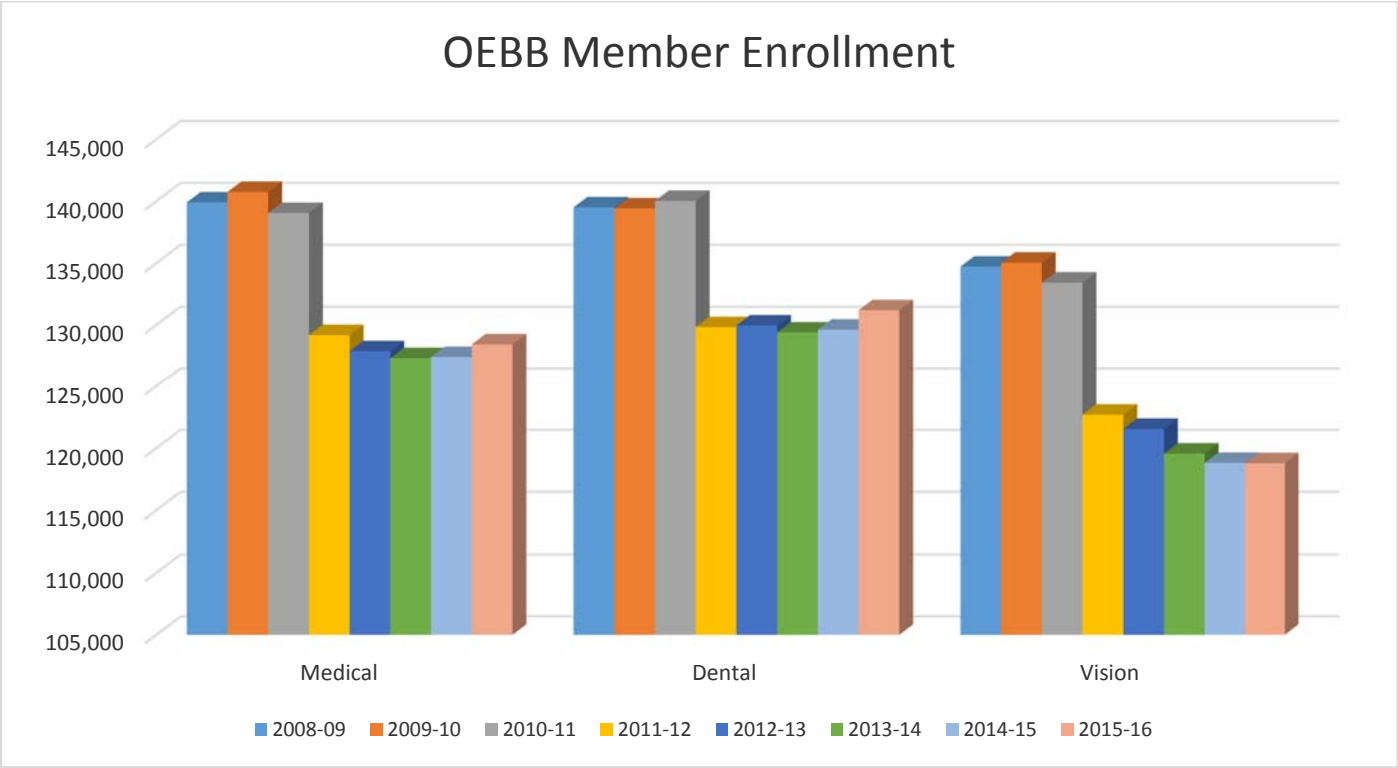
* Because program changes were implemented during the 2015-2016 enrollment period, the first plan year will serve as the baseline for enrollment

OEBB supports the Oregon Health Authority's goal to transform the health care system in Oregon and to fundamentally improve how care is paid for and delivered. This transformation process focuses on health and preventive care for Oregonians and reducing waste in the health care system.

OEBB believes the coordinated care model (CCM) is essential for achieving success in these goals. As a result, OEBB is conducting a Request for Proposal (RFP) for comprehensive medical, pharmacy and vision services. OEBB is hoping to add "systems of care" throughout the state for the 2017-2018 plan year to provide members improved, more integrated care and ultimately reduce health care costs. OEBB is pursuing plans and providers that use creative and innovative evidence-based practices.

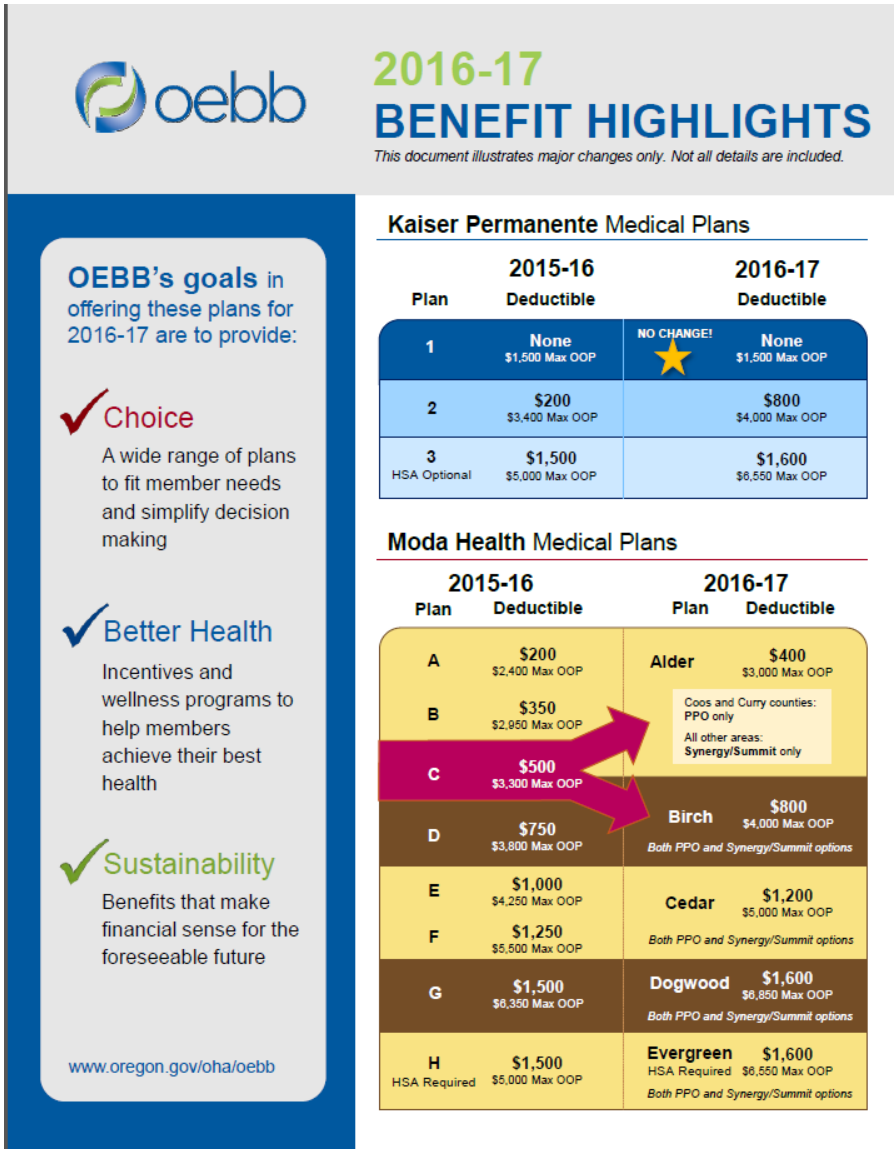
OEBB supports prevention and member wellness by offering members no-cost programs through our carrier partners. Programs include:

- Better Choices Better Health helps people living with a chronic condition to live healthier lives
- Healthy Team Healthy U offers members a foundation of knowledge and skills to help them live a healthier lifestyle
- MoodHelper online helps members overcome depression
- Tobacco Cessation helps members overcome tobacco use
- Weight Watchers is designed to help members achieve their weight loss goals and maintain them
- Diabetes Prevention Program effective October 2016



Program performance:

- OEBB is incorporating key elements of the coordinated care model into all OEBB medical plans. They are particularly evident in the structure of the Moda Health Synergy and Summit plans, as well as the health care delivery system inherent in the Kaiser Permanente plans.
- Plans are required to meet and report high quality measures of care by:
    - Prioritizing health and prevention services
    - Managing costs by cutting waste and requiring health plans and providers to be efficient, coordinated and focused on the patient



During the 2016 medical plan renewal, reduced the number of plans offered, in an effort to consolidate pools and moderate cost increases. As a result, OEBB introduced new medical plans for the 2016-2017 plan year (see infographic). OEBB's goals in offering these plans are to provide:

- Choice: a wide range of plans to fit member needs and simplify decision making
- Better Health: Incentives and wellness programs to help members achieve their best health
- Sustainability: Affordable benefits that make financial sense for the State and OEBB members for the foreseeable future

Strategies for Success: The OEBB Board and staff are committed to our mission and guiding principles and have developed strategies to achieve long term results:

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

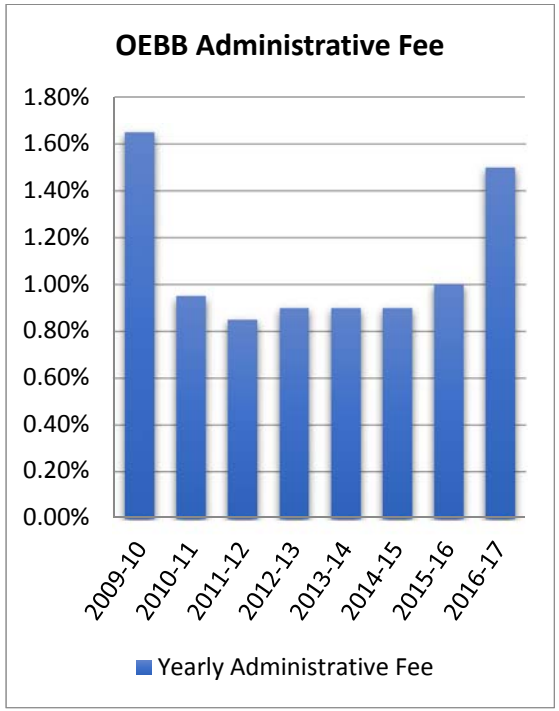
Enabling legislation/program authorization:

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

Funding streams:

ORS 243.880 authorizes the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated by an administrative assessment paid by members along with their premiums. The administrative assessment cannot exceed 2 percent of total monthly premiums. As of the 2015-2016 plan year, the administrative fee was 1 percent. The OEBB Board recently voted to increase the fee to 1.5 percent effective October 1, 2016, for the 2016-2017 plan year. The increase helps to stabilize rates and ensure sufficient funding for the new wellness programs. The administrative fee is the sole source of revenue for the OEBB benefits program. OEBB is funded entirely with Other Funds.

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 2015-2017:

The following legislative concepts are being proposed:

- Treat long-term care insurance as all other optional benefits. OEBB would have the ability to offer the plan if they chose to do so, but it would not be mandated. Employees currently pay 100 percent of cost.
- Add the same proposal confidentiality provision to PEBB and OEBB statutes that is already included in the public contracting code. This would simply put PEBB and OEBB on equal footing with most other agencies and programs.

OREGON HEALTH AUTHORITY: OREGON EDUCATORS BENEFIT BOARD

Program Unit Narrative: Oregon Educators Benefit Board

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ -	$ 1,597.5	$ -	$ 1,597.5	22	22.00
Governor's Budget 17-19	$ -	$ 1,663.4	$ -	$ 1,663.4	20	20.00
Difference	$ -	$ 65.9	$ -	$ 65.9	-2	-2.00
Percent Change	0%	4%	0%	4%	-9%	-9%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

OEBB supports the Oregon Health Authority's (OHA) goal to transform the health care system in Oregon and is committed to improving members' health and well-being through affordable health care. The OEBB Board developed strategies that align with OHA's vision and mission and to achieve the desired results of member accountability, stakeholder collaboration, high-quality services, affordability and measurable outcomes.

Offer high-quality, affordable health plans:

- Provide plan and benefit designs that clarify present and future costs and are affordable to members
- Offer members at least two affordable plan options
- Use performance measures that ensure carrier accountability and adherence to federal, state, and board benefit mandates

Support member wellness and population health through culturally and linguistically responsive communication and engagement:

- Increase engagement in Healthy Futures and other wellness programs and activities with member accountability for health
- Educate members about the value of health data and provide incentives for participation in health-promoting programs
- Offer evidence-based wellness programs applicable to a broad base of OEBB members

Create streamlined operations and organization effectiveness:

- Modernize the Benefit Enrollment System to enhance the end user experience
- Ensure OEBB's workforce is well-trained and fully equipped to perform their job functions efficiently and effectively
- Increase system integration capabilities and improve security

Provide enhanced member outreach and communications:

- Adopt a detailed and transparent communication plan that addresses the needs of members, participating entities, and stakeholders and is culturally and linguistically responsive
- Provide members and stakeholders with clear and relevant information about costs and critical metrics
- Deliver information to members in a convenient and accessible manner
- Ensure information is culturally and linguistically responsive
- Empower members to become educated health care consumers

Cultivate a customer service culture:

- Focus staff resources on meeting the needs of members and stakeholders driven by data analysis
- Broaden interaction and communication with participating entities
- Partner with participating entities and vendors to create a culture that rewards quality, culturally responsive and timely service to members

Create a Financially Sustainable Organization:

- Create an organization that addresses current business needs and is financially responsive to changes

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Major program challenges

Controlling premium costs

Premium costs are affected by external drivers, such as:

- Inflation in health care costs
- Chronic conditions
- Significant percent of population are obese or overweight

Legislative cap on premium rate increases

- Limiting renewal rate increases at or below the 3.4 percent increase cap established by the Legislature is another challenge for OEBB and something on which the Board will need to focus for the next renewal period.

Consistency and standardization

OEBB serves its employer entities in a manner similar to the Health Insurance Marketplace by offering a menu of plan options from which employers can select to offer to their members.

- Contribution levels (employer and member) are established for each entity through collective bargaining.
- Each OEBB employer entity:
    - Selects the plans it will offer
    - Selects the rate structure, tiered or composite

These variables pose a challenge to ensuring consistency and fairness for all OEBB members.

Process improvement efforts

Shared functions serving PEBB and OEBB

In an effort to address staffing issues, provide program cross-training and support, and streamline business processes, OEBB and the Public Employees' Benefit Board (PEBB) now share business services including budget, accounting, contracts and communication.

2017-2019 planning and program priorities

High-quality and affordable health plans

During the 2016 medical plan renewal process OEBB introduced new medical plans for the 2016-2017 plan year. As the Board evaluated plan offerings and geared up to release the Medical Request for Proposal (RFP), they created a focus group to evaluate affordability among employer entity plan offerings. This Affordability focus group established criteria to ensure affordable health plan options across the state. In the upcoming biennium OEBB will:

- Engage entities at regular intervals to ensure the affordability definition remains relevant to all districts
- Monitor and audit utilization and plan performance to ensure high-quality benefits and services
- Incorporate criteria specific to legislative cost requirements (3.4 percent renewal increase cap) into carrier contracts
- Evaluate vendor and carrier contracts at regular intervals to ensure a balanced portfolio of quality plan and program offerings

Request for proposal

OEBB believes the coordinated care model (CCM) is essential for achieving success in these goals. As a result, OEBB is conducting an RFP for comprehensive medical, pharmacy and vision services. OEBB is:

- Hoping to add "systems of care" throughout the state with a focus on integrated care and reducing health care costs and health disparities
- Pursuing plans and providers that use creative and innovative evidence-based practices

The RFP questionnaire addresses the importance of delivering culturally competent health care and health equity. It requires proposers to outline their plans and specific steps they will take to promote this for OEBB members in medical offices and other care locations.

Communication and outreach

OEBB will focus on enhanced member communication, outreach and engagement. In the next biennium, OEBB hopes to:

- Leverage innovative technology to connect more frequently with members and become more accessible, including with underserved populations
- Generate new brand awareness that promotes the OHA and OEBB mission and goals
- Create live-stream and on-demand webinars and recordings
- Improve outreach and target messaging related to specific health conditions and traditionally underserved populations
- Align with OHA and commercial insurers to obtain health care market data and track cost and quality metrics for use in outreach and communications materials

Metrics and outcome reporting

OEBB staff will:

- Continue working with carriers to refine contractual performance metrics analysis and reporting
- Develop and implement appropriate outcome measures and reporting
- Continue to collect data on race and ethnicity and will evaluate the timeline to add language and disability demographic data elements into the MyOEBB system

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

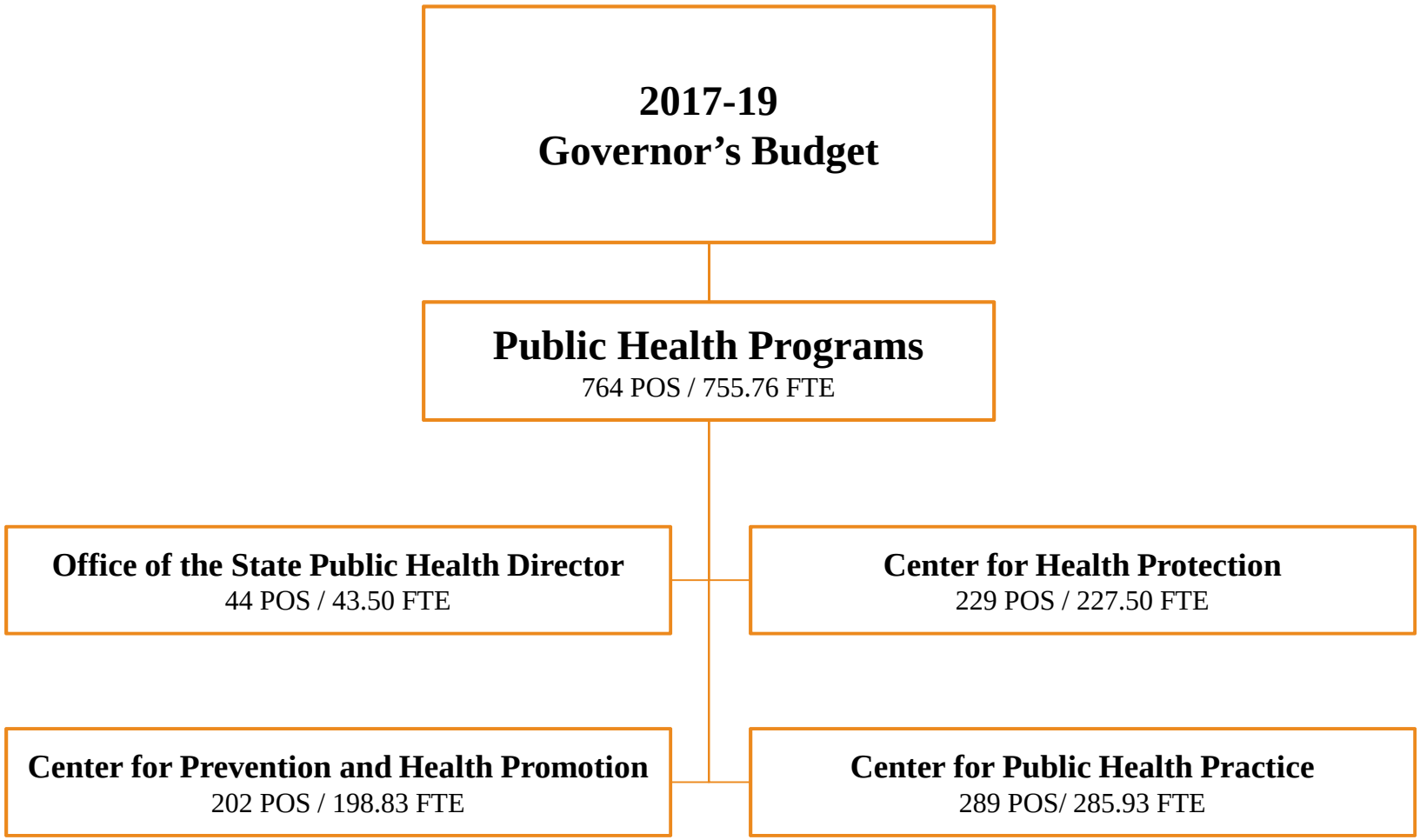
ORS 243.880 established the Oregon Educators Benefit Account to cover administration expenses. The account's revenue is generated through an administrative fee included in premiums for OEBB medical, dental and vision benefits, which is considered Other Fund revenue. By statute, the administrative fee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

ORS 243.884 established the Oregon Educators Revolving Fund to pay premiums, control expenditures, provide self-insurance and subsidize premiums. There is no dedicated revenue source for the OEBB Revolving Fund other than interest earned on the premium collection pass-through account.

Proposed new laws that apply to the program unit

The following legislative concepts are being proposed:

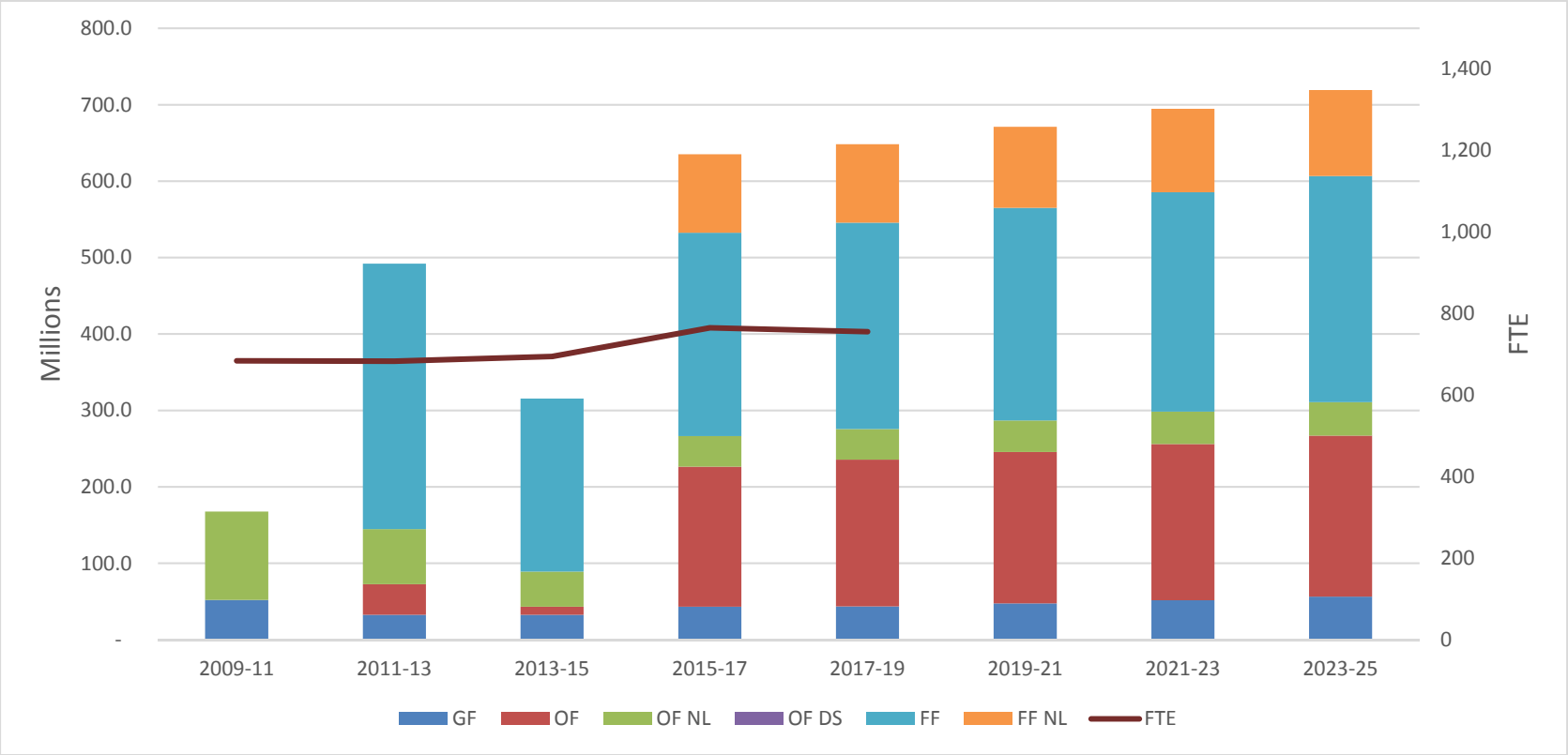
- Treat long-term care insurance as all other optional benefits. OEBB would have the ability to offer the plan if they chose to do so, but it would not be mandated. Employees currently pay 100 percent of cost.
- Add the same proposal confidentiality provision to OEBB statutes that is already included in the public contracting code. This would put OEBB on equal footing with most other agencies and programs.
- Removes the authority of the Department of Consumer and Business Services to enforce specified health benefit plan coverage requirements applicable to OEBB.


2017-19
Governor's Budget
Public Health Programs
764 POS / 755.76 FTE
Office of the State Public Health Director
44 POS / 43.50 FTE
Center for Health Protection
229 POS / 227.50 FTE
Center for Prevention and Health Promotion
202 POS / 198.83 FTE
Center for Public Health Practice
289 POS/ 285.93 FTE

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Executive Summary

Primary Focus Area: Safer, Healthier Communities
Secondary Focus Area: Responsible Environmental Stewardship
Program contact: Lillian Shirley, Public Health Director
971-673-1300



Program overview

Public health is a cost-effective means to promote health, improve care and lower or contain health care costs by preventing the leading causes of death, disease and injury in Oregon. Today medical care accounts for only about 10 percent of our health status, while lifestyle, behavior, environmental, and social and genetic factors account for the rest.

Public health programs address behavioral and social drivers of health by working to ensure physical and social environments that promote health and make it easier for people to make healthy choices and live unencumbered by social and environmental conditions that can compromise health. Public health programs complement and amplify investments in health care programs. By focusing on prevention, they have the potential to reduce the need for health care and ultimately may help in containing health care costs. Public health also directly helps clinical health care providers including coordinated care organizations, adopt evidence-based best practices for the delivery of clinical preventive health services.

Program funding request

	General	Other NL	Other/Lottery	Federal NL	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 43.1	$ 40.0	$ 183.3	$ 102.7	$ 266.1	$ 635.3	785	763.71
Governor's Budget 17-19	$ 43.5	$ 190.6	$ 192.2	$ 102.7	$ 270.0	$ 648.4	762.50	441.16
Difference	$ 0.4	$ 150.6	$ 8.8	$ (0.0)	$ 3.8	$ 13.2	-22.5	-322.55
Percent Change	1%	376%	5%	0%	1%	2%	-3%	-42%

For the 2017-2019 biennium, the Oregon Health Authority requests the following budget (in millions) for Public Health Division:

- 2017-2019 Request: $648.4 TF ($44.5 GF, $382.7 OF and $102.7 FF)

The Governor's Budget of $648.8 Total Funds continues funding for the Public Health programs at the current service level for 2015-2017. This request includes policy option package requests for investments to improve the lifelong health of all Oregonians, preventing leading causes of death, injury and disease.

Program description

The Public Health Division's mission is to promote health and prevent the leading causes of death, disease and injury in Oregon. In addition to addressing the drivers of chronic illness such as tobacco and obesity, among other services the state public health programs ensure the safety of drinking water in public water systems, investigate disease outbreaks, respond to public health emergencies, license hospitals, and provide services to prevent unintended pregnancies. These programs and services serve all people in Oregon, including its most vulnerable populations.

The vision is lifelong health for all people in Oregon. To achieve this vision, public health has identified two main goals;

- To make Oregon one of the healthiest states
- To transform the state's public health system into a national model of excellence

To make Oregon one of the healthiest states, state public health is focusing on areas where there is the potential to make significant progress to improve the health of the population. Tobacco and obesity prevention are priorities. The programs are directly working to achieve outcomes, including supporting the achievement of 100 percent tobacco-free state properties and the establishment of a statewide nutrition policy for all state agencies, and statewide nutrition standards in procurement contracts.

Other areas of focus, all in the context of health equity, include reducing the incidence of heart disease and stroke and increasing survival of stroke patients; decreasing suicide (which kills more people than motor vehicle crashes in Oregon); preventing family violence, which causes a wide range of physical and mental health problems and also is a major factor in the development of chronic disease later in life for children exposed to violence; and increasing community resilience in public health emergencies.

To create a public health system that is a national model of excellence, Public Health is preparing for a time when nearly all people are covered by health insurance by developing its capacities to:

- Support coordinated care organizations with technical assistance in the areas of prevention and community health assessment
- Carry out health impact assessments
- Connect health improvement policies and strategies to social determinants of health and collaborate with other state and local cross-sector entities to address determinants of health and health disparities
- Achieve excellence in the assessment and monitoring of the health of the public through epidemiology and surveillance
- Collaborate with other state agencies to ensure that health is considered in policymaking across state government as appropriate

The state public health system works as a partner in a national system of local public health agencies, other state agencies, and federal partners. Partnerships with local public health departments, coordinated care organizations, transportation, education, federal partners, and health care providers are essential to the work, and contribute toward providing Oregon with the backbone for a strong economy and education system.

Program justification and link to long-term outcomes:

These programs provide cost-effective ways to meet the goals in the Long Term Outcomes. Public health programs can fundamentally change how health care is delivered by shifting resources toward the prevention of chronic disease, and ensuring access to sufficient, affordable, and nutritious food. Public Health Division is designing strategies to decrease obesity among adults and children, and is actively engaged in measuring and increasing the percent of Oregonians consuming five or more servings of fruits and vegetables per day. Additionally, Public Health Division programs work to achieve Healthy People 2020 objectives, which tie directly to the Safer, Healthier Communities goals of the Long Term Outcome plan, as well as health equity and eliminating health disparities.

Program performance:

Public Health Division has a system of performance measurement and quality improvement to address its programs, including data related to the return on investment for many of these programs. Performance and return on investment data are available for the full range of public health programs. Performance outcomes for key areas – tobacco, family planning and epidemiology – are listed below.

The Tobacco Prevention and Education program delivers community-based interventions to control tobacco. The program has averted $3.8 billion in future health care costs since 1997, a return of $45 for every dollar invested in the program. As a result of the program, cigarette consumption declined in Oregon from 92 packs per capita in 1996 to 43 packs per capita in 2013.

Family Planning program has served more than 100,000 clients per year for each of the past five years, providing free or low-cost birth control options to women and men who lack other sources of coverage. The total savings from unintended births averted in 2011 was more than $28 million dollars for the state and more than $81 million in federal Medicaid funds. The rate of pregnancy among 15- to 17-year-old women in Oregon dropped from 23.8 percent in 2004 to 22.4 percent in 2009.

Epidemiology and data collection are critical to Oregon's ability to measure the health status of all of its people and to identify trends in infectious diseases, chronic diseases, and injuries and the disparities that exist. This capacity is essential for policymakers and critical for tracking how the population's health is affected by well-community prevention, coordinated care organizations and other changes yet to come in the health system.

Enabling legislation/program authorization

The Oregon Health Authority plays a central role in ensuring the health of all people in Oregon. Chapters 431 and 433 of Oregon Revised Statutes set forth hundreds of code sections enabling and mandating a wide range of public health activities carried out by state public health and its county partners.

Funding streams

For the 2017-2019 biennium, Public Health Division's budget comprises 7% General Fund, 57% Federal Funds and 36% Other Funds. The federal revenue includes not only entitlement grants such as Medicaid (with 90-10 match for contraceptive care) but more than 120 grants that are categorically dedicated to public health programs such as emergency preparedness and hospital preparedness, cancer prevention and control, and safe drinking water.

In addition, Public Health Division's Other Fund revenue sources include fees for activities in such areas as newborn screening tests (including test services for eight other states); licensing of facilities including hospital and special inpatient care facilities; registration inspection and testing of X-ray equipment; testing and certification of emergency medical technicians; registration of medical marijuana card holders, growers, dispensaries and processors; fees for issuing certified copies of vital records; and statutorily dedicated funds from the Tobacco Use Reduction Account. Other Fund fees generally are dedicated to entirely support the program that assesses the fee, except Medical Marijuana program funds, which were legislatively approved to support additional programs.

Significant proposed program changes from 2015-2017

Public Health Division has carried out a statewide health assessment, developed a strategic plan, and is engaging in planning with partners to continue its work to integrate Oregon's public health system with health system transformation, and continue its work during 2017-2019 to reduce the leading causes of disease, injure, and death. Public Health continues to be primarily funded through federal grants. During 2015-2017, several federal grants have decreased or remained flat. This decline in federal funding is expected to continue during 2017-2019, and the programs will need to adjust services accordingly.

Since 2013, Oregon has been working to modernize its governmental public health system. The goals of a modern public health system include achieving sustainable and measurable improvements in population health, protecting individuals from injury and disease, closing the gap on health disparities and being fully prepared to respond to public health threats.

In July 2015, the Legislature passed HB 3100, which sets forth a clear path and timeline for the implementation of a modernized public health system in Oregon that will meet the needs of Oregonians.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Office of the State Public Health Director

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 6.3	$ 11.2	$ 13.4	$ 30.8	50.00	49.50
Governor's Budget 17-19	$ 6.1	$ 11.4	$ 12.5	$ 30.0	44.00	43.50
Difference	$ (0.2)	$ 0.3	$ (0.9)	-0.83	-6.00	-6.00
Percent Change	-3%	2%	-7%	-3%	-12%	-12%

The Governor's Budget of $30.0 continues funding for the Office of the State Public Health Director programs at the current service level for 2017-2019.

Activities, programs and issues in the program unit base budget

The Office of the State Public Health Director (OSPHD) provides scientific, fiscal, communications, policy and operations leadership to the public health programs. The office sets public health priorities that meet the needs of all Oregonians in collaboration with state and local agencies and organizations.

Under the leadership of the OSPHD, state public health is organized by three centers: Center for Public Health Practice, Center for Prevention and Health Promotion and Center for Protection. The various categorical programs are located in these centers.

The office guides the strategy, operations, scientific activities, communication and policies of all public health programs and ensures that Oregon's public health system is effective and coherent.

The office has units focused on policy, public health systems innovation and partnerships, communication, legislative affairs, fiscal management, operations, science and epidemiology. These units provide enterprise-wide support and guidance in areas that include:

- Supporting accreditation, quality improvement and performance management
- Health assessments and statewide health improvement planning
- Health equity and the social determinants of health
- Contracting with local health departments and conducting reviews of each local health department every three years
- Coordination of partnerships to achieve improved population health with the 34 local health departments and nine federally-recognized tribes in Oregon
- Policy development, implementation and administrative rulemaking
- Providing technical support to local health departments in nurse practice and administrative requirements
- Legislative support
- Coordination of public health issues related to health system transformation
- Risk management and safety
- Workforce development and volunteer coordination
- Budget and finance
- Communication
- Business continuity planning
- Scientific processes including the Institutional Review Board and manuscript and project review

Any additional important background. Include trends in caseload, workload or other external factors that may influence the operation of the program

The Office of the State Public Health Director's work affects all Oregonians and responds to public health issues by providing leadership and oversight to public health programs that:

- Protect the public through public health regulations
- Identify and respond to disease outbreaks
- Develop population-wide public health policies, practices, systems and environmental changes that will improve public health

The office works to ensure that decisions made and priorities set in Oregon are data-driven and use evidence-based practices. As more Oregonians have access to health care, public health's activities will continue to transition away from providing safety-net health care services toward population-wide policy, systems and environmental changes.

This work includes extensive interaction with Oregon's 34 local public health departments. The state public health programs also partner with a range of state and local agencies and organizations, health care providers, insurers, coordinated care organizations, nonprofit organizations, federal agencies and the private sector. Within state government, the office's staff work closely with and serve as liaisons between public health programs and the state departments of Human Services, Transportation, Education, Environmental Quality, Agriculture and Forestry, and other programs within the Oregon Health Authority.

The office is responsible for the State Health Profile, originally published in 2012. The State Health Profile includes a set of key population health indicators that are updated annually and include breakouts by race and ethnicity and coordinated care organization region. Using the data from the State Health Profile and feedback from a series of community engagement meetings held across Oregon in 2014, the Public Health Division launched Oregon's Statewide Health Improvement Plan (SHIP) in July 2015. Oregon's SHIP includes seven priority areas organized by health equity interventions, population-wide interventions and health system interventions, which if fully implemented would

contribute to substantial improvements in the health of Oregonians and cost savings to the health care delivery system. The seven priority areas included in Oregon's SHIP:

- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

The OSPHD oversees Oregon's SHIP, working closely with Public Health Division programs on implementation of evidence-based strategies and building partnerships to align work across public health, health care, community-based organizations, state agencies and other key partners. The OSPHD partners with the OHA Transformation Center to support implementation of community health improvement plans by local public health authorities, coordinated care organizations and nonprofit hospitals so that these plans can also be used to achieve statewide health outcomes. In 2017-2019, the OSPHD will continue to focus on the collection and reporting of public health data in accordance with the Race, Ethnicity, Language and Disability (REAL+D) law, recognizing that this level of information is critical to the identification of health needs and prioritization of public health initiatives to serve the needs of Oregon's diverse communities. In addition, the interventions in the SHIP will be reviewed and strengthened to better address health equity needs.

Since 2013 the Office of the State Public Health Director 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, designed to create recommendations for the Legislature on a governmental public health system for the future. The task force met for nine months in 2014, submitting recommendations to the Legislature in the *Modernizing Oregon's Public Health System* report in September 2014. These recommendations were used to introduce House Bill 3100, which was signed by Governor Brown in July 2015. Since then, the Office of the State Public Health Director has worked to implement the provisions included in House Bill 3100, which:

- Adopted a series of foundational capabilities and programs, including cultural responsiveness and health equity, for governmental public health
- Changed the composition and role of the Oregon Public Health Advisory Board on January 1, 2016
- Required an assessment of how foundational capabilities and programs are provided and what resources are needed to achieve full implementation
- Requires that local public health authorities shall submit plans for implementing the foundational capabilities and programs no later than December 2023

In order to accomplish this work in the timeline set forward by House Bill 3100, the OSPHD:

- Facilitated a process by which state and local public health authorities defined each foundational capability and program, and compiled these definitions into the Public Health Modernization Manual, published in December 2015.
- Engaged a contractor to complete a public health modernization assessment with each local public health authority and the Public Health Division.
- Partnered with the Coalition of Local Health Officials on a successful application to the Robert Wood Johnson Foundation for a $250,000, two-year grant to support implementation of public health modernization across Oregon.
- Engaged Program Design and Evaluation Services to develop an estimate of the health outcomes and cost savings anticipated by public health modernization.
- Began engaging partners outside of the governmental public health system in public health modernization, including county commissioners, coordinated care organizations, and the nine federally-recognized tribes in Oregon, which will be exploring how the public health modernization initiative aligns with their own goals for population health improvement. In 2017-2019 the OSPHD will work closely with the OHA Office of Equity and Inclusion to engage diverse communities in the effort to develop state and local public health modernization plans. In June 2016 OHA held a tribal consultation on public health modernization to receive guidance from tribes on how they would like to engage in public health modernization.

As a critical component of the implementation of House Bill 3100, Governor Brown appointed the new Public Health Advisory Board in December 2015. This 16-member board oversees Oregon's governmental public health system and acts in a subcommittee capacity to the Oregon Health Policy Board. The Public Health Advisory Board makes recommendations to the Oregon Health Policy Board on numerous initiatives related to public health modernization, while also overseeing Oregon's SHIP and the Preventive Health and Health Services Block Grant. The Public Health Advisory Board and two subcommittees meet monthly:

- The Incentives and Funding Subcommittee is charged with developing a formula for the distribution of state funds for local public health authorities using the criteria set forward in House Bill 3100
- The Accountability Metrics Subcommittee is identifying a series of quality measures for which state and local health departments will be financially accountable through the implementation of public health modernization

The Public Health Advisory Board has committed to applying an equity lens to its work and will be developing guiding principles to ensure that a focus on health equity is inherent in all of its work. To date the Incentives and Funding Subcommittee has committed to including a diversity variable in the draft local public health authority funding formulas, and the Accountability Metrics Subcommittee has prioritized the ability to meaningfully affect health equity as a criteria for the selection of quality measures for state and local public health authorities. The Public Health Advisory Board has had numerous discussions about the importance of having robust state and local data that complies with the REAL+D law in order to inform the work of a modern public health system.

In addition to several system-wide public health initiatives, the OSPHD has assumed leadership for new and emerging issues that affect the health of Oregonians. It has coordinated the state's responses to the public health impact of marijuana legalization, air toxics, lead and other emerging issues, in collaboration with Public Health Division' centers, other state agencies, and local public health authorities.

The office continues to lead the Public Health Division's performance improvement efforts, and has established performance dashboards for all of the division's programs as well as a monthly reporting and review process.

The office also oversees and participates in regular program reviews of Oregon's local public health departments to ensure their compliance with federal and state regulations.

Revenue sources and proposed revenue changes

The 2017-2019 budget for the Office of the State Public Health Director is composed of 38 percent Other Funds and 42 percent Federal Funds (primarily through the agency's federally approved cost allocation plan), and 20 percent General Funds. Of the General Funds, 39 percent is pass-through funding to local health departments to support local communicable disease outbreak surveillance. The remaining General Funds are used to meet the state participation required by the agency's federally approved cost allocation plan.

The 2015-2017 Legislative Approved Budget (LAB) for the Office of the State Public Health Director included General Funds of $500,000 to implement the 2015-17 deliverables associated with House Bill 3100, the Modernization of the Public Health. Those funds have been used to publish the Public Health Modernization Manual, conduct the public health modernization assessment and develop the public health modernization assessment report, estimate the health outcomes and cost savings attributable to public health modernization, develop targeted public health modernization communications, and engage Oregon's nine federally-recognized tribes in an effort to identify aspects of public health modernization that might be implemented to improve the health of tribal members.

The 2015-2017 LAB also included $1 million in General Funds to support planning and operational readiness to prepare for, respond to and mitigate public health disasters. During 2015-2017, these funds were used for response to Ebola, meningococcal, Zika virus, environmental health hazards caused by heavy metals, and response to Douglas County to assist with recovery following the Umpqua Community College shootings.

The 2017-2019 Agency Request Budget included a policy option package to continue the implementation of the provisions included in HB 3100 (2015), the Modernization of the Public Health system. The policy option package is not included in the Governor's Budget.

The office also receives federal funding from the Centers for Disease Control Preventive Health and Health Services Block Grant to address state-determined public health priorities. During 2015-2017 the office received $6.5 million from the Oregon Medical Marijuana Program in lieu of General Funds to help support communicable disease outbreak surveillance at the local level.

Proposed new laws that apply to the program unit

The Office of the State Public Health Director is proposing a legislative concept to continue to advance the timeline and deliverables associated with House Bill 3100, including implementation of state and local public health quality measures.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Center for Health Protection

Expenditures by fund type, positions and full-time equivalents

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 3.4	$ 37.2	$ 19.4	$ 60.0	232	223.66
Governor's Budget 17-19	$ 4.2	$ 40.8	$ 18.5	$ 63.5	229	227.50
Difference	$ 0.8	$ 3.6	$ (0.9)	$ 3.5	-3.00	3.84
Percent Change	24%	10%	-5%	6%	-1%	2%

The Governor's Budget of $63.5 continues funding for the Center for Health Protection programs at the current service level for 2017-2019. This request includes Policy Option Package 401 for $275,741 (Total Funds) and Package 409 for $1,077,034 (Total Funds) to improve the lifelong health of all Oregonians.

Activities, programs and issues in the program unit base budget

The Center for Health Protection (CHP) protects the health of individuals and communities through establishing, applying and ensuring compliance with regulatory and health-based standards. It protects Oregonians from environmental health hazards in areas including drinking water, radiation, recreational waters, and foodborne illness. The center also develops and helps set health care policy and requires patient safety efforts and quality improvement activities across all health care providers. The center's six sections partner with local health departments, private practitioners and medical experts.

Radiation Protection Services (RPS) conducts statewide radiological health and safety programs to protect workers 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, and radio analytical laboratory services. This section provides Oregon's sole public resource for radiation-related incidents, whether accidental or intentional. In addition, the section collaborates with licensing boards to ensure operators and workers are properly trained and credentialed.

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; prevents contamination of public drinking water systems by protecting drinking water sources; ensures that public water systems meet standards for design, construction and operation; certifies and trains water system operators; inspects public water systems and ensures that identified deficiencies are corrected; and provides technical assistance to public water suppliers to solve operational problems. DWS also provides financial assistance to communities to construct safe drinking water infrastructure, and is expanding funding assistance to underserved and economically disadvantaged communities for these projects.

Environmental Public Health (EPH) identifies, assesses and reports on threats to human health from exposure to environmental and occupational hazards. It also advises the people and communities of Oregon about potential risks where they live, work and play. EPH works closely with local, state and federal natural resource management, occupational safety, environmental and other agencies to understand risks to human health posed by changing conditions, policies and practices. EPH recognizes that communities of color and lower-income communities are disproportionately at risk for environmental exposures and prioritizes its work accordingly.

Oregon Medical Marijuana Program (OMMP*)* administers the registration program of the Oregon Medical Marijuana Act (OMMA). The OMMP oversees the medical marijuana cardholder registry for patients and regulates medical marijuana dispensaries, processors and grow sites. The program ensures compassionate and responsible access to medical marijuana products. This includes the timely review of cardholder registry applications and maintaining and ensuring patient

confidentiality. The program also regulates medical marijuana facilities that include dispensaries, growers, and processors through its compliance and enforcement unit ensuring compliance with the OMMA and administrative rules. Compliance with the requirements set forth in the OMMA also include the administration of a database for registering patients, growers and facilities and for reporting and tracking medical marijuana products.

Health Care Regulatory and Quality Improvement (HCRQI) regulates an array of health facilities and providers. The Health Facility Licensing and Certification program licenses and certifies all health care facilities, providers and suppliers in acute care and community-based programs. These include hospitals, home health agencies, in-home care agencies, hospice programs, ambulatory surgical centers, rural health clinics, special inpatient care facilities, kidney dialysis facilities, birthing centers, rehabilitation agencies and clinics, comprehensive outpatient rehabilitation facilities, community mental health centers, hemodialysis technicians, and portable x-ray suppliers.

The Emergency Medical Services and Trauma Systems (EMS/TS) program ensures the effectiveness and coordination of the state's emergency 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 victims of 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 qualification, conducts examinations, inspects thousands of licensed facilities and independent contractors, responds to and investigates consumer complaints, and disciplines licensees who are found in violation of state requirements.

Programs in the Center for Health Protection are engaged in or working toward the following health equity and inclusion strategies:

- Increasing cultural competency assessment among staff and advisory board members
- Increasing workforce diversity efforts

- Expanding funding assistance to underserved and economically disadvantaged communities for safe drinking water system construction projects
- Reviewing regulatory and complaint procedures to address discrimination issues
- Collecting and reporting data disaggregated by race, ethnicity, language and disability (REAL+D)
- Conducting health equity impact analyses on new and existing efforts

Any additional important background. Include trends in caseload, workload or other external factors that may influence the operation of the program

The majority of the Center for Health Protection programs are grounded in the principles of population-based public health, providing services and oversight for all Oregonians.

Radiation Protection Services licenses or registers 13,350 sources of radiation statewide. It inspects those radiation sources in more than 4,300 facilities including hospitals, dental and medical clinics, radiation oncology clinics, tanning salons, high tech manufacturing firms, academic and research facilities, paper and pulp processing plants, foundries, and mineral extraction facilities. These facilities are located across all 36 counties and are inspected on a routine basis.

Drinking Water Services regulates more than 3,400 public water systems statewide, which serve drinking water to more than 4 million Oregonians and our visitors. The section certifies 1,700 public water system operators, and 1,500 backflow device testers and specialists. Contracts with county health departments and the Oregon Department of Agriculture help facilitate the inspections of these public water systems.

Environmental Public Health (EPH) protects Oregon communities from health risks in the environment and is the state's primary point of scientific and technical expertise on health concerns pertaining to the built and natural environments. Every day we encounter chemicals, physical agents, and other substances in the air, water, soil and even the food we eat. During 2015-2017 the program has been heavily engaged with the Oregon Department of Environmental Quality in the Governor's "Cleaner

Air Oregon" initiative. Recent concerns about air quality have significantly increased the section's workload. This increased workload includes many types of activities including assessment, risk communication and the engagement of diverse communities. The section is organized into regulatory, assessment and surveillance units.

EPH's primary regulatory program is Food, Pool and Lodging Health and Safety which provides leadership for local health departments to ensure safety for more than 20,000 full-service and temporary restaurants, public pools and tourist accommodations. Other programs regulate clandestine drug lab clean-up (2,100 cleaned up since 1990), and lead-based paint-related activities. This unit also includes the newly developed Toxic-Free Kids program which regulates hazardous chemical reporting by manufacturers of children's products.

The assessment programs evaluate areas of environmental concern including emissions from industrial facilities, contamination from hazardous wastes sites, brownfield (former industrial land that may be contaminated) redevelopment plans, transportation and land use plans, hazards related to climate change, harmful algae blooms, and fish consumption to ensure impacts to public health are included in action plans. Assessments and stakeholder engagement activities take into consideration the fact that some communities face greater and more environmental risks or are more vulnerable to these risks and make recommendations to address environmental health inequities.

The surveillance programs monitor data on environmental hazards and potentially related health outcomes to provide Oregonians access to data and information related to lead poisoning, radon, pesticide exposures, occupational health, domestic well safety, beach safety, and other environmental health concerns.

Oregon Medical Marijuana Program (OMMP) serves patients statewide. The number of medical marijuana cardholders has grown continually since the program's inception in 1998. To date, approximately 72,801 patients, 31,483 caregivers, and 43,291 growers are registered with the program. This program allows Oregonians suffering from debilitating medical conditions to access medical marijuana without fear of civil or criminal penalties. In addition, HB 3400, passed during the 2015 legislative session, greatly expanded the program by including the medical marijuana dispensary registration program, adding a

registration program for medical marijuana processors, and directing the program to create a database for the tracking and reporting of medical marijuana products throughout the state. In the summer of 2016 there were 423 registered dispensaries and over 178 applications for registered processing sites. However, the Oregon Liquor Control Commission (OLCC) assumed licensure of retail dispensaries in the fall of 2016, and it is presently unknown how many registered dispensaries, processors and growers will opt to be licensed by OLCC to participate in the retail market. While the cardholder program is expected to remain flat, it is anticipated that fee revenue from OMMP-registered facilities will decrease significantly in 2017.

Health Care Regulatory and Quality Improvement (HCRQI*)* oversees an array of health facilities, providers, the Health Facilities Planning and Safety program, and the Certificate of Need program.

The Health Facility Licensing and Certification program licenses approximately 88 ambulatory surgical centers, 15 birthing centers, 67 dialysis facilities, 683 hemodialysis technicians, 77 home health agencies, 61 hospice agencies, 65 hospitals, 146 in-home care agencies, 63 rural health clinics, six special inpatient care facilities and 44 designated trauma hospitals.

The Health Facilities Planning and Safety program works to ensure that newly constructed facilities provide safe, adequate care and lodging, minimize the need for costly changes and delays, correct deficiencies in newly constructed facilities and promote cost containment. The Certificate of Need program evaluates whether a proposed service or facility is actually needed, and works to control the rapidly escalating costs of health care through planning and regulation.

Emergency Medical Services and Trauma Systems (EMS/TS) program licenses approximately 12,500 emergency medical services providers (EMSPs): 2,131 EMRs, 5,152 EMTs, 821 EMT-intermediate, 104 advanced EMTs and 3,754 paramedics. The program also licenses 133 ambulance service agencies and 691 ambulances. It also certifies all EMT training courses and provides training services to nearly 200 rural and frontier communities through our mobile training unit.

HCRQI also serves as the pass-through entity for the authorized $1.95 million General Fund to support the Early Discussion & Resolution program at the Oregon Patient Safety Commission.

Health Licensing Office (HLO) works with 14 boards, councils and programs including the boards of: Athletic Trainers; Cosmetology; Denture Technology; Respiratory Therapy; Environmental Health Specialists; Hearing Aid Specialists; Direct Entry Midwifery; Sex Offender Treatment; Nursing Home Administrators; Licensed Dietitians; Body Art Practitioners; Behavior Analysis, and Music Therapy. In 2015 HLO administered 7,789 examinations, issued 6,776 licenses and registrations, renewed 42,549 licenses and registrations, conducted 9,648 inspections, investigated 317 complaints and monitored 5,173 facilities and 39,077 licensees.

Revenue sources and proposed revenue changes

The 2017-2019 Center for Health Protection budget comprises 64% Other Funds, primarily in the form of fees for services, 29% Federal Funds, and 7% state General Funds. Funding for each program is described below.

Radiation Protection Services receives funding from three fee-based regulatory programs. They are the X-Ray Machine Program, Radioactive Material Licensing Program and the Tanning Device Program. All three collect fees by licensing or registering devices which produce or contain radiation sources. Gross fees total approximately $4.3 million per biennium. Individual or business entities that own these devices pay the fees.

Drinking Water Services receives funding from multiple sources. This section has two federal grants from the Environmental Protection Agency (EPA). They are the Water Primacy grant and the Drinking Water State Revolving Fund grant. Combined gross revenues per biennium total over $28 million. Approximately 72 percent of those funds are transferred to other state agencies or counties. Most of that transferred funding supports the Oregon Safe Drinking Water Revolving Fund, which helps communities pay for safe drinking water infrastructure construction projects. This section also has four fee-based programs. They are Backflow Tester/Specialist Certification, Water System Operator Certification, Water System Inspections and Water System Plan Review. These programs combined generate approximately $2 million per biennium. Certification fees are paid by individuals seeking certification, and inspection and plan review fees are paid by public water suppliers. The Drinking Water

Services section also receives about $4.4 million per biennium from the Oregon Medical Marijuana Program in lieu of General Funds. These fees and other funds also provide the required state match for the EPA grants.

Environmental Health Protection receives funding through a variety of sources including federal grant dollars, fees, and funding through intergovernmental agreements with state and county partners. The section also receives a small amount of General Funds to help support its assessment and surveillance efforts, and to support the establishment of the Toxic Free Kids Act (TFKA) Program authorized in SB 478 during the 2015 legislative session. The TFKA also included fee authority for some requirements within the Act. The Governor's Budget includes Policy Option Package 409, which requests ratification of fees established January 2017 through Oregon Administrative Rule. The Governor's Budget also includes Policy Option Package 401, which will support the work associated with the Governor's Cleaner Air Oregon initiative. Cleaner Air Oregon is a new program announced by the Governor to overhaul industrial air toxics regulation in Oregon. This effort is being led by the Public Health Division and the Oregon Department of Environmental Quality. The policy option package would provide funding to support the work in this new program.

Other Funds revenue is received through intergovernmental agreements with county health authorities to support foodborne illness, public pool, and tourist facility health and safety activities. The Pesticide Exposure Safety and Tracking Program is funded with an intergovernmental agreement with Oregon Department of Agriculture, and the Brownfield Program receives its funding through Business Oregon. Fee-based revenue supports the Clandestine Drug Lab Program and some lead-based paint activities.

The section receives Federal Funds revenue from the Centers for Disease Control and Prevention grants for Climate and Health, Environmental Public Health Tracking, Domestic Well Safety, and Childhood Lead Poisoning Prevention; the National Institute for Occupational Safety and Health grant for Occupational Public Health; Agency for Toxic Substances and Disease Registry grant for Environmental Health Assessment; and Environmental Protection Agency grants for Radon Monitoring, Beach Monitoring, and Childhood Lead Monitoring and Lead Based Paint Monitoring.

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. Biennial revenues are approximately $25 million. Approximately $16 million of those revenues is transferred to other Public Health programs that include State Support for Local Public Health Departments, Safe Drinking Water Program, Emergency Medical Services, School Based Health Centers, Contraceptive Care, and WIC Farmers Market. However, program fee revenues may be reduced significantly during the 2015-2017 biennium and future biennia as a result of registered medical dispensaries, processors and growers opting to be licensed by OLCC to participate in the retail market.

Health Care Regulation and Quality Improvement section receives federal funding from the Centers for Medicare and Medicaid Services to perform health facility surveys and certification. The section also has a number of regulatory responsibilities supported by fees. The Health Facility Licensing and Certification program funding sources include: certificate of need, hospital and health facility plan review, ambulatory surgery centers, birthing centers, dialysis facilities, hemodialysis technicians, home health agencies, hospice, caregiver registries, in home care agencies. The Governor's Budget includes Policy Option Package 409 to raise fees for hospice, in-home care agencies and health facility plan review services to support program current service levels.

Emergency Medical Services and Trauma Systems (EMS/TS) program receives federal funding from the Health Resources & Services Administration to administer the Oregon EMS for children program. In addition to federal funds, EMS/TS has four primary funding sources. Fees support the licensing and oversight of emergency medical services providers and ambulance services. EMS/TS also receives about $3.1 million per biennium from the Oregon Medical Marijuana Program in lieu of General Funds and ORS 137 directs roughly $331,000 per biennium from the Criminal Fines and Assessment Account.

During the 2015 legislative session SB 469 established the Hospital Nurse Staffing law and authorized General Funds to support this measure. The section also receives $1.95 million General Funds as a pass-through to support the Oregon Patient Safety Commission's Early Discussion and Resolution program.

The Health Licensing Office (HLO) collects fees for applications, examinations, issuance of license/registration, renewals of license/registration, disciplinary actions and other administrative fees. Each board, council and program has its own fees, which are used to cover administrative costs for it and HLO. They collect more than $7 million in fees, which continues to increase as new boards, programs or license types are added to HLO.

Proposed new laws that apply to the program unit

The center is funded almost entirely through fees and continuing federal grants. During 2015-2017, several fees have been established or adjusted. The fee establishment and adjustments were reviewed and approved by the Legislature during the 2015 and 2016 sessions. These include: Fee establishment and adjustments for the Oregon Medical Marijuana Program (HB 3400, 2015 session) fee adjustments for Drinking Water Services fees for water system operators, back flow testers, water system construction plan review, and water system inspection; and fee adjustment for the Lead Based Paint accredited training providers (SB 5526, 2015 session). The center is proposing one legislative concept for 2017 that would increase licensing fees for hospice and in-home care to support the current service level.

Potential changes in the laws legalizing the use of marijuana could have significant impact on funds that come from the Oregon Medical Marijuana Program, which support core public health programs. The passage of SB 1511 during the 2016 session allows for the sale, production and processing of medical marijuana to be licensed and regulated by the Oregon Liquor Control Commission (OLCC). It is unknown at this time how many registered facilities will remain with OHA. This could significantly reduce or eliminate roughly $16 million in Oregon medical marijuana registration fees that are legislatively directed to fund core public health services. Registered medical marijuana dispensaries, processors and growers that opt to be licensed by OLCC to participate in the retail market could reduce OMMP fee revenue significantly during the 2015-2017 biennium.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Center for Prevention and Health Promotion

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

	General	Other NL	Other/Lottery	Federal NL	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 19.4	$ 40.0	$ 38.6	$ 102.7	$ 144.1	$ 344.8	217	208.02
Governor's Budget 17-19	$ 20.0	$ 40.0	$ 41.6	$ 102.7	$ 149.5	$ 353.9	202	198.83
Difference	$ 0.7	$ -	$ 3.0	$ (0.0)	$ 5.4	$ 9.1	(15)	(9)
Percent Change	3%	0%	8%	0%	4%	3%	-7%	-4%

The Governor's Budget of $353.9 continues funding for the Center for Prevention and Health Promotion programs at the current service level for 2017-2019. This request includes Policy Option Package 501 for $4,515,635 to improve the lifelong health of all Oregonians.

Activities, programs and issues in the program unit base budget

The Center for Prevention and Health Promotion's mission is to help Oregon's communities and residents to achieve and sustain lifelong health, wellness and safety through partnership, science and policy. The center has five sections that primarily address these health issues:

- Prevention of risks leading to lifelong and costly chronic diseases

- Provision of adequate nutrition and access to healthy foods
- Child developmental delays
- Oral health across the lifespan
- Injuries, toxic stress, violence and unsafe relationships
- Physical and behavioral problems

The center promotes policy and system changes that lead to reduction of risks, such as:

- Reducing tobacco use
- Increasing access to healthy food, healthy eating and physical activity for all Oregonians
- Reducing risky prescribing of opioids
- Increasing stability and safety in families
- Increasing access to healthy options
- Decreasing health disparities

In collaboration with stakeholders and partners across Oregon, the center invests resources to address health problems and inequities statewide. It does this via data- and analysis-driven changes in policy and systems. Those partners and stakeholders include:

- Local public health departments and mental health providers
- Primary health care providers and health systems
- Early child care, early learning, primary and secondary education systems
- Dental care systems
- Health care systems
- Diverse community-based organizations
- Aging services
- Land use and transportation agencies

- Emergency medical providers
- Law enforcement
- Tribes
- Academic institutions
- Employers
- Parents and youth

The center is engaged in numerous health equity and inclusion strategies as reflected in Oregon's State Health Improvement Plan (SHIP). These target various health disparities across the numerous SHIP strategic objectives including tobacco use, secondhand smoke, access to healthy foods, physical activity, breastfeeding, participation in the Diabetes Prevention Program, access to recreational opportunities, weight management and chronic disease self-management, alcohol consumption, opioid overdose, oral health, and suicide prevention. In addition, the center is leading an effort to build health equity capacity within the division to include:

- Recruiting and developing a division-wide health equity committee charged with adopting a comprehensive health equity conceptual framework designed to foster a deeper understanding of how the social determinants of health influence health disparities and inequities;
- Revisiting previous health equity planning and identifying gaps;
- Consulting and collaborating with the OHA Office of Equity and Inclusion, regional health equity coalitions, and affected communities and populations regarding comprehensive health equity planning and development;
- Assessing our ability to identify inequities in communities, identifying ways to increase data collection capacity to include collection around REALD (race, ethnicity, language and disability) and highlighting the most striking inequities and communicating those through clear, consistent and widespread messages to decision-makers, affected communities, partners, and the general public;
- Examining data on social determinants of health (SDOH) by race, ethnicity and language, place, poverty status, and SDOH indicators such as housing, transportation, agriculture, labor, and education; selecting, designing, implementing

and evaluating additional health equity strategies for the SHIP and applying equity impact assessments to all proposed strategies to determine their likelihood of effectively impacting targeted disparities;
- Building PHD organizational structures, policies and supports to promote health equity, diversity, workforce development and cultural responsiveness;
- Examining the state's Health in All Policies and Health Impact Assessment approaches to determine how our current work to address SDOH might be strengthened to increase collective impact; and
- Facilitating and promoting multi-sector leadership teams, coalitions and community engagement across the state to promote targeted strategies.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Adolescent, Genetics and Reproductive Health promotes health, well-being and quality of life for all Oregonians 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. More specifically, the section:

- Monitors the health status of adolescents, showing data by race and ethnicity, sex, gender identity, sexual orientation and geographic location
- Promotes the adoption of evidence-based programs and practices that support positive youth development
- Develops public health systems and public-private partnerships that provide high-quality guidelines-based preventive health services for adolescents, women of reproductive age and individuals at high risk from genetic conditions, and
- Through the school-based health centers (SBHCs), family planning clinics, and the Breast and Cervical Cancer program, provides access to underserved populations, targets disparities and collectively serves more than 125,000 adolescents and adults each year.

Health Promotion and Chronic Disease Prevention (HPCDP*)* works to help people eat better, move more, live tobacco-free, and take care of themselves. HPCDP does this by:

- Analyzing and monitoring the occurrence of chronic diseases and their risk factors by demographic characteristics such as gender, race, ethnicity, geography, income, disability, education, age, etc. and
- Developing and administering programs and promoting policies to prevent chronic diseases and associated risk factors

Chronic diseases include asthma, arthritis, cancer, diabetes, heart disease and stroke. Risk factors for chronic conditions include tobacco use, alcohol and drug misuse, physical inactivity, and poor nutrition. Examples of HPCDP's strategies to prevent and manage chronic disease include:

- Funding for local public health authorities, tribes, regional health equity coalitions and coordinated care organizations to work on evidence-based tobacco cessation and community-based strategies to address the CCO tobacco incentive metric, and implement the new Health Evidence Review Commission's required tobacco cessation benefits
- Implementing a marijuana prevention media campaign to prevent or delay initiation of marijuana use among Oregonians ages 12-20
- Funding for local public health authorities, tribes, and other diverse communities to collaborate on local approaches to reduce tobacco use, alcohol and drug misuse, and increase access to healthy eating and physical activity

Injury Prevention and Violence Prevention (IVPP) works with people to help prevent injuries and deaths due to violence, suicide, prescription drugs, senior falls, motor vehicle crashes, child maltreatment, and unintentional injuries. Some of IVPP's strategies include:

- Providing the Web-based Prescription Drug Monitoring Program, which serves 13,000 prescribers and pharmacists to inform clinical practice
- Establishing opioid prescribing guidelines and working within health systems and CCOs to use them to will improve patient safety, reduce incidence of opioid use disorder, and reduce unintentional prescription opioid overdose

- Working with the judicial system and the alcohol treatment system to increase the use of interlock systems in the motor vehicles of persons convicted of driving under the influence of alcohol
- Working with diverse communities, tribal health service hospitals, health care and behavioral health care agencies to establish zero-suicide initiatives to reduce suicide
- Development with partners of an EPIC software module for assessment of senior fall risk that is being adopted in Oregon and nationwide through EPIC;
- Improving patient care and care coordination with regard to opioid prescription with implementation of HB 4124 (2015) which modifies the Prescription Drug Monitoring Program (PDMP) to allow authorized practitioners or pharmacists to access PDMP information through a health information technology system when certain criteria are met, and allowing pharmacists and other specific health professionals to prescribe and dispense one-dose naloxone to individuals or family members who have completed training.

Additionally, IVPP manages the Oregon Emergency Medical Services data system, the Oregon Trauma Registry, and the Oregon Violent Death Reporting System. These systems and other administrative data are used to track key information on the health status of Oregonians and provide information to inform policy and improve practices in the community and within institutions

Maternal and Child Health (MCH) promotes health across the lifespan of individuals and families by investing in preconception, pregnancy and early childhood health. Its programs address perinatal health (before, during and after pregnancy), infant and child health, newborn hearing screening, home visiting, oral health and family violence prevention. Through partnerships with local public health, other state agencies, and health care and early learning providers, MCH serves Oregon's population in general, as well as those most vulnerable to poor health outcomes (safety net). To better understand and identify changing problems and population needs, the program monitors the health of Oregon's pregnant women and families with toddlers through the Pregnancy Risk Assessment and Monitoring System (PRAMS, PRAMS 2); and monitors the state of oral health through the Oregon Oral Health Surveillance System. The program manages data systems for infant hearing screenings, the home visiting system and its programs, and statewide oral health, showing data by race and ethnicity.

MCH is the home of Oregon's Title V program. This program supports state and local initiatives across six population domains that focus on well-women care, breastfeeding, child physical activity, adolescent well visits, medical home, transition into adulthood, oral health, smoking cessation and reduced exposure for children, toxic stress, and trauma, food insecurity, and culturally and linguistically responsive services. Title V supports the following activities:

- Assessment and monitoring of MCH health needs and disparities
- Policy and program development
- Workforce development
- Program assurance through technical assistance and oversight
- Coordination with state agencies and community partners
- Systems development to better address the needs of Oregon's MCH population, including children and youth with special health needs
- Statewide health promotion activities

Nutrition and Health Screening (NHS) The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) safeguards the health of low-income women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating and referrals to health care. The Oregon Farm Direct Nutrition Program (FDNP) provides WIC families and low income seniors with FDNP checks once a year to purchase fresh, locally-grown fruits, vegetables and cut herbs directly from local farmers. The program services are delivered through public health and non-profit programs. They focus on:

- Maternal and child growth and health
- Breastfeeding education and support, including peer-to-peer breastfeeding support through the WIC Breastfeeding Peer Counseling Program
- Nutrition and physical activity
- Promotion of a healthy lifestyle and prevention of chronic diseases including obesity

- Culturally and linguistically appropriate services and materials

The program also influences the larger community food environment by requiring WIC-authorized grocery stores to carry a minimum stock of low-fat milk, whole grains, low-sugar cereals, and produce. The foods available through WIC offer a variety that is culturally appropriate for the wide range of families served. The program collaborates with farmers and farmers markets statewide to provide vouchers for fresh produce for WIC families and low-income seniors. WIC provides critical surveillance data on the maternal and child population by race, and ethnicity and other demographcis, evaluates programs and carries out competitively funded research studies. In 2016 Oregon WIC converted all benefits from paper to an electronic benefit transfer (EBT) system.

NHS program staff provide a variety of training to local paraprofessional staff who deliver WIC services. Annual civil rights training is also provided. The 2016 training focusing on services to Limited English Proficiency participants, and the 2016 statewide training conference will include sessions on cultural competency including focused training on implicit bias.

Revenue sources and proposed revenue changes

The 2017-2019 biennial budget request for the Center for Prevention and Health Promotion is 6% General Fund, 71% Federal Funds and 23% Other Funds.

General Fund for Center for Prevention and Health Promotion include funding for the School Based Health Centers (SBHCs) program and the Oregon Contraceptive Care program (Family Planning Waiver program). Additionally during the 2015 session several measures were passed that included General Fund for specific activities. SB 698 provided General Funds for a state school nurse consultant, SB 5507 provided increased parity of funding to SBHCs and three new SBHCs, SB 606 provided funding for the Dental Pilot Program, and SB 660 provided funding for the training, certification and monitoring of school-based dental sealant programs.

Federal Funds for the center include funding under the Centers for Disease Control and Prevention grants for Core Injury Prevention, National Violent Death Reporting System, Prevention for States Prescription Drug Overdose Prevention; the Substance Abuse and Mental Health Services Administration (SAMHSA) grants for Youth Suicide Prevention and Early Intervention and State Prevention Framework for Preventing Prescription Drugs; U.S. Department of Agriculture WIC Nutritional and Health Screening Program; Health Resources and Services Administration (HRSA) for Maternal and Child Health Title V and Home Visiting programs; and the Medicaid Title XIX entitlement supporting the Oregon Contraceptive Care program (Family Planning Waiver program) which provides a 9:1 Medicaid match through the Centers for Medicare and Medicaid Services.

Other Funds revenue for the center include statutorily dedicated funds under the Tobacco Use Reduction Account (TURA) and Tobacco Master Settlement Agreement revenue for tobacco prevention and cessation. The Governor's Budget includes Policy Option Package 501, which increases revenues available for tobacco prevention and includes a strategy to reduce tobacco use among youth and other vulnerable populations by raising the price of a pack of cigarettes by 85 cents. Center Other Funds revenue also includes beer and wine tax revenues for substance abuse prevention; and revenues from the Oregon Medical Marijuana Program that helps support the Oregon Contraceptive Care Program (family planning) and the School Based Health Center programs. Additionally, HB 4014 (2016) authorizes use marijuana revenues from the Oregon Liquor Control Commission to pilot a youth marijuana prevention campaign.

The center is primarily funded through competitive federal grants. Federal grant award amounts continue to remain flat or decline through 2015-2017 and are expected to continue this trend during 2017-2019. The center will need to adjust program service levels accordingly. During 2017-2019, the center also will see some continued changes in funding levels and program services as a result of health system transformation.

Proposed new laws that apply to the program unit

The programs in the Center for Prevention and Health Promotion are accountable for federal laws and regulations that govern the federal funding resources implemented through the Center.

The program unit is proposing a legislative concept for 2017 to require ambulances and emergency medical services providers to report electronic patient care data to the state emergency medical services data system. In addition, this concept requires trauma centers to report a discrete set of patient disposition information back to the transport agencies that provided emergency medical services. The automation of the electronic patient information will improve efficiency and save time for both hospital staff and transport staff while creating a seamless record of patient care from the time of a call for emergency services to discharge from the hospital. These disaggregated data are used for quality improvement, research and public health practice.

OREGON HEALTH AUTHORITY: PUBLIC HEALTH DIVISION

Program Unit Narrative: Center for Public Health Practice

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

	General	Other/Lottery	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	$ 14.0	$ 96.3	$ 89.3	$ 199.7	290	284.04
Governor's Budget 17-19	$ 13.1	$ 98.3	$ 89.5	$ 201.0	289	198.83
Difference	$ (0.9)	$ 2.0	$ 0.2	$ 1.3	-1.00	-85.21
Percent Change	-6%	2%	0%	1%	0%	-30%

The Governor's Budget of $201.0 continues funding for the Center for Public Health Practice programs at the current service level for 2017-2019. This request includes Policy Option Package 409 for $27,587 to improve the lifelong health of all Oregonians.

Activities, programs and issues in the program unit base budget

The Center for Public Health Practice protects the health of individuals and communities through the prevention and control of infectious diseases, provision of integrated care and treatment for persons living with HIV, issuing Oregon vital records, monitoring population health, and ensuring emergency public health services in natural and human-caused disasters. The center's programs are the essential services in the state public health's Continuity of Operations Plan.
The center has six sections:

- Center for Health Statistics, also known as vital records – birth, death and marriage certificates

- Acute and Communicable Disease Prevention
- Oregon State Public Health Laboratory
- HIV, Sexually Transmitted Diseases and Tuberculosis Prevention,
- Immunizations
- The federally-funded programs for Health Security, Preparedness and Response

In collaboration with stakeholders, the center invests resources to reduce the burden of disease and health inequities across the state. The center's programs work with local and tribal governments, a wide range of community partners, health care providers, and affected communities to prevent, investigate and control infectious diseases. It coordinates interventions to control disease outbreaks. It also screens all newborn infants for biochemical disorders to prevent disability or death, and collects and analyzes vital record data needed to understand and plan for health trends. As part of public health emergency preparedness, the center also conducts testing for biological agents of mass destruction (e.g., anthrax, plague) and emerging public health events and diseases (e.g., wildfires, Zika, Ebola).

The Center for Public Health Practice delivers the core public health services necessary to maintain a healthy population and to recover from disasters. Preventable disease vaccine programs ensure that children are healthy enough to attend school regularly and learn successfully. Its interventions for influenza and foodborne disease outbreaks (e.g., salmonella, hepatitis, norovirus) allow parents to attend work and sustain a healthy economy. Its HSPR programs coordinate the surge capacity of hospitals and public health agencies to respond in health emergencies (e.g., floods, wildfires, pandemics and earthquakes). The center's HIV program works with clients and their local providers to ensure that persons with HIV take the medicines they need to render them non-infectious and control the spread of HIV. The center's services are delivered every day of every week throughout the year. Duty officers are on call 24/7 at the public health lab, Acute and Communicable Disease program and Health Security, Preparedness and Response program.

Programs in the Center for Public Health Practice are engaged or working toward the following health equity and inclusion strategies:

- Increasing cultural competency assessment among staff
- Increasing workforce diversity efforts
- Conducting health equity impact analyses on new and existing efforts

Additional program specific strategies are identified in section narratives.

Any additional important background. Include trends in caseload, workload or other external factors that may influence the operation of the program

Below are highlighted activities among the Center for Public Health Practice programs:

Center for Health Statistics, also known as Vital Records, is responsible for registering, certifying, amending, and issuing Oregon vital records, including:

- Maintaining approximately 6 million vital records for birth, death, marriage, divorce, fetal death
- Registering 132,000 vital events that occur in Oregon annually
- Issuing 167,000 certified copies of records and 40,000 amendments annually

Acute and Communicable Disease Prevention (ACDP) section works with Oregon's local health departments, tribal health jurisdictions, health care providers, and community members to identify diseases, collect case information, identify risk factors and means of transmission, protect exposed individuals, and stem community transmission.

ACDP works to identify and prevent the spread of communicable diseases such as salmonellosis, *E. coli* O157 infection, meningococcal disease, influenza, hepatitis, and antibiotic-resistant bacteria. These diseases, which cause significant illness and death, often disproportionately affect people of color, people with limited English proficiency, people with disabilities; and the people in the lesbian, gay, bisexual, transgender and queer communities. ACDP works with all stakeholders to reduce disease transmission through various pathways including food, water, animals, insects, human contact, and in health care.

The Oregon State Public Health Laboratory comprises three sections: Communicable Disease Testing, Newborn Screening, and Laboratory Compliance. The laboratory performs 11.2 million tests on 400,000 human specimens annually, including newborn screening of all infants born in Oregon, Alaska, Idaho, New Mexico and Hawaii. The lab's specimens come from 34 local health departments and 68 hospital and clinical labs in Oregon, as well as 3,000 individual medical practitioners in the region. The Laboratory Compliance section oversees certification of clinical laboratories and accredits environmental laboratories that monitor the safety of drinking water, and is responsible for accrediting cannabis laboratories in Oregon. The OSPHL is also responsible for emergency laboratory response to biological and chemical threats throughout Oregon. The lab supports the OHA mission through the following statewide and multi-state activities:

- Medical laboratory tests for state and local health department communicable disease control programs for purposes of disease diagnosis, prevention, surveillance, and treatment
- Tests for food, water and other environmental samples for evidence of microbial contamination
- Providing 2 million tests annually of 287,000 newborn babies for genetic disorders of body chemistry that can cause severe mental retardation or death if undetected
- Providing highly specialized reference tests that are unavailable elsewhere, especially for diseases of public health significance (rabies, anthrax, botulism, tuberculosis, *E. coli* serotyping, Zika and newly identified pathogens)
- Responding to public health emergencies including outbreaks of infectious diseases and bioterrorism
- Ensuring, through regulation, the quality of testing in 3,100 medical, marijuana, environmental, and drug screening laboratories throughout Oregon

HIV, Sexually Transmitted Diseases and Tuberculosis Prevention

The HIV, STD and TB section encompasses:

- HIV care and treatment (CAREAssist and HIV Community Services)
- HIV behavioral surveillance
- HIV/STD prevention
- TB prevention and disaggregated data analysis, which includes the Medical Monitoring Project

The section's client population includes individuals who are already diagnosed with HIV, STDs or TB, as well as individuals at risk. The section specifically targets resources to populations that are disproportionately affected, such as people who inject drugs, men who have sex with men, people of color, immigrants and refugees. Services promote sustainable adherence to medications, improved health outcomes and the elimination of HIV/STD/TB transmission. Funded services include medications and medical services for uninsured or under-insured low income Oregonians diagnosed with HIV/STD/TB; case management, disease intervention and linkage to care; HIV/STD/TB testing services; condom distribution; and disease monitoring and evaluation.

The **Immunization** section works collaboratively with county health departments, immunization providers and local (county) coalitions, which include a diverse range of participants and focus on meeting vaccination needs in vulnerable populations, to reduce the incidence of vaccine-preventable disease in Oregon by:

- Supporting the state's immunization infrastructure
- Identifying and promoting evidence-based public health practices
- Collecting immunization data (available by age, gender, and race) from health care providers to achieve complete and timely immunization of all Oregonians

The program maintains: the ALERT Immunization Information System (IIS); provider services to manage the federal Vaccines for Children (VFC) program; school law; and readiness and epidemiology, which includes serving as a CDC IIS Sentinel Site. Immunization promotes the health of all Oregonians by investing in activities that ensure access for all to vaccines. These efforts include the work of the Vaccines for Children program, which provides vaccine at no cost to 52 percent of Oregon's children, who might not otherwise be vaccinated due to inability to pay; support for the Immunize Oregon Coalition, whose work focuses on partnering to ensure vaccine opportunities for underrepresented communities; the use of ALERT immunization information system data to identify pockets of need across gender, race or ethnicity; or our new Equity workgroup which is developing a diversity based internship for a bachelor- or master-level student in hopes of broadening our hiring recruitment pools.

The Health Security, Preparedness and Response (HSPR) section develops public health systems to prepare for and respond to threats and emergencies that affect the health of people in Oregon. HSPR emphasizes cultural responsiveness while working closely with tribal governments, hospitals and health care systems, emergency medical services, law enforcement, fire and local public health authorities to build community resiliency through emergency preparedness planning, training, exercises and coalition building. The 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 disease control. The program works to ensure equitable inclusion of persons with limited English proficiency and other language and access needs in planning activities. Current planning activities address:

- Cascadia Subduction Zone earthquakes
- Emerging infectious diseases such as Zika virus
- Mass casualty response
- Seasonal hazards such as wildfires, floods, heat waves, and drought

HSPR also manages:

- State Emergency Registry of Volunteers in Oregon, with 2,750 licensed health professionals registered and trained to help all communities during a disaster. In 2016 SERV-OR provided free counseling services for 16 weeks in Douglas County in response to the mass shooting at Umpqua Community College.
- AmeriCorps VISTA program, which places new public health professionals in public health and nonprofit agencies for one year of national service in order to build public health capacity and eliminate poverty. HSPR oversees 60 national service volunteers annually.
- Critical public health information platforms such as the Health Alert Network and Hospital Capacity System, which allow 24/7/365 mass communication and situational awareness between public health and health care organizations with the option for hearing-impaired communication.

Revenue sources and proposed revenue changes

The 2017-2019 Center for Public Health Practice budget request is composed of 6 percent state General Fund, 45 percent Federal Funds, and 49 percent Other Funds.

While the center has been successful in writing grants, the majority of funding is categorical, finite and directed toward federal priorities, which do not always align with state-defined priorities. Given that the center's work to protect Oregonians is funded mostly by CDC and HRSA, our staff focus must be on federally prescribed deliverables. The center's programs have responded creatively to state-directed work 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.

Oregon's General Fund revenue accounts for 6% of the overall budget. It is used to pay for staff, supplies and equipment necessary to coordinate and deliver services to Oregonians. The center pays counties to deliver the Vaccines for Children program, using Medicaid matching funds generated by the use of state General Fund.

In the HIV, STD and TB prevention (HST) section, federal funding for HIV care and treatment programs has remained level in recent years; however the CAREAssist program has seen rapid growth in revenue generated as a result of the pharmacy model implemented in 2010-2011. Though the program has seen a large increase in available funding, factors such as restricted use of the funds and staffing limitations have inhibited the program's ability to increase spending, which resulted in a $34.8 million Other Fund carryover balance from the 2013-2015 to 2015-2017 biennium. A proposal is under development to use these available resources to increase program capacity and expand HIV prevention services in order to eliminate HIV transmission in Oregon.

All other programs in the HST section are seeing funding stabilize after several years of consistent funding decreases in federal awards, and anticipate relatively flat funding for the remainder of current project periods.

State funding supports three critical areas for the Immunization section: support for local public health as pass-through dollars to the counties; a maintenance and support contract with Hewlett Packard Enterprise for ALERT immunization information system; and general staff and infrastructure support for the program. Due to the overall growth of ALERT, the maintenance and support contract continues to increase and strains program resources. Increasing CDC requirements attached to the Immunizations cooperative agreement also strain the program's ability to meet requirements while also maintaining our support for Oregon counties.

The Acute and Communicable Disease Prevention section receives about $10 million per biennium from CDC, primarily through the Emerging Infections Program and the Epidemiology and Laboratory Capacity grants. Along with roughly $1 million from State General Fund, these grants support communicable disease monitoring, outbreak investigation, interventions and evaluation activities. The program maintains Orpheus, a statewide case reporting and outbreak information system, as well as ESSENCE, a statewide syndromic surveillance system that monitors all emergency department visits (data available by race and ethnicity via a medical record or using CDC-specified designations). As CDC-required activities and the cost of informatics infrastructure continue to expand, program resources are increasingly stretched. The growth of funding and program activities focus largely on reducing health care-associated infections and antimicrobial-resistant disease strains.

The Oregon State Public Health Laboratory’s biennial budget is approximately $30.5 million, of which 9 percent comes from General Fund, 29 percent comes from federal funds and 62 percent from fees. In the 2013-2015 biennium, the cost of operating OSPHL far outpaced revenues and OSPHL assumed additional responsibilities for accrediting marijuana testing laboratories. Work is underway to amend Oregon Administrative Rules to update the environmental laboratory fee schedule to cover the costs of accrediting marijuana laboratories. Work is also underway to evaluate the costs of providing newborn screening services in Oregon. The current fee structure for Oregon is below the national average, and the program is evaluating whether it can continue this trend. On January 1, 2016, an out-of-state fee increase went into effect. The evaluation will include an analysis of whether a proposal should be taken forward to increase Oregon newborn screening fees to align with out-of-state fees. Communicable disease testing fees also are under review. Communicable disease testing increases access to health care by providing testing regardless of ability to pay or insurance coverage. Primary submitters are local health departments and

community clinics. OSPHL bills for as many tests as possible using the Medicaid fee-for-service fee schedule, but does not recover enough revenue to fund the testing. New laboratory technology is changing the number and types of specimens sent to OSPHL, shifting the workload to OSPHL without corresponding funding to support the testing. OSPHL is also experiencing increased costs associated with maintaining laboratory information systems to support electronic data collection and transmission among local, state and federal partners. The center has contracted with a consulting firm to assess OSPHL business practices and operations in order to recommend a business model that is financially and operationally sustainable. Recommendations were received in October 2016, and are being evaluated by agency leadership

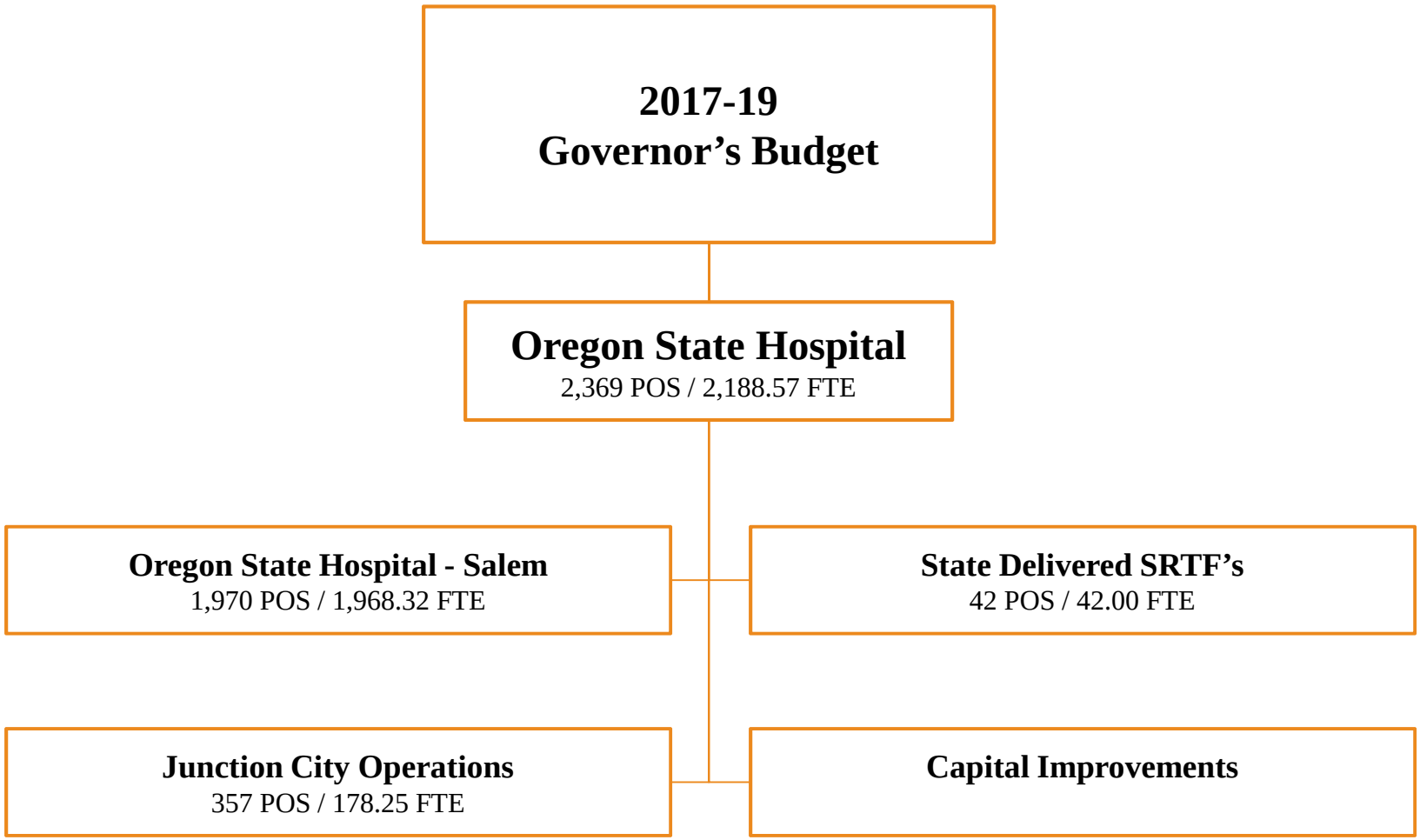
The Center for Health Statistics' budget comprises 84 percent Other Funds, primarily in the form of fees for services and 16 percent federal funds, in the form of deliverable-based contracts for timely and accurate birth and death data. Other funding includes payments from state agencies that use vital records information to conduct their business. Vital records fees were increased on January 1, 2016, to ensure that the program remained solvent throughout the 2015-2017 biennium. Fees from the sale of birth certificates comprises most of the fee revenue. The remaining revenue comes from sales of other types of certificates and extra fees for expedited processing and amendments. Revenue projections for 2015-2017 account for an expected decline in the number of birth certificates sold starting July 1, 2016. After July 1, 2016, persons renewing their driver's license will have already provided evidence of citizenship to DMV and will no longer need to purchase a birth certificate from CHS; thus there will be an expected decline in birth certificate sales.

The Health Security, Preparedness and Response section is funded through two federal grants, Public Health Emergency Preparedness and the Healthcare Preparedness Program. The program's biennial budget is about $22 million, which funds state and local health department preparedness staff and activities, regional health care coalitions, and grants to partners for innovative community planning and response.

Proposed new laws that apply to the program unit

During 2015-2017, fees for environmental laboratory accreditation have been established or adjusted via the SB 333 process in Oregon Administrative Rules. The fee changes are to provide revenues to support the environmental laboratory accreditation program current service level and are included in the Governor's Budget in Policy Option Package 409.

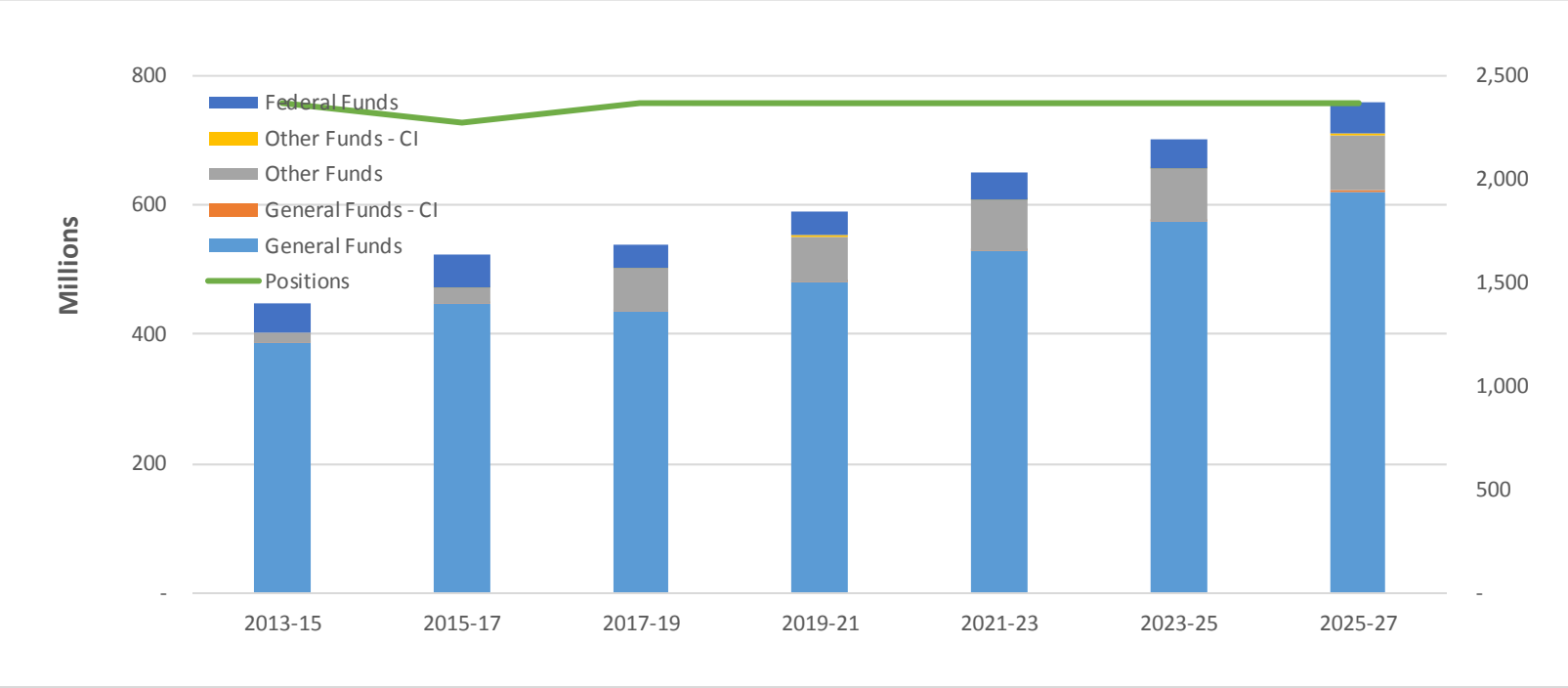
Other than ratification of the fee increases during the 2017 session, no new laws have been proposed that directly affect this program unit.


2017-19
Governor's Budget
Oregon State Hospital
2,369 POS / 2,188.57 FTE
Oregon State Hospital - Salem
1,970 POS / 1,968.32 FTE
State Delivered SRTF's
42 POS / 42.00 FTE
Junction City Operations
357 POS / 178.25 FTE
Capital Improvements

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Executive Summary

Long Term Focus Areas: Safer, Healthier Communities; Excellence in State Government
Primary contact: John Swanson, COO/CFO
503 945-2968



** Inflation factors used for 2019-21, 2021-23, 2023-25 and 2025-27 in the graph above were provided by DAS-CFO.*

Program 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. Services in a secure setting promote public safety by treating people who are dangerous to themselves or others. The hospital works in partnership with the Oregon Health Authority, Health Systems Division (HSD), the Psychiatric Security Review Board (PSRB), regional hospitals, community mental health programs, advocacy groups and other community partners to deliver the right care, at the right time, in the right place.

OSH operates two campuses with the capacity to serve up to 794 Oregonians, with 620 beds in Salem and 174 beds in Junction City. Services are provided 24 hours per day, seven days a week. OSH currently operates 578 beds on the Salem campus and 100 beds in Junction City. Commitment types include:

- **Civil commitment/voluntary by guardian** – People who are dangerous to themselves or others, or who are unable to provide for their basic needs due to their mental illness. A subset of this population includes those who have significant co-occurring medical issues, such as those with dementia, Alzheimer's or traumatic brain injury.
- **Guilty except for insanity** – People who committed a crime related to their mental illness. Depending on the nature of their crime, patients are under the jurisdiction of the PSRB or the State Hospital Review Panel (SHRP).
- **Aid and Assist** – People who have been charged with a crime but are unable to participate in in their trial due to their mental illness. The courts refer them to OSH under Oregon Revised Statute (ORS) 161.370 for "competency restoration" which is treatment that will help them understand the criminal charges against them and assist in their own defense.

Oregon State Hospital's role is to provide services and treatment to individuals that will prepare them to return to the community as soon as they are ready. Services include 24-hour on-site nursing, psychiatric and other credentialed professional staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational and educational services. The hospital is accredited by The Joint Commission on the Accreditation of Health Organizations, and five units are currently certified by the Centers for Medicare & Medicaid Services (CMS). Services are provided by psychiatrists, nurses, and other mental health

professionals. Upon release, people transition to the community with better skills to understand and manage their symptoms, fully participate and live in their local community in a variety of community-based settings, and when able, hold down a job. Management of the overall behavioral health system has a huge impact on the success of OSH. In order to ensure that only people who need hospital-level care are admitted, a robust array of preventive, treatment and crisis services must be available in the community. In addition, to ensure that people can be released from the hospital when they are ready, the community behavioral health system must have sufficient capacity to provide services and supports in a variety of integrated and independent settings to meet each individuals' needs. Any restrictions within the community-hospital continuum can result in a back-up of the behavioral health system which can reach as far as community hospital emergency departments.

Oregon's only state-operated secure residential treatment facility also reports to the superintendent of OSH. The 16-bed facility, called Pendleton Cottage, 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.

Program funding request

For the 2017-2019 biennium, OHA requests the following budget for OSH:

	General	General Cap Impr	Other	Other Cap Impr	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	447,522,215	699,615	23,381,729	699,615	49,800,786	522,103,960	2,268	2,261.90
Governor's Budget	435,847,834	725,501	65,572,453	725,501	34,477,750	537,349,039	2,369	2,188.57
Difference	(11,674,381)	25,886	42,190,724	25,886	(15,323,036)	15,245,079	101	(73.33)
Percent Change	(3%)	4%	180%	4%	(31%)	3%	4%	(3%)

** Federal Fund decrease is primarily a result of the loss of Designated State Health Program (DSHP) funding.*

OHA estimates the following cost for OSH programs through the 2025-2027 Biennium:

BIENNIUM	2017-19	2019-21	2021-23	2023-25	2025-27
General Fund	435,847,834	480,278,834	529,523,703	573,329,408	620,824,056
General Fund - CI	725,501	753,070	783,946	816,872	851,181
Other Funds	65,572,453	70,363,985	75,685,859	80,705,863	86,088,910
Other Funds - CI	725,501	753,070	783,946	816,872	851,181
Federal Funds	34,477,750	37,751,554	41,381,384	44,650,078	48,186,275
Total Funds	537,349,039	589,900,513	648,158,838	700,319,093	756,801,603

Program description

Vision – We are a psychiatric hospital that inspires hope, promotes safety and supports recovery for all.

Mission – Our mission is to provide therapeutic, evidence-based, patient-centered treatment focusing on recovery and community reintegration all in a safe environment.

How we deliver services

Interdisciplinary treatment teams

Each patient is assigned an interdisciplinary treatment (IDT) team. Treatment teams consist of one of each of the following disciplines:

- Nursing
- Psychiatry
- Psychology
- Rehabilitation, including vocational and occupational specialists

- Social work
- Treatment care plan specialists

Patients also are considered members of their own treatment team, as well as designated family members when appropriate. Treatment teams also may include someone from Peer Recovery Services, which comprises staff with lived experience within the behavioral health system, and someone from the patient's community mental health program, which helps provide a continuity of care as patients are admitted and released from the hospital.

Clinical treatment

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. This includes any accommodations for specific cultures, languages, religions, LGBTQ+ status, or disabilities. 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.

Treatment malls

In the same way that a shopping mall offers a variety of retailers in one location, treatment malls offer a variety of group therapy options in one location. Treatment teams determine which groups will help patients meet their treatment goals, needs and interests. Mimicking the work or school-day routines patients will face outside the hospital, patients are offered at least four hours of active treatment on the mall every weekday. The malls also offer less-structured social activities in the evenings and on weekends. Treatment mall groups are designed to help patients learn to manage illness and build the skills they will need to be successful after they are released.

Some examples of treatment mall groups are supported education, art therapy, music therapy, mindfulness (yoga, meditation), peer-delivered services, legal skills, and dual diagnosis (for people who also have a substance use disorder). Many groups focus on community reintegration, such as cooking skills or community volunteering.

Who provides services

Of the 2,369 positions in the Governor's Budget, 73 percent are direct-care staff such as nurses, psychiatrists, psychologists, etc.; 21 percent support the direct-care staff (indirect care) including food services, environment care (housekeeping), and safety and security staff; and the remaining 6 percent are hospital administrative staff. Salaries, taxes and benefits for staff comprise 85 percent of OSH's 2017-2019 Governor's Budget. The number of staff the hospital needs is based on the level of acuity (the severity of symptoms, how much care patients need), commitment type (civil, guilty except for insanity, aid and assist) and agreements between hospital and union leadership. 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. Sufficient staffing is also key to OSH's ability to remain compliant with the United States Department of Justice's (USDOJ's) guidelines for the Civil Rights of Institutionalized Persons Act, specifically those areas related to adequate nursing care, adequate protection from harm, ability to provide adequate mental health care, and appropriate use of seclusion and restraint.

Program justification and link to long term outcomes

OSH's key goals are:

- Excelling in recovery-oriented care and treatment
- Ensuring safety in care environments
- Improving processes and performance
- Recruiting and engaging outstanding staff
- Employing information technology effectively

Program performance

OSH uses Lean methodology as our primary foundation for continuous improvement and organizational performance. Through Lean, OSH has a robust system to align and link all of the services it provides with organizational goals and desired outcomes. OSH also tracks performance metrics throughout each level of the hospital using the **Lean Daily Management System (LDMS)** and the **OSH Performance System**. This framework provides a clear line of sight to ensure the work is achieving the desired outcomes.

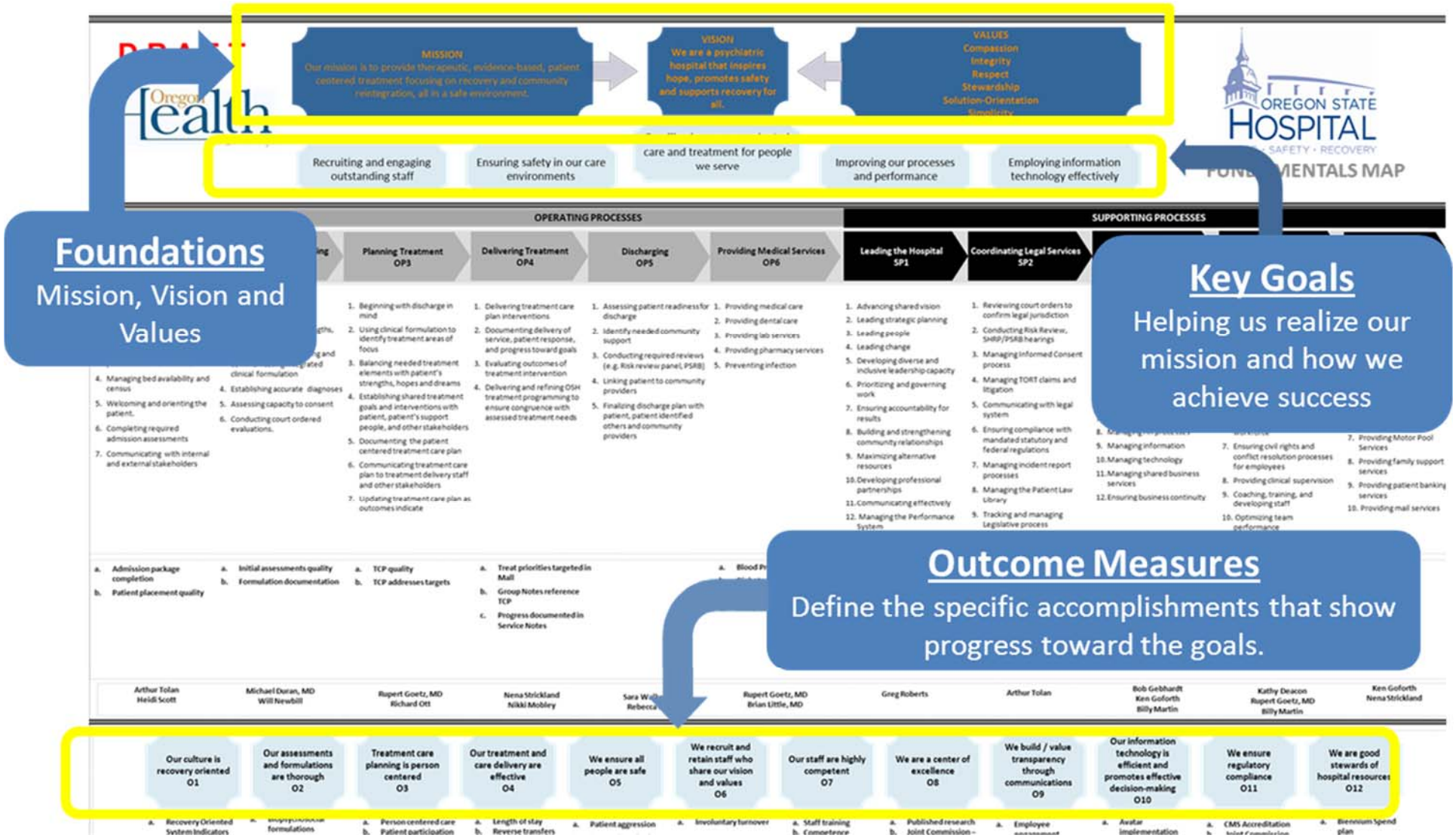
Lean Daily Management System

LDMS is implemented in more than 90 sites throughout the hospital to provide structure for teams to make continuous improvement a part of their everyday work. Work teams track metrics on LDMS boards that are then linked to the OSH Performance System and key organizational goals. LDMS gives each work group a common system for communication, taking action and evaluating results.

Performance System

The OSH Performance System focuses on the hospital's fundamental work processes and desired outcomes, while forcing 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 Performance System works by addressing the two major components of running the hospital. The first component is the fundamentals (all of the routine work and core processes that drive key goals). Because the fundamentals represent 90-95 percent of all resource use and have the greatest opportunity for improving patient outcomes and reducing costs, OSH started with creation of the Fundamentals Map.


MISSION
Our mission is to provide therapeutic, evidence-based, patient centered treatment focusing on recovery and community reintegration, all in a safe environment.
VISION
We are a psychiatric hospital that inspires hope, promotes safety and supports recovery for all.
VALUES
Compassion
Integrity
Respect
Stewardship
Solution-Orientation
Recruiting and engaging outstanding staff
Ensuring safety in our care environments
care and treatment for people we serve
Improving our processes and performance
Employing information technology effectively
OREGON STATE HOSPITAL
Foundations
Mission, Vision and Values
Key Goals
Helping us realize our mission and how we achieve success
OPERATING PROCESSES
SUPPORTING PROCESSES
Planning Treatment OP3
Delivering Treatment OP4
Discharging OP5
Providing Medical Services OP6
Leading the Hospital SP1
Coordinating Legal Services SP2
Outcome Measures
Define the specific accomplishments that show progress toward the goals.
Our culture is recovery oriented O1
Our assessments and formulations are thorough O2
Treatment care planning is person centered O3
Our treatment and care delivery are effective O4
We ensure all people are safe O5
We recruit and retain staff who share our vision and values O6
Our staff are highly competent O7
We are a center of excellence O8
We build / value transparency through communications O9
Our information technology is efficient and promotes effective decision-making O10
We ensure regulatory compliance O11
We are good stewards of hospital resources O12

The second component is the breakthroughs, new competencies and major function improvements in existing work processes (all of the strategic initiatives).

The scorecard monitors the hospital's outcome and process measures from the Fundamentals Map, which show progress toward key goals. In essence, 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
- Wait list times
- Time between placement on the Ready-to-Transition List and discharge
- Staff turnover

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

Participants at QPRs include executive leadership, mid-level management, measure owners, front-line staff and union representatives. Measure owners' present data related to their assigned measure at the QPR. If performance measures are below the desired target (in the red zone of the measure target) the measure owner is required to develop a detailed Measure Action Plan to improve measure performance.

Expanding collaborative problem solving
Collaborative problem solving (CPS) has proven to increase safety for both patients and staff. In 2014, OSH selected CPS as its foundational treatment approach and an alternative to historic approaches of coercion and control. The CPS model provides cutting-edge mental health treatment to the patients, and it has been proven to reduce violence, injuries to both staff and patients, and episodes of patient seclusion and restraint. The CPS model focuses on including the patient as an equal partner in their recovery journey. Patients and CPS treatment providers work together to develop and strengthen the skills required to transition back into the community and avoid re-admission.

OSH has expanded the CPS model from four to ten units, focusing on those with the highest acuity. The results have been very promising. Since the original four units began using CPS in January 2015, patient restraints dropped by 34 percent, patient seclusions dropped by 33 percent, aggression toward staff has dropped by 38 percent and aggression toward other patients has dropped by 15 percent.

Financial Management
OSH has created a robust budget management system to ensure the hospital stays within its Legislatively approved budget, including:

- A comprehensive spend plan comprising 73 cost centers;
- A designated manager is accountable for each cost center;
- Regularly updated and detailed hospital-wide staffing plan; and
- Weekly reviews of actual expenditures, monthly spend projections, and management of requests for hire within the staffing plan.

In addition, the hospital has increased Federal reimbursements by updating cost reports to raise the Medicare reimbursable daily rate from $310.73 to $859.89 and implementing a modern billing system that improves accuracy and expands the hospital's ability to bill for services. OSH is also working with the Centers for Medicare and Medicaid Services (CMS) to increase the number of beds eligible for Medicare funding from 115 to 569.

Enabling legislation/program authorization

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

Funding streams

All OSH programs receive a combination of funds.

State General Fund

Other Funds:

- Medicare
- Third-party insurance
- Private payments
- Local revenue (e.g., wood products, café, coffee shop, safety grant)
- Capital improvement

Federal Funds:

- Medicaid matching funds
- Disproportionate Share Hospital (DSH)

Significant proposed program changes from 2015-2017

Through a Policy Option Package (POP), Oregon State Hospital seeks to reduce the need for state General Fund to operate the hospital by increasing federal and other funding streams through an accurate and robust revenue cycle management plan. The ability to qualify for this increase in federal and other funds will require the use of a portion of this new revenue to invest in improvements to the hospital which will also enhance active restorative treatment of our patients and improve safety and regulatory compliance.

With the recent improvement of OSH facilities, staffing, and management since the arrival of Superintendent Greg Roberts, OSH was able to increase the number of beds eligible for federal and third-party insurance reimbursement for an additional 445 hospital level of care beds. This eligibility will be retroactive to July 1, 2016. Currently, OSH has only 124 of its civil commitment beds are certified. Since 2014, the hospital has also made significant improvements in its infrastructure, staff, and management to more accurately reflect cost of care in reporting and rate setting, and to collect revenues from insurance plans for patients covered under Medicare, Medicaid, and Third Party (Commercial) insurances. To assure and sustain CMS certification, additional investments will be needed in the areas of utilization management, improved safety, improved compliance with CMS regulations, and reduced seclusion and restraint. With the additional 445 hospital beds receiving CMS certification for participation and the improved reimbursement rates achieved, increased federal and other fund revenues are conservatively estimated to increase by $30 – 40 million for 2017-19 and $40-$60 or more in subsequent biennia. Investments in 2017-19 needed to achieve and maintain CMS certification are estimated at $10-$15 million, to come from the new revenues generated, leaving a net General Fund reduction of $20-25 million in 2017-19 and $30-45 million or more in subsequent biennia.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: Salem Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	370,185,560	17,392,990	45,166,222	432,744,772	1,804	1,803.82
Governor's Budget	397,349,705	56,974,827	31,112,443	485,436,975	1,970	1,968.32
Difference	27,164,145	39,581,837	-14,053,779	52,692,203	166	164.50
Percent Change	7%	228%	-31%	12%	9%	9%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

Salem Campus Detail

- Capacity – 24 units, 6 cottages (620 beds)
- Operating – 24 units, 0 cottages (578 beds)
- Populations served – civil commitment (includes voluntary commitments by guardian), neuropsychiatric (high medical need), guilty except for insanity (GEI), aid and assist
- Census – 536 (daily average population for 2016)
- Square feet – 1.3 million
- Position authority – 1,970

Populations Served

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

There are for different commitment types:

- **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.

- **Voluntary by Guardian** – Working through the court system, legal guardians may commit their wards who meet civil commitment criteria: they must pose a danger to themselves or others and/or they must be unable to provide for their own basic needs due to their mental illness.

- **Guilty Except for Insanity (GEI)** – Oregon State Hospital serves patients who have successfully pled Guilty Except for Insanity (GEI) to criminal behavior related to their mental illness. Depending on the nature of their crime, these patients are under the jurisdiction of either the Psychiatric Security Review Board or the Oregon State Hospital Review Panel.

- **Aid & Assist** – Some patients are ordered to Oregon State Hospital by the courts 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.

Treatment Programs
Oregon State Hospital serves patients in the program that best meets their needs. Each program is designed to treat a specific segment of our patient population.

- **Crossroads** – The Crossroads program provides services for people who have been civilly committed or voluntarily committed by a guardian. Patients each have an individual treatment care plan and attend the treatment mall every weekday. Groups help patients learn how to manage their symptoms and medications, develop coping and recreational skills, budget and manage their money, and plan and prepare meals. Community reintegration is the focus of weekly group trips to community settings. Treatment includes educational support, psychotherapy and help for alcohol and drug abuse.

- **Springs** – The Springs program primarily serves patients who have been civilly committed and voluntarily committed by a guardian. These patients experience co-occurring mental and physical illnesses that often require hospital-level care for dementia or organic brain injuries. Springs uses treatments that feature sensory and behavioral therapy. Through these treatments, patients learn daily living, coping and problem-solving skills via group and individual therapy.

- **Archways** – Archways serves people under Aid and Assist court orders. In this program, we help patients stabilize, gain the ability to cooperate with attorneys, understand the charges against them, and participate in their own defense. All patients are enrolled in a legal skills group where they learn basic legal terminology. Other treatment groups and resources include a law library, legal assistance, symptom management, anger management, mindfulness such as tai chi, physical fitness, medication management and drug and alcohol education. During their stay, patients are periodically evaluated to determine if they are able, never able or not yet able to stand trial.

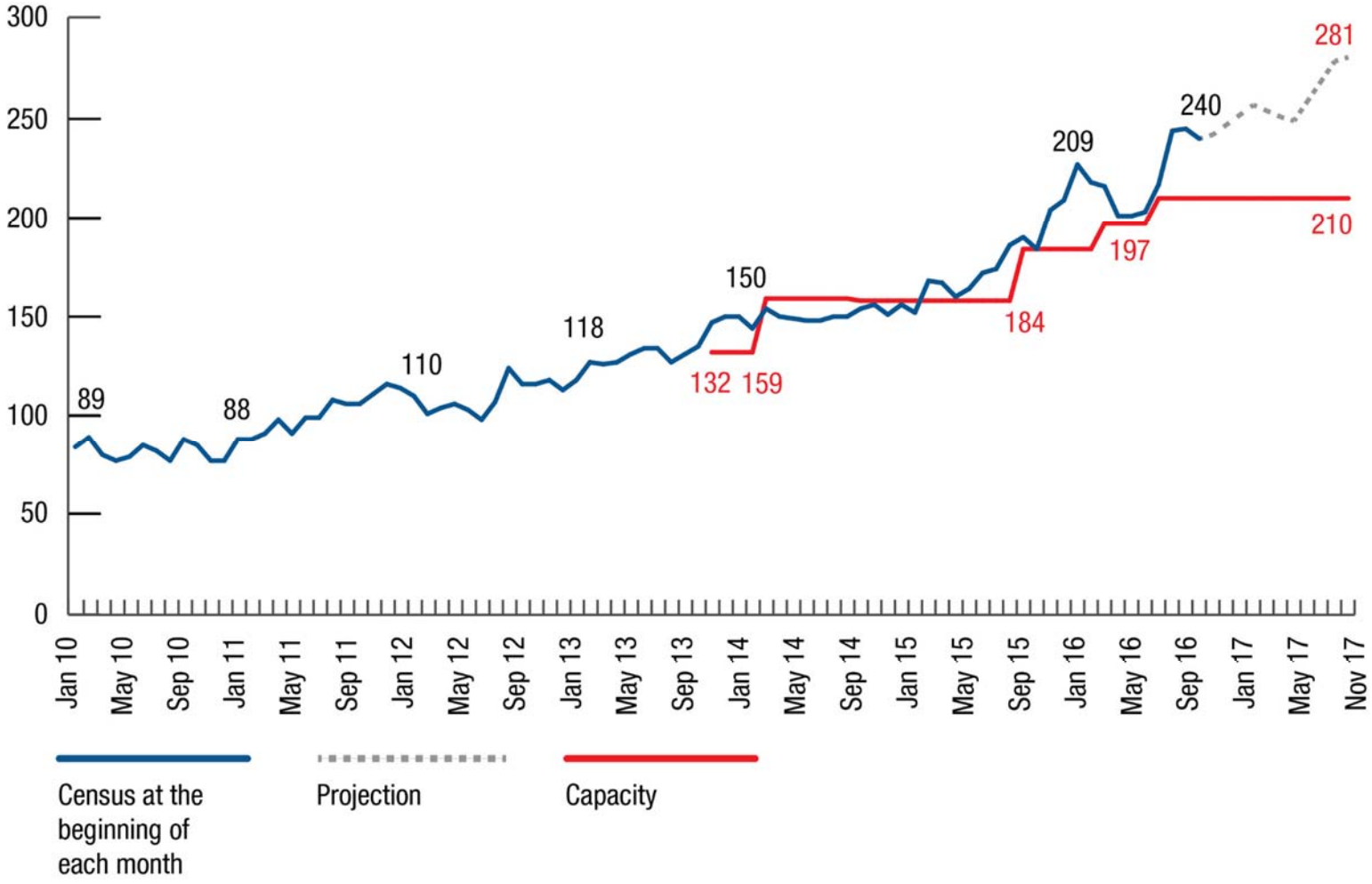
- **Harbors** – The Harbors program primarily serves patients in the Aid & Assist and GEI populations. Patients each have individual treatment care plans and attend the treatment mall every weekday. Groups help patients prepare to return to the community or move to lesser levels of care within the hospital. During their stay, patients learn how to manage their symptoms and medications and they develop coping, recreational and legal skills. Programing may also provide educational and employment assistance, psychotherapy, spiritual care and help for alcohol and drug abuse.

- **Pathways/Bridges** – Patients in our Pathways/Bridges program belong to the GEI population. Pathways serves patients from the Harbors program and have progressed in their recovery. Bridges serves patients who are preparing to transition back to the community. The goal of the transition program is to help patients achieve their highest level of health, safety and independence as they prepare for discharge or conditional release to a less-restrictive community setting. Individuals work on living skills through daily treatment mall activities, classes and approved outings. They also participate in discharge planning with their treatment team members.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Increasing aid and assist population
The number of people sent to OSH to be restored to competency so they can aid and assist in their own defense has grown significantly over the past several years. If this trend continues, OSH will not have sufficient capacity to serve this population without cutting back on services to other populations.

In 2015, the Salem campus converted one unit from serving people who have been civilly committed to serving people under Aid and Assist orders. Then, in April 2016, the Salem campus closed two cottages and used the staff to open its last vacant unit to meet Aid and Assist population demands. The final two cottages closed in December 2016. Even with these additional beds, the Aid and Assist population continues to rise above capacity, and these individuals are housed on units not designed to serve them.



Key to addressing this issue is developing a robust array of community services, including crisis interventions such as mobile crisis teams and assertive community treatment that enable law enforcement and other community partners to connect people with mental health services rather than arrest them. The OHA Health Systems Division (HSD) and OSH are working with community partners to strengthen and expand these services.

Staffing

Adequate staffing is fundamental for safety at OSH. Per Oregon Revised Statute 441.154 and 441.155, the staffing plan for OSH is set by the nurse staffing committee, composed of both nurse management and AFSCME-RN union members. On average, about 12 percent of the OSH direct care staff (registered nurses, licensed practical nurses, and mental health technicians) are absent each day – this does not include planned absences such as vacation or personal business. In order to meet minimum staffing requirements, direct care staff are asked to work overtime or are mandated to work overtime. But even with overtime shifts, staffing needs are not always met.

OSH nursing staffing requirements are affected by:

- Acuity – Higher staff-to-patient ratios are needed to maintain a safe treatment environment for patients and staff when there is a high acuity related to the patient population
- Precautions – Additional staff are needed to carry out physician-ordered patient "precautions," in which one or two staff are assigned to watch an individual patient who the physician has assessed as a risk for harming themselves or others

In 2015, the firm of AKT conducted an independent review of OSH nurse staffing practices. The report concluded that "*the methodology of the calculation appears to be sound. In speaking with our outside counsel, OSH's delivery model is well known and viewed favorably by others in the industry."* The nurse staffing plan established by the OSH Staffing Committee will be the standard that the Centers for Medicare & Medicaid Services (CMS) expects OSH to maintain as part of certification requirements.

The prevalence of staff call-outs and physician-ordered patient precautions (where one to two staff are assigned to one individual patient) has driven staffing needs well beyond the basic ratio-based nurse staffing plan. This drives overtime hours well beyond the planned level and increases the need for Limited Duration "float" staff positions and contract staff (nursing agencies).

Historically and currently, OSH has relied on overtime as the primary means to meet staffing needs when direct care staff are absent. Over the last three biennia, OSH has averaged 26,969 hours and $808,767 in monthly overtime to fill planned and unplanned direct-care staff vacancies. However, the 2015 Secretary of State audit of OSH overtime practices pointed out that *"Excessive overtime creates safety risks because it can lead to fatigue, affecting nursing staffs' ability to deliver good patient*

care, making good clinical decisions, and communicating effectively. Fatigued nursing staff could make errors, take unnecessary risks, be forgetful, and be in a poor mood."

In 2016, The Joint Commission visited OSH to follow up on concerns of inadequate staffing levels. The surveyor investigated the following standard: *EP 3 §482.62(d)(2) - (B150) - (2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.* Because the surveyor observed the high level of unplanned direct-staff absences at OSH, her finding was: "*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 addition, sufficient staffing also is key to OSH's ability to remain compliant with the United States Department of Justice's (USDOJ's) guidelines for the Civil Rights of Institutionalized Persons Act, specifically those areas related to adequate nursing care, adequate protection from harm, ability to provide adequate mental health care, and appropriate use of seclusion and restraint.

The hospital has a policy option package (POP) that reduces the financial burden on patients by enhancing the hospital's ability to bill Medicare and third-party insurances. These reimbursements would help offset the hospital's need for General Fund dollars. The POP would also improve the quality of patient care and treatment by expanding the float pool, increasing the hospital's ability to meet staffing levels and avoid excessive overtime and mandatory overtime. With a robust nursing float pool, OSH would be able to maintain safe staffing levels, cover unplanned absences without overreliance on overtime, and maintain compliance with regulations necessary for CMS certification.

USDOJ/Olmstead

Per the three-year Oregon Performance Plan that was developed by the Oregon Health Authority and approved by the United States Department of Justice, the hospital must meet the following targets:

1. Discharge from OSH for patients who have been civilly committed will occur as soon as an individual is ready to return to the community. The target changes over the plan's first three year.
   a. Year 1 target – **75 percent** within **30** days of placement on the Ready to Transition List by **June 30, 2017**
   b. Year 2 target – **85 percent** within **25** days of placement on the Ready to Transition List by **June 30, 2018**

c. Year 3 target – **90 percent** within **20** days of placement on the Ready to Transition List by **June 30, 2019**

2. At the end of Year 1, OSH will discharge 90 percent of all patients who have been civilly committed within 120 days of admission.

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

State General Fund.

Other Funds:

- Medicare
- Third party insurance
- Private payments
- Local revenue (e.g., wood products, café, coffee shop, safety grant)

Federal Funds:

- Medicaid Matching Funds
- Disproportionate Share Hospital (DSH)

Proposed new laws that apply to the program unit

OSH has experienced a dramatic increase in the number of Aid and Assist (.370) patients. Because of this, OSH is struggling to find beds for patients under .370 orders. OSH must meet the requirements of the federal order in Oregon Advocacy Center v. Mink, which requires OSH to admit defendants under .370 orders within seven days of the court finding them unable to aid and assist in their defense. The average daily population for patients under .370 orders at OSH has more than doubled over the past five years, from 109.7 in January 2012 to 239.0 in November 2016.

OSH has submitted five legislative concepts each aimed at easing the .370 crisis:

- LC 556 – Divert from OSH those .370 defendants with 90 days or less on their sentences;
- LC 565 – OSH forensic evaluations as arm of court;

- LC 571 – Give .370 patients credit for time in jail; and
- LC 578 – OSH preliminary and subsequent forensic evaluations may be shorter.

Legislative Concept 556 – Divert from OSH those .370 defendants with 90 days or less on their sentences

Many defendants sent to OSH have 90 days or less left in their sentence before their commitments expire. Because of the statutory and constitutional limits of how long a person may be confined, such defendants/patients must be discharged from OSH relatively soon after they are admitted. In such cases, being admitted to OSH makes little sense, because OSH has very little time to stabilize the person before the person's charges will be dropped soon after they are discharged. Thus, sending defendants with less than 90 days left on their charges to OSH is not a prudent plan for the individuals or for the state. OSH has proposed that Oregon Revised Statute (ORS) 161.370 be amended so that defendants with 90 days or less left on their charges cannot be committed to OSH.

Legislative Concept 565 – OSH forensic evaluations as arm of court (rather than competing evaluations)

Courts often receive competing evaluations from defense attorneys and prosecutors about whether a defendant is able to aid and assist. Similar to how civil commitment courts use court visitors to determine who needs to be civilly committed, OSH has proposed that a statutory change be made so evaluations will be done locally as an arm of the court by an objective evaluator.

Legislative Concept 571 – OSH give .370 patients credit for time in jail

The Attorney General's office has advised OSH that .370 patients cannot get credit for time they spend in jail unless the court explicitly orders that they get credit. In other words, the statute gives credit only for time spent at the hospital. (In the order templates on OSH's website, which many counties use, OSH added the option for judges to order that defendants get credit for jail time, but not all judges choose to do so.) When the court does not explicitly give patients credit for time served in jail, their time at OSH is lengthened. (Note that "GEI" patients, meaning patients found guilty of a crime except for insanity, do get credit for time they spent in jail.) OSH proposes amending ORS 161.370 so that .370 patients will automatically get credit for time spent in jail.

Legislative Concept 578 – OSH preliminary and subsequent forensic evaluations may be shorter

Currently, evaluators must draft comprehensive evaluations every time they evaluate a defendant/patient. This is true regardless of whether the evaluation is a preliminary .365 evaluation or a subsequent .370 evaluation. This takes up a great deal of resources – and a lot of time – even though the defendant/patient may need only an updated evaluation.

Allowing shorter evaluations would allow them to be completed sooner, and this would lead to patients getting out of OSH sooner. OSH proposes amending ORS 161.370 so that the first .370 evaluation must be thorough, but subsequent .370 evaluations may simply be updates. Similarly, OSH proposes amending ORS 161.365 so that .365 evaluations – which are supposed to serve as preliminary evaluations – may be shorter.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unit Narrative: State Delivered Secure Residential Facility

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	6,197,834	413,095	1,906,097	8,517,026	42	42.00
Governor's Budget	6,565,657	415,657	2,011,932	8,993,246	42	42.00
Difference	367,823	2,562	105,835	476,220	0	0.00
Percent Change	6%	1%	6%	6%	0%	0%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

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 residential treatment services for adults in a more home-like setting. 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 who are transitioning from the state hospital to a life in the community.

People served

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

Treatment philosophy
Pendleton Cottage uses person-centered treatment planning in which residents direct their own treatment. Together, residents and their treatment teams create an integrated service and support plan, which incorporates the resident's residential service plan, treatment care plan and the resident's individual, 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 plans. 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 psychiatric services
- Individual therapy
- Vocational services including on-site paid employment opportunities
- Recreational services, both on- and off-site
- Religious services provided by a contracted chaplain service for weekly services and scripture studies
- In-house case management
- Medication administration, monitoring and teaching
- Nursing services for individuals who have significant medical needs, such as diabetes, chronic obstructive pulmonary disease, or physical disabilities that affect their ability to walk

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 patients develop the skills they need to successfully step down to a lower level of care.

Staffing
Pendleton Cottage has 42 staff including the administrator to meet the residents' complex behavioral and medical needs. The average staffing ratio is three staff to eight patients, with at least three direct-care staff and one nurse on every shift. Staff provide:

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

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

None.

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

State General Fund.

Other Funds:

- Veterans Transportation Reimbursement
- Room and board (private payments)
- Meal tickets

Federal Funds:

- Medicaid Matching Funds

Proposed new laws that apply to the program unit.

None.

OREGON HEALTH AUTHORITY: OREGON STATE HOSPITAL

Program Unity Narrative: Junction City Campus

Expenditures by fund type, positions and full-time equivalents

	General	Other	Federal	Total Fund	Pos.	FTE
Leg. Approved 15-17	71,138,821	5,575,644	2,728,467	79,442,932	422	416.08
Governor's Budget	31,932,472	8,181,969	1,353,375	41,467,816	357	178.25
Difference	-39,206,349	2,606,325	-1,375,092	-37,975,116	-65	-237.83
Percent Change	-55%	47%	-50%	-48%	-15%	-57%

Activities, program and issues in the program unit base budget that may require further explanation than allowed in the Program Unit Executive Summary

Junction City Campus detail

- Capacity – 6 units, 3 cottages (174 beds)
- Operating – 4 units, 0 cottages (100 beds)
- Populations served – civil commitment (includes voluntary commitments by guardian), guilty except for insanity (GEI)
- Census – 77 (daily average population for 2016)
- Square feet – 220,000
- Position authority – 357

Populations Served

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

There are for different commitment types 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.

- **Voluntary by Guardian** – Working through the court system, legal guardians may commit their wards who meet civil commitment criteria: they must pose a danger to themselves or others and/or they must be unable to provide for their own basic needs due to their mental illness.

- **Guilty Except for Insanity (GEI)** – Oregon State Hospital serves patients who have successfully pled Guilty Except for Insanity (GEI) to criminal behavior related to their mental illness. Depending on the nature of their crime, these patients are under the jurisdiction of either the Psychiatric Security Review Board or the Oregon State Hospital Review Panel.

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.

Any additional important background for decision makers that is not mentioned above. Include trends in caseload, workload or other external factors that may influence the operation of the program

Increasing civil population

Due to the rising number of patients under Aid and Assist orders at the Salem Campus, Junction City has accommodated the displaced civil population. In June 2016, the Junction City Campus opened a fourth unit, which helped the hospital reduce the wait list and reduce pressure on acute care hospitals that had people waiting to be admitted to OSH. Because Aid and Assist services are so specialized, they are available only at the Salem Campus. If the Aid and Assist population continues to increase, OSH will rely on its Junction City campus to serve more and more patients who have been civilly committed. The Governor's Budget calls for the closure of the Junction City campus in July 2018.

Revenue sources and proposed revenue changes. For Lottery Funds, Other Funds, and Federal Funds revenues

State General Fund.

Other Funds:

- Medicare
- Third-party insurance
- Private payments
- Local revenue (e.g., café, coffee shop)

Federal Funds:

- Medicaid Matching Funds

Proposed new laws that apply to the program unit

OSH has experienced a dramatic increase in the number of Aid and Assist (".370") patients. Because of this, OSH is struggling to find beds for patients under .370 orders. OSH must meet the requirements of the federal order in Oregon Advocacy Center v. Mink, which requires OSH to admit defendants under .370 orders within seven days of the court finding them unable to aid and assist in their defense. The average daily population for patients under .370 orders at OSH has more than doubled over the past five years, from 109.7 in January 2012 to 239.0 in November 2016.

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	2017-19 OHA - PROPOSALS/POLICY OPTION PACKAGES								
POP #	**Lead Program Area**	**Official Title (45 Character Limit)**	**Description (limit to 700 characters)**	**General Fund**	**Other Funds**	**Federal Funds**	**Total Funds**	**POS**	**FTE**
201	Shared Services - OIS	**Integrated Eligibility Project - Tied to DHS POP**	DHS is seeking legislative approval for a project that would transfer human service eligibility determination functionality from Kentucky to add to the new integrated OregONEligibility system. This will impact eligibility for Non-MAGI Medicaid, ERDC, SNAP and TANF programs. The OHA portion of Operations & Maintenance funding is what is represented on this POP.		$ 10,762,599		$ 10,762,599	22	19.75
	DHS/OHA Shared	**DHS Shared services- OHA Portion TIED TO DHS POPS**							
205	HR DHS/OHA	Background Check Unit Workload	Requests staff to meet currently required background checks within required time limits and to meet projected needs due to program growth and new federal and state statutes implementing during the 2017-19 biennium. Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks.	$ 113,534	$ 19,214	$ 41,921	$ 174,669		
401	Public Health	**Cleaner Air Oregon Initiative**	This POP would build the foundational capacity of the Environmental Public Health Section of the Public Health Division and protect Oregon communities from environmental health risks. Preventing environmental exposures can reduce the rates of illness and decrease the overall costs of healthcare in Oregon. Environmental health issues such as childhood lead poisoning, poor air quality and the effects of climate change disproportionately affect low income and minority populations. By funding this POP, OHA will have the capacity to work with the Oregon Department of Environmental Quality to support and implement health based environmental regulations to protect the health of all Oregonians.	$ 720,290	$ 32,124	$ (476,673)	$275,741		
402	CFO/HSD	**Enhance OHA Office of Program Integrity**	This request enhances staff in Provider Audits for CCO oversight and monitoring and creates a unit specific to the auditing, oversight and monitoring of long term care services and supports (LTCSS) and home and community-based Medicaid providers. The request also includes contract expenditures for data analysis necessary to build a more robust analytic operation within Medicaid. These positions will generate revenue that creates General Fund savings in the 2019-21 biennium.	$ 1,566,735	$ 2,050,000	$ 3,614,761	$ 7,231,496	7	6.16

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
403	HSD - Medicaid	**Hepatitis C Treatment Expansion**	Hepatitis C is a viral infection that primarily affects the liver and progresses through several stages of increasing disease severity (Stages F0 through F4). Higher stage disease results in chronic liver disease, liver failure and possibly liver cancer. Direct acting antiviral (DAA) medications are available to treat Hepatitis C infection and frequently results in a cure. DAAs are in general expensive medications relative to other prescription drugs. Treatment of Hepatitis C in the Oregon Health Plan has been offered for Stage F3 and F4 disease with limited earlier stage treatment. This POP would fund cover treatment to those clients with stage F2.	$ 31,962,732	$ 14,345,088	$ 150,118,333	$196,426,153	-	-
404	HSD - Non-Medicaid	**Juvenile Fitness to Proceed**	This POP corresponds to the Juvenile Fitness to Proceed (Aid and Assist) legislative concept, which would make changes to Oregon Revised Statutes in the area of Juvenile Fitness to Proceed. The concept, if passed into law, would increase the likelihood that youth receiving restorative services would receive services and supports that meet their medical, behavioral, and emotional needs in a community, non-residential setting, reducing the burden on the youth mental health residential system. The revised process would generate GF savings due to decreased utilization of residential treatment for these youth.	$ (438,984)	$ -	$ -	$ (438,984)		
405	Shared Services - OIS	**Medicaid Management Information System (MMIS) Strategic Plan for Modularization**	The Centers for Medicare and Medicaid Services (CMS) requires all states to plan and implement modular solutions to support Medicaid, using a competitive process. Oregon's current Medicaid Management Information System (MMIS) is a monolithic system implemented in 2008. Oregon's Medicaid Management Information System (MMIS) was originally designed to primarily support a fee for service-based model, with extensive modifications done later to support Oregon's Coordinated Care Organization (CCO) capitation-based model. This POP requests state funds to secure 90% federal financial participation funds to: define Oregon's Medicaid Service Delivery strategy; assess other states modularization approaches; identify options for modular solutions; define certification requirements; and, begin procurement activities to secure modular solution components.	$ 367,739	$ 2,022,391	$ 3,241,513	$5,631,643	9	9.00

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
406	HSD - Admin	**ONE System Enhancements**	The Centers for Medicare and Medicaid Services (CMS) offers additional enhanced funding for updating eligibility systems. This policy option package is requesting the authority to fund enhancements to Oregon's Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination system (called ONE). Currently, OHA has a contract with Deloitte Consulting—the systems integrator that built the ONE system—to continue to enhance it while maintaining and operating it. The plan is to implement new functionality several times a year as prioritized by Health Systems Division. This POP would also support anticipated necessary changes when CMS issues new requirements for MAGI Medicaid eligibility systems.	$ 1,283,680	$ -	$ 11,516,320	$12,800,000		-
407	HSD - Medicaid	**OHP Coverage for All Kids**	This POP would provide the Oregon Health Plan (OHP) benefit package to children who do not qualify for full OHP benefits solely because they do not meet federal citizenship and immigration status requirements under Medicaid and the Children's Health Insurance Program (CHIP). Income eligibility would be up to 300 percent of the federal poverty level. Coverage would be for children through 18 years of age.	$ 55,030,483			$ 55,030,483		
070		**OHA Fee Changes.**							
	HSD	Tobacco Master Settlement Revenue decrease	Other Fund revenue shortfall. No corresponding POP request.		$ (2,158,800)		$ (2,158,800)		
	PH	Tobacco Master Settlement Revenue decrease	Other Fund revenue shortfall. No corresponding POP request.		$ (850,200)		$ (850,200)		
	PH	Oregon Environmental Laboratory Accreditation Program (ORELAP)	Other Fund revenue shortfall. See corresponding POP request below.		$ (16,417)		$ (16,417)		(0.04)
	PH	Newborn Screening	Other Fund revenue shortfall. See corresponding POP request below.		$ (11,170)		$ (11,170)		(0.08)
	PH	Health Care Regulation and Quality Improvement (HCRQI)	Other Fund revenue shortfall. See corresponding POP request below. This is inclusive of Hospice, In-Home Care Licensing, and the Health Facilities Plan Review.		$ (936,475)		$ (936,475)	(2)	(2.79)

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
409	PH	Oregon Environmental Laboratory Accreditation Program (ORELAP) Fee Changes	Proposing fee increases to insure revenue covers cost of administrating the following program: Oregon Environmental Laboratory Accreditation Program (ORELAP) for implementation of fees for Marijuana testing labs		$ 16,417		$ 16,417	-	0.04
	PH	Newborn Screening Fee Changes	Proposing fee increases to insure revenue covers cost of administrating the following program: Oregon Newborn Screening program		$ 11,170		$ 11,170	-	0.08
	PH	Health Facilities Plan Review Fee Change	Proposing fee increases to insure revenue covers cost of administrating the following program: Facility Planning and Safety Construction Plan Review		$ 761,008		$ 761,008	2	2.00
	PH	Hospice & In-Home Care Licensing Fee Changes	Proposing fee increases to insure revenue covers cost of administrating the following program: 1) In-Home Care Agency Licensing ($173,823) 2) Hospice Agency Licensing ($1,644)		$ 175,467		$ 175,467	-	0.79
	PH	SB 478 Toxic-Free Kids Act Fee Establishment (Dec. 2016 Rebalance C-2)			$ 294,238	$ (153,679)	$ 140,559	-	-
	PH	Immunization Alert Fee Establishment			$ 1,213,362	$ (1,009,723)	$ 203,639	-	-
	HPA - OHIT	Office of Health Information Technology Fee	This POP is necessary for OHA to obtain Other Fund limitation and establish fee structures to support three health information technology efforts in Oregon: the Oregon Common Credentialing Program as mandated by Senate Bill 604 (2013 Regular Session); the statewide Provider Directory; and, the CareAccord® program. Other Fund limitation allows the collection and utilization of fees to cover operating costs of these programs.		$ 12,983,343		$ 12,983,343		

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
410	OSH	**Oregon State Hospital Improvements**	Oregon State Hospital is positioned to certify up to an additional 454 hospital-licensed beds with the Centers for Medicare & Medicaid Services (CMS). CMS certification allows OSH to bill insurance plans for patients covered by Medicare, Medicaid, and third-party commercial insurance. Positions are required to maintain the revenue. Positions will used for revenue billing and collection and to maintain accreditation and compliance. Although included in the 2017-19 Current Service Level budget, an important component supporting OSH improvement efforts is the expansion of the Collaborative Problem Solving (CPS) treatment model, which has demonstrated success in improving treatment and safety. Through CPS and the help of a CPS coach, staff and patients work together to develop the skills needed to recover, successfully transition back to the community, and avoid re-admission.	$ (20,055,765)	$ 34,346,184		$ 14,290,419	49	49.00
			Expand position authority and budget to properly fund nursing float pool. OSH relies on overtime to maintain safe direct-care staffing levels, because it does not have enough legislatively approved positions to replace staff who call-out sick, are on medical leave, or assigned to one patient for safety precautions. As a result, even with overtime, patient units often work with less than the number of staff needed to provide treatment and ensure safety.		$6,142,845		$6,142,845	34	34.00
501	HSD - Medicaid	**Statewide Tobacco Tax change**	The Governor's Budget proposes to increase the Cigarette Tax from $1.33 per pack to $2.18 per pack effective January 1, 2018. The increase is estimated to generate an estimated $21.5 million for the General Fund per the Department of Revenue. The distribution formula will be in exact proportion to the existing distributions. The Governor's Budget also proposes to increase taxes on Other Tobacco Products, generating an estimated $13.7 million for the General Fund, in the following ways: • Increase the per cigar cap from $0.50 to $1.00; • Increase the rate on moist snuff by $0.89 per ounce; and, • Increase the rate on all other tobacco products from 65 percent of the wholesale price to 75 percent of the wholesale price.	$ (109,007,434)	$ 109,007,434		$0		-
	PH				$ 4,515,635		$4,515,635		-
			Total OHA Policy Option Packages	**$ (38,456,990)**	**$ 194,725,457**	**$ 166,892,773**	**$ 323,161,240**	**121**	**117.91**

	2017-19 OHA - PROPOSALS/POLICY OPTION PACKAGES								
POP #	**Lead Program Area**	**Official Title (45 Character Limit)**	**Description (limit to 700 characters)**	**General Fund**	**Other Funds**	**Federal Funds**	**Total Funds**	**POS**	**FTE**
201	Shared Services - OIS	**Integrated Eligibility Project - Tied to DHS POP**	DHS is seeking legislative approval for a project that would transfer human service eligibility determination functionality from Kentucky to add to the new integrated OregONEligibility system. This will impact eligibility for Non-MAGI Medicaid, ERDC, SNAP and TANF programs. The OHA portion of Operations & Maintenance funding is what is represented on this POP.		$ 10,762,599		$ 10,762,599	22	19.75
	DHS/OHA Shared	**DHS Shared services- OHA Portion TIED TO DHS POPS**							
205	HR DHS/OHA	Background Check Unit Workload	Requests staff to meet currently required background checks within required time limits and to meet projected needs due to program growth and new federal and state statutes implementing during the 2017-19 biennium. Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks.	$ 113,534	$ 19,214	$ 41,921	$ 174,669		
401	Public Health	**Cleaner Air Oregon Initiative**	This POP would build the foundational capacity of the Environmental Public Health Section of the Public Health Division and protect Oregon communities from environmental health risks. Preventing environmental exposures can reduce the rates of illness and decrease the overall costs of healthcare in Oregon. Environmental health issues such as childhood lead poisoning, poor air quality and the effects of climate change disproportionately affect low income and minority populations. By funding this POP, OHA will have the capacity to work with the Oregon Department of Environmental Quality to support and implement health based environmental regulations to protect the health of all Oregonians.	$ 720,290	$ 32,124	$ (476,673)	$275,741		
402	CFO/HSD	**Enhance OHA Office of Program Integrity**	This request enhances staff in Provider Audits for CCO oversight and monitoring and creates a unit specific to the auditing, oversight and monitoring of long term care services and supports (LTCSS) and home and community-based Medicaid providers. The request also includes contract expenditures for data analysis necessary to build a more robust analytic operation within Medicaid. These positions will generate revenue that creates General Fund savings in the 2019-21 biennium.	$ 1,566,735	$ 2,050,000	$ 3,614,761	$ 7,231,496	7	6.16

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
403	HSD - Medicaid	**Hepatitis C Treatment Expansion**	Hepatitis C is a viral infection that primarily affects the liver and progresses through several stages of increasing disease severity (Stages F0 through F4). Higher stage disease results in chronic liver disease, liver failure and possibly liver cancer. Direct acting antiviral (DAA) medications are available to treat Hepatitis C infection and frequently results in a cure. DAAs are in general expensive medications relative to other prescription drugs. Treatment of Hepatitis C in the Oregon Health Plan has been offered for Stage F3 and F4 disease with limited earlier stage treatment. This POP would fund cover treatment to those clients with stage F2.	$ 31,962,732	$ 14,345,088	$ 150,118,333	$196,426,153	-	-
404	HSD - Non-Medicaid	**Juvenile Fitness to Proceed**	This POP corresponds to the Juvenile Fitness to Proceed (Aid and Assist) legislative concept, which would make changes to Oregon Revised Statutes in the area of Juvenile Fitness to Proceed. The concept, if passed into law, would increase the likelihood that youth receiving restorative services would receive services and supports that meet their medical, behavioral, and emotional needs in a community, non-residential setting, reducing the burden on the youth mental health residential system. The revised process would generate GF savings due to decreased utilization of residential treatment for these youth.	$ (438,984)	$ -	$ -	$ (438,984)		
405	Shared Services - OIS	**Medicaid Management Information System (MMIS) Strategic Plan for Modularization**	The Centers for Medicare and Medicaid Services (CMS) requires all states to plan and implement modular solutions to support Medicaid, using a competitive process. Oregon's current Medicaid Management Information System (MMIS) is a monolithic system implemented in 2008. Oregon's Medicaid Management Information System (MMIS) was originally designed to primarily support a fee for service-based model, with extensive modifications done later to support Oregon's Coordinated Care Organization (CCO) capitation-based model. This POP requests state funds to secure 90% federal financial participation funds to: define Oregon's Medicaid Service Delivery strategy; assess other states modularization approaches; identify options for modular solutions; define certification requirements; and, begin procurement activities to secure modular solution components.	$ 367,739	$ 2,022,391	$ 3,241,513	$5,631,643	9	9.00

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
406	HSD - Admin	**ONE System Enhancements**	The Centers for Medicare and Medicaid Services (CMS) offers additional enhanced funding for updating eligibility systems. This policy option package is requesting the authority to fund enhancements to Oregon's Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination system (called ONE). Currently, OHA has a contract with Deloitte Consulting—the systems integrator that built the ONE system—to continue to enhance it while maintaining and operating it. The plan is to implement new functionality several times a year as prioritized by Health Systems Division. This POP would also support anticipated necessary changes when CMS issues new requirements for MAGI Medicaid eligibility systems.	$ 1,283,680	$ -	$ 11,516,320	$12,800,000		-
407	HSD - Medicaid	**OHP Coverage for All Kids**	This POP would provide the Oregon Health Plan (OHP) benefit package to children who do not qualify for full OHP benefits solely because they do not meet federal citizenship and immigration status requirements under Medicaid and the Children's Health Insurance Program (CHIP). Income eligibility would be up to 300 percent of the federal poverty level. Coverage would be for children through 18 years of age.	$ 55,030,483			$ 55,030,483		
070		**OHA Fee Changes.**							
	HSD	Tobacco Master Settlement Revenue decrease	Other Fund revenue shortfall. No corresponding POP request.		$ (2,158,800)		$ (2,158,800)		
	PH	Tobacco Master Settlement Revenue decrease	Other Fund revenue shortfall. No corresponding POP request.		$ (850,200)		$ (850,200)		
	PH	Oregon Environmental Laboratory Accreditation Program (ORELAP)	Other Fund revenue shortfall. See corresponding POP request below.		$ (16,417)		$ (16,417)		(0.04)
	PH	Newborn Screening	Other Fund revenue shortfall. See corresponding POP request below.		$ (11,170)		$ (11,170)		(0.08)
	PH	Health Care Regulation and Quality Improvement (HCRQI)	Other Fund revenue shortfall. See corresponding POP request below. This is inclusive of Hospice, In-Home Care Licensing, and the Health Facilities Plan Review.		$ (936,475)		$ (936,475)	(2)	(2.79)

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
409	PH	Oregon Environmental Laboratory Accreditation Program (ORELAP) Fee Changes	Proposing fee increases to insure revenue covers cost of administrating the following program: Oregon Environmental Laboratory Accreditation Program (ORELAP) for implementation of fees for Marijuana testing labs		$ 16,417		$ 16,417	-	0.04
	PH	Newborn Screening Fee Changes	Proposing fee increases to insure revenue covers cost of administrating the following program: Oregon Newborn Screening program		$ 11,170		$ 11,170	-	0.08
	PH	Health Facilities Plan Review Fee Change	Proposing fee increases to insure revenue covers cost of administrating the following program: Facility Planning and Safety Construction Plan Review		$ 761,008		$ 761,008	2	2.00
	PH	Hospice & In-Home Care Licensing Fee Changes	Proposing fee increases to insure revenue covers cost of administrating the following program: 1) In-Home Care Agency Licensing ($173,823) 2) Hospice Agency Licensing ($1,644)		$ 175,467		$ 175,467	-	0.79
	PH	SB 478 Toxic-Free Kids Act Fee Establishment (Dec. 2016 Rebalance C-2)			$ 294,238	$ (153,679)	$ 140,559	-	-
	PH	Immunization Alert Fee Establishment			$ 1,213,362	$ (1,009,723)	$ 203,639	-	-
	HPA - OHIT	Office of Health Information Technology Fee	This POP is necessary for OHA to obtain Other Fund limitation and establish fee structures to support three health information technology efforts in Oregon: the Oregon Common Credentialing Program as mandated by Senate Bill 604 (2013 Regular Session); the statewide Provider Directory; and, the CareAccord® program. Other Fund limitation allows the collection and utilization of fees to cover operating costs of these programs.		$ 12,983,343		$ 12,983,343		

POP #	Lead Program Area	Official Title (45 Character Limit)	Description (limit to 700 characters)	General Fund	Other Funds	Federal Funds	Total Funds	POS	FTE
410	OSH	**Oregon State Hospital Improvements**	Oregon State Hospital is positioned to certify up to an additional 454 hospital-licensed beds with the Centers for Medicare & Medicaid Services (CMS). CMS certification allows OSH to bill insurance plans for patients covered by Medicare, Medicaid, and third-party commercial insurance. Positions are required to maintain the revenue. Positions will used for revenue billing and collection and to maintain accreditation and compliance. Although included in the 2017-19 Current Service Level budget, an important component supporting OSH improvement efforts is the expansion of the Collaborative Problem Solving (CPS) treatment model, which has demonstrated success in improving treatment and safety. Through CPS and the help of a CPS coach, staff and patients work together to develop the skills needed to recover, successfully transition back to the community, and avoid re-admission.	$ (20,055,765)	$ 34,346,184		$ 14,290,419	49	49.00
			Expand position authority and budget to properly fund nursing float pool. OSH relies on overtime to maintain safe direct-care staffing levels, because it does not have enough legislatively approved positions to replace staff who call-out sick, are on medical leave, or assigned to one patient for safety precautions. As a result, even with overtime, patient units often work with less than the number of staff needed to provide treatment and ensure safety.		$6,142,845		$6,142,845	34	34.00
501	HSD - Medicaid	**Statewide Tobacco Tax change**	The Governor's Budget proposes to increase the Cigarette Tax from $1.33 per pack to $2.18 per pack effective January 1, 2018. The increase is estimated to generate an estimated $21.5 million for the General Fund per the Department of Revenue. The distribution formula will be in exact proportion to the existing distributions. The Governor's Budget also proposes to increase taxes on Other Tobacco Products, generating an estimated $13.7 million for the General Fund, in the following ways: • Increase the per cigar cap from $0.50 to $1.00; • Increase the rate on moist snuff by $0.89 per ounce; and, • Increase the rate on all other tobacco products from 65 percent of the wholesale price to 75 percent of the wholesale price.	$ (109,007,434)	$ 109,007,434		$0		-
	PH				$ 4,515,635		$4,515,635		-
			Total OHA Policy Option Packages	**$ (38,456,990)**	**$ 194,725,457**	**$ 166,892,773**	**$ 323,161,240**	**121**	**117.91**

Department of Human Services
2017-19 Policy Option Package

Agency Name:	**Department of Human Services**
Program Area Name:	**Program Design Services**
Program Name:	**Information Technology Business Supports**
Policy Option Package Initiative:	**DHS Integrated Eligibility Project**
Policy Option Package Title:	**Integrated Eligibility**
Policy Option Package Number:	**201**
Related Legislation:	**N/A**

Summary Statement:

This POP will provide resources to support the continuation of the Department's Integrated Eligibility Project during FY17-19 resulting in a single eligibility determination system for Non-MAGI Medicaid, Supplemental Nutrition Assistance Program (SNAP Food Stamps), Temporary Assistance for Needy Families (TANF Cash Assistance), and Employment Related Day Care (ERDC Child Care subsidies).

This POP would further the design, development, and implementation period for the Integrated ONE System – jointly shared by DHS and OHA for the purposes of Eligibility Determination work. DHS plans to put the system into pilot in the summer of 2018, followed by a four month implementation roll-out. This POP takes advantage of enhanced federal funds across two separate federal agencies. Without funding, DHS will not be able to continue its project in a timely manner, resulting in increased state general fund cost for work after the A87 Cost Allocation exception process expires.

This POP also has a corresponding POP at DAS Enterprise Technology Services for support of DHS' business needs, and is related to the Legacy System Project that DHS is undertaking to

ensure that functionality not assumed into the IE system from legacy systems will still be available for DHS business usage.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing Total:	**$11,959,788**	**$29,037,599**	**$101,794,707**	**$142,792,094**
DHS – PDS (ITBS)	$7,609,969	$18,275,000	$101,794,707	$127,679,676
DHS – DEBT SERVICE	$4,349,819	$0	$0	$4,349,819
OHA (DHS Sister POP)	$0	$10,762,599	$0	$10,762,599

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP will provide resources, primarily in the form of federal fund limitation, XI Q-Bond financing proceeds, and position authority) to support the continued work of the DHS Integrated Eligibility Project and its transition into maintenance and operations.

DHS has engaged with system integrator, Deloitte Consulting, in a transfer project to expand the functionality of the OregONEligibility system for MAGI Medicaid, known as the ONE system. DHS seeks to bring the human service financial eligibility determination functionality from Kentucky's benefind system to Oregon, resulting in a single system that Oregonians can apply for and receive benefits from OHA or DHS in Medicaid, SNAP, TANF, or ERDC program areas. By the conclusion of the 15-17 biennium, the Department will have completed the Fit/Gap phase of the project, and begun the design, development, and implementation phase. Using iterative development, DHS will have completed all of the

design, and development activities should be underway. The first DHS testing activities are scheduled to occur in May 2017.

This POP continues those efforts, and sees the project through complete implementation and transition to maintenance & operations of the system. Implementation activities should be completed by December of 2018, followed by a warranty period and the beginning of maintenance and operation by June 30, 2019, resulting in the roll-out of the Integrated ONE system which will be used by both OHA and DHS.

2. WHY DOES DHS PROPOSE THIS POP?

DHS wishes to maximize the increased federal funding associated with this system project, by utilizing the A87 Cost Allocation Exception process, which allows for CMS 90/10 funding to be used for any system functionality that benefits Medicaid recipients. This increased federal funding greatly exceeds the amount of federal funds available from either USDA Food & Nutrition Services in support of SNAP system enhancements or Administration on Children & Families in support of TANF or ERDC system enhancements. This reduces the amount of state general fund necessary to support the technology upgrade off of legacy, mainframe based eligibility determination systems.

It will also enhance the potential for better care coordination for Oregonians by having all financial eligibility information in a singular system of record. It sets a common platform for both OHA and DHS eligibility, allowing for a systematic approach to further work to bring in additional programs and fully transition to a single eligibility system over the coming years.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

The project will assist Oregonians to achieve wellbeing and independence by providing timely and efficient eligibility determinations for the Department's programs. It will allow Oregonians to self-service by applying through the applicant portal at times that are convenient for them, minimizing time needed in DHS field offices to complete the process. The system will also generate notices in seven languages and in five alternate formats, helping to reduce barriers for traditionally underserved populations. It will also gather and store applicants preferred race and ethnicity values allowing for culturally competent care.

4. IS THIS POP TIED TO A DHS PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS MEASURE THE SUCCESS OF THIS POP?

This POP supports clients accessing our services and measurements around outreach and quality of services.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

No new alternatives were considered as this is an extension of previous investment.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Failure to fund this POP would result in the IE project coming to a halt; and increased general fund cost to bring it to its eventual completion.

(a) What services and programs would be affected?

APD Non-MAGI Medicaid eligibility determination, SSP eligibility determination for SNAP, TANF, ERDC.

(b) What client or population groups would be affected?

All department clients of programs in (a) above, including aged and disabled adults, people living nearest to poverty line.

(c) What providers would be affected?

Medicaid providers, CDDPs/Brokerages (for financial eligibility only) and child care providers potentially

(d) Would federal or other funding be reduced?
Enhanced federal funding for the project runs out on December 31, 2018.

(e) Would the agency be out of compliance with federal requirements?
N/A

(f) What are the expected results?

Timely and correct eligibility determinations and redeterminations for Non-MAGI Medicaid, SNAP, TANF, ERDC

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?
OHA is impacted because POP enhances their current system.
DAS is impacted because equipment and services at ETS are required to support POP.
DOJ is impacted because DHS system will need to interface with new Child Support system.
OED is impacted because DHS system will have interface with Employment Department.
ODE is impacted because DHS system will interface with system that makes payments to Early Learning Division Child Care Providers.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?
None

10. WHAT IS YOUR EQUITY ANALYSIS?
DHS System will be able to support notice generation in seven languages and five alternate formats. It will gather applicants preferred written and spoken language as well as race and ethnicity to help department

providers provide culturally competent care. This will bring us into compliance with REAL+D work, and allow another way for communities and individuals in Oregon to interact with DHS.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2017 (ongoing-continuing 15-17 Investment)
End Date (if applicable): June 30, 2019

a. Will there be new responsibilities for DHS? Specify which Program Area(s) and describe their new responsibilities.

☒ Aging & People with Disabilities
☒ Intellectual/Developmental Disabilities
☒ Self-Sufficiency Program
☒ IT Business Supports
☒ OIS

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected. See Addendum A – Shared, OIS and Central Offices Services LC/POP Impact Questionnaire.

Yes – OIS and ITBS.
There will be additional costs associated with facilities for staffing.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No, however, through the process of updating the system Oregon may find some of our eligibility criteria or work around determining benefits may not have been accurate and have subsequent changes to eligibility. We don't expect any substantial changes from this at this time and cannot model or predict beyond anecdotal assumptions.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

Yes.

1.5 FTE of PEM G for 24 months (LD) (DHS)
1 Pub Affairs Specialist 3 for 24 months (LD) (DHS)
16 OPA3 for 18 months (LD) (DHS)
1 Office Mgr 2 for 18 months (LD) (DHS)
2 TDS 2 for 18 months (LD) (DHS)
1 ISS4 for 18 months (LD) (OHA)
3 ISS6 for 18 months (LD) (OHA)
10 ISS8 for 18 months (LD) (OHA)
3 PM2 for 18 months (LD) (OHA)
3 PM3 for 18 months (LD) (OHA)

These limited duration positions are being requested to allow program to backfill individuals that come onto the project. As part of our solutions for success, this project is bringing key subject matter experts from our field structure and from policy and business support to participate throughout the process. We want these individuals to come with their knowledge, so we will utilize the limited duration authority to allow program to fill behind key individuals while they are on the project.

1 PEME for 24 months (Perm) (DHS)
1 PEME for 24 months (Perm) (OHA)
6 OPA3 for 9 months (Perm) (DHS)
1 OPA4 for 24 months (Perm) (DHS)
1 OPA 4 for 24 months (Perm) (OHA)
2 TDS2 for 9 months (Perm) (DHS)
4 HSS4 for 24 months (Perm) (DHS)
2 PA1 for 24 months (Perm) (DHS)

There are also a PEM H and ESS2 who are work charging towards the IE project from DHS.

9 ISS8, an ISS7, FA3, PM1, PM3, PEM F, and PEM E dedicating time to this project from OIS.

There are 4 positions (2 OPA3 and 2 OPA4) from ITBSU who are on Modernization positions and working on this project. They will NOT be charging to IE, their time will be charged to ITBSU where the budget sits for their positions.

There are 9 positions from OIS who are on Modernization positions and working on this project. They will NOT be charging to IE, their time will be charged to the Shared Services Budget where their budget sits for those positions.

Additional modernization positions continue to support the original infrastructure that exists even with the implementation of Integrated ONE. OHA and DHS will continue to evaluate these positions and in subsequent releases and updates to the system, as legacy systems are sunset, these positions may be reallocated to Integrated ONE support. These positions continue to support the totality of the Modernization goal, in which Integrated ONE is the first step in setting the platform realization of that goal.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

There may be additional infrastructure costs, such as servers or costs to ETS, but these are being developed and projected into this POP.

f. What are the ongoing costs?

There are ongoing costs associated with maintenance and operations of the system, and is included in the cost projections.

g. What are the potential savings?

None.

h. Based on these answers, is there a fiscal impact?
Yes.

TOTAL FOR THIS PACKAGE (DHS+OHA)

Category	GF	OF	FF	TF	Position	FTE
Personal Services	976,299	9,893,732	4,661,661	15,531,692	60	48.04
Services & Supplies	6,489,137	18,626,010	96,473,691	121,588,838		
Special Payments	144,533	517,857	659,355	1,321,745		
Debt Service	4,349,819	0	0	4,349,819		
Total	**$11,959,788**	**$29,037,599**	**$101,794,707**	**$142,792,094**	**60**	**48.04**

DHS - Fiscal Impact Summary by Program Area:

	DHS PDS (ITBS)	DHS Debt Svc	OHA/OIS	Total
General Fund	**$7,609,969**	**$4,349,819**	**$0**	**$11,959,788**
Other Fund	**$18,275,000**	**$0**	**$10,762,599**	**$29,037,599**
Federal Funds- Ltd	**$101,794,676**	**$0**	**$0**	**$101,794,676**
Total Funds	**$127,679,676**	**$4,349,819**	**$10,762,599**	**$142,792,094**
Positions	**38**	**0**	**22**	**60**
FTE	**28.29**	**0.00**	**19.75**	**48.04**

What are the sources of funding and the funding split for each one?

(DHS – PDS-ITBS) Revenue Impact:

Description of Revenue	OF	FF	TF
Medicaid (Comp Srce 0995)	0	102,867,645	102,867,645
GF Q-Bonds(Comp Srce 0555)	18,000,000	0	18,000,000
Other (Comp Srce 0975)	626,010	0	626,010
Total	**$18,626,010**	**$102,867,645**	**$121,493,655**

(OHA -OIS) Revenue Impact:

Description of Revenue	OF	FF	TF
NON-Add OF Limitation (0975)	$10,762,599	0	$10,762,599

Department of Human Services / Oregon Health Authority
2017-19 Policy Option Package

Agency Name:	**Department of Human Services / Oregon Health Authority**
Program Area Name:	**Shared Services Human Resources Center**
Program Name:	**Background Check Unit (BCU)**
Policy Option Package Initiative:	**N/A**
Policy Option Package Title:	**Background Check Unit Workload**
Policy Option Package Number:	**205**
Related Legislation:	**N/A**

Summary Statement:

Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines. BCU completes checks for a variety of groups including but not limited to:

- Home Care Workers (HCWs);
- Personal Support Workers (PSWs);
- Subsidized child care providers;
- Child caring agencies (CCAs) staff, volunteers, and proctor foster parent applicants;
- System of Care (SOC) and Strengthening, Preserving and Reunifying Families (SPRF) providers;
- Staff and volunteers from residential care, nursing, and adult foster home facilities;
- Department of Human Services (DHS) and Oregon Health Authority (OHA) employees, volunteers, and contractors.

The staff requested in this Policy Option Package (POP) would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet all Supplies & Services needs and a majority of projected staffing needs due to program growth and new federal and state statutes to be implemented during the 2017-19 biennium if fully funded for the 24 months of the biennium.

The result would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks.

In addition, DHS has identified a variety of expansion options to current background check criteria for DHS and OHA providers whose fitness determination is completed by the Background Check Unit (BCU).

These options would provide more intensive background checks by improving communication about adverse actions on providers across unit and program lines, and increasing use of child protective service (CPS) information across the DHS provider community. The result would be increased health, safety and financial wellness for vulnerable Oregonians.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing Total:	**$6,231,800**	**$7,271,014**	**$1,263,747**	**$14,766,561**
DHS	$6,118,266	$7,251,800	$1,221,826	**$14,591,892**
OHA	$113,534	$19,214	$41,921	**$174,669**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

WORKLOAD-RELATED INCREASES

Steadily increasing numbers of background checks per year and growing complexity of work combined with stagnant or decreased staffing for the Background Check Unit (BCU) over the last few biennia have resulted in mounting backlogs and processing timelines for background checks.

Examples of how task complexity will have shifted from 2012-2017 are:

2012

- For almost all 2012 checks BCU only acquired Oregon criminal history records and sent those records to Qualified Entities (QEs) for fitness determination. By the end of 2012, to improve consistency of determinations and broaden depth of checks, BCU centralized fitness determination with BCU.

2013-2014

- In addition to running criminal history, BCU began evaluating that history, court and police records, abuse records, counseling and treatment records, weighed safety and risk factors, and documented and sent fitness determination to QEs.

2015-2016

- Centers for Medicare and Medicaid Services (CMS) required mandatory fingerprinting of all "high risk" roles.
- Increasing requirements for FBI checks from new legislative programs. FBI and other national checks using out-of-state history are more difficult.
- New review criteria for specific Adam Walsh programs.
- CMS requirements necessitated a January 2016 rule change for many DD providers that previously did not require recertification. In 2015, 23,819 or 77.8% of DD providers did not require recertification but will now be on a two-year cycle.

- Changes in how FBI information was provided via LEDS requires due diligence fingerprinting in cases where an out-of-state identifier code is not present. Expected to increase fingerprinting and related workload by 15% or more.

2017

- As of October 2017 new Child Care Development Fund Block Grant (CCDFBG) requirements will add mandatory FBI and ***national*** child protective service (CPS) checks of ***all*** child care providers and household members (12,000+ individuals). Currently:
  - Only 5.7% of child care cases currently require FBI checks.
  - Only Oregon CPS checks are now required.

The staff requested in this policy option package would meet currently required needs to maintain timely background checks for all regulated groups handled by BCU, and meet projected needs due to program growth and new federal and state statutes implementing during the 2017-19 biennium.

Regulated groups for whom BCU completes background checks include but are not limited to home care workers, developmental disability and mental health personal support workers, subsidized child care providers, Child Caring agencies, Traditional Health Workers, System of Care (SOC) and Strengthening, Preserving and Reunifying Families (SPRF) providers, and staff and volunteers from residential care, nursing, and adult foster home facilities. BCU also handles background checks for employees, volunteers and contractors of the Department of Human Services and Oregon Health Authority.

The result of increased staffing would be faster background checks to assist regulated Oregon employers in meeting their required staffing levels while maintaining health, safety and financial wellness for vulnerable Oregonians through quality background checks.

Implementation would require the following staff:

- +15 POS/14.40 FTE permanent Administrative Specialist 1 (Fitness Determiner) positions

These positions are to handle 2017 and 2018 growth in complexity and volume, including work from new federal CCDBG out-of-state child protective service checks and other exclusion list checks effective 10/2017, and changes from the Centers of Medicare and Medicaid Services (CMS).

Please note: These positions at 24 month funding are insufficient to match workload increases through 2019. Consequently even at 24 months DHS anticipates some backlog at the end of the biennium due to projected increases in complexity and numbers over the biennium. Reduced to only 12 months of funding commencing July 2018, between July 2017 and June 2018 the backlog will increase to approximately 6.78 weeks. Permanent staff placed after July 2018 will not be sufficient to reduce that backlog, nor sufficient to hold the backlog steady.

- +1.0 POS/0.88 FTE permanent Principle Executive/Manager C (BCU Supervisor) positions

  The PEM-C position would be added for the 2017-19 since staff additions would bring the total BCU classified staff to 58 (a 1:19 staffing proportion; without the position, the staffing ratio would be 1:29).

  Managers provide crucial clinical supervision of fitness determination, hearings and policy staff, and improve consistency, manage audit and review processes, and maintain quality customer service in background check processes supporting client safety, security and health.

Current 2015-17 costs in Services & Supplies are expected to increase to a total $8,842,569 for the 2017-19 biennium. These additional costs are itemized as:

- +$5,335,316 from Oregon State Police and FBI fingerprint processing fees
- +$37,739 total for Adam Walsh and Child Care out-of-state CPS check costs.
- +$12,000 total for background check research site costs.

- +$307,514 total for agency-paid fingerprint capture for DHS and OHA employees and volunteers, Criminal Justice Information Services (CJIS) clearance, and Child Welfare foster and adoptive parents.
- +$50,000 for annual maintenance on the Criminal Records Information Management System (CRIMS).

These Services & Supplies costs are expected to increase due to the following factors:

- Increased statutory requirements for fingerprinting.

  For example, the federal Child Care Development Block Grant Act of 2014 (CCDBG) requires mandatory fingerprinting for all child care providers by October 2017. This alone will require fingerprinting on approximately 11,000 more background checks for DHS child care providers per year.

- Steadily increasing numbers of background checks. Fingerprinting averages over 40% in non-mandatory programs and 100% fingerprinting when mandatory.

  In 2012, BCU completed 111,538 background checks across all DHS and OHA programs served. By 2015 that number had grown to 157,038, a 41% increase. These numbers are anticipated to increase +80% by the end of the 2017-19 biennium, resulting in approximately 207,654 checks in 2019, of which approximately 170,812 would require fingerprinting.

- To comply with FBI requirements, a reduced amount of FBI information is being presented in Oregon's Law Enforcement Data System (LEDS) checks, requiring increased fingerprinting for due diligence on potential out-of-state history.

- New CCDBG requirements for out-of-state child protective service checks on child care providers. Many states charge fees for these checks; the average is $17 per check.

Remaining S&S costs would be consistent with trends from the 2015-2017 biennium.

BACKGROUND CHECK EXPANSION

DHS has identified a variety of expansion options to current background check criteria for DHS providers whose fitness determination is completed by the Background Check Unit (BCU). These include home care workers, personal support workers, subsidized child care providers, private licensed agencies, System of Care and Strength, Preserving and Reunifying Families (SPRF) providers, and staff and volunteers from residential care, nursing, and adult foster home facilities.

Each of these expansions will necessitate the following to implement:

- Permanent rules changes to allow use of the selected expansions as potentially disqualifying conditions.
- Additional permanent staffing to handle the increased workload per expansion option.
- Training on selected expansions for veteran background check staff and new staff.

The selected expansions are as follows, in order of DHS-recommended priority for implementation:

1. Establish a comprehensive process for sharing adverse actions and terminations taken by one unit with another (i.e. Provider Relations Unit, Office of Licensing and Regulatory Oversight and other licensing units, Direct Payment Unit and Background Check Unit).

   This communication would allow separate units to review other units' adverse actions and terminations for fraud, health or safety concerns and apply that information to their provider enrolment processes where statute or rule allows.

Implementation would require one (1.0 POS/0.88 FTE) Administrative Specialist 1 to coordinate the information sharing at a total cost of $146,319 per biennium.

2. Provide child protective service (CPS) checks on all Aging and People with Disabilities (APD), Intellectual/Developmental Disability (I/DD), and mental health (OHA Health Systems) providers, regardless of whether they directly serve children.

   BCU currently does CPS checks on all DHS and OHA employees and volunteers, all child care providers and their household members, Child Welfare provider (SOC, SPRF, etc.) determinations, Adam Walsh determinations, and various other positions serving children through other programs. Child Welfare (CW) foster and adoptive parents have CPS checks completed by branches as part of CW evaluation process. Most APD, DD and mental health (OHA Health Systems) providers have not received CPS checks.

   Implementation requires four (4.0 POS/3.52 FTE) Administrative Specialist 1 positions to perform CPS research and fitness determination at a total cost of $585,276 per biennium. It would also require one (1.0 POS/0.88 FTE) Compliance Specialist 2 position to handle increases in hearing requests based on increases in abuse-related denials at a total cost of $180,912 per biennium. Permanent rules were published December 1, 2016 to allow information from this option to be considered as potentially disqualifying conditions.

   Please note that projected numbers of these checks would require an additional +2.87 FTE Administrative Specialist 1 to maintain staffing-to-workload by 2019. Consequently at the requested staffing level there is anticipated to be some backlog from this expansion by the end of the biennium.

   Limited duration staff are currently in place to implement this expansion effective December 2016 in order to improve child safety. However if this expansion is chosen for continuance into the 2017-19

biennium at a prospective 12-month staffing level, any workload-related backlog will be increased by approximately +1.42 weeks.

Another recommendation would be the use of the placement on the Centers for Medicare and Medicaid Services (CMS) Office of the Inspector General (OIG) Fraud List for Medicaid and Medicare, and other states' exclusion lists as potentially disqualifying conditions for all long term care-related subject individuals handled by the Background Check Unit. The CMS OIG and other states' exclusion lists may hold currently unconsidered information that reveal past history of abuse or fraud. The addition of these exclusion list checks to long term care background checks is a requirement of the CMS National Background Check Program (NBCP) grant for which DHS was approved by the Oregon Legislature in 2013.

However, implementation of the CMS exclusion lists across required programs would require additional staffing beyond this request, and based on the current level of funding**,** further expansion into CMS grant requirements would be impossible without incurring considerable backlogs.

FEE-FOR-SERVICE

Currently the Background Check Unit (BCU) does not charge background check fees to subject individuals or Qualified Entities of DHS and OHA; the costs for regulatory checks are currently paid by the DHS and OHA programs BCU serves. ORS 181.534 (9)(g) grants authority to charge fees for criminal history portions of checks but is not currently doing so. Fee-for-service is a potential manner of acquiring additional funds for criminal history portions of each check. Statutory changes to ORS 181.534 (9)(g) would be required to charge fees for costs from labor, research, and out-of-state fees related to providing protective service checks for Adam Walsh and the Child Care Development Block Grant Act of 2014.

Each fingerprinted background check requires $28 in processing fees to the Oregon State Police. In addition, as of October 2016 the FBI charges $10.75 for volunteers or $12.00 for employment/licensing/certification in processing fees per check.

If only fingerprint processing fees are charged to subject individuals or Qualified Entities when fingerprints are required for a check, at approximately 207,654 subject individuals fingerprinted during the course of 2017-19, BCU could gain back $8,330,203 in funds to offset Services and Supplies costs.

Other options, including a set background check fee based on average costs, are possible. BCU could work with DHS Budget to establish an appropriate fee-for-service schedule if the Legislature determined fee-for-service was the most appropriate funding mechanism for the Background Check Unit.

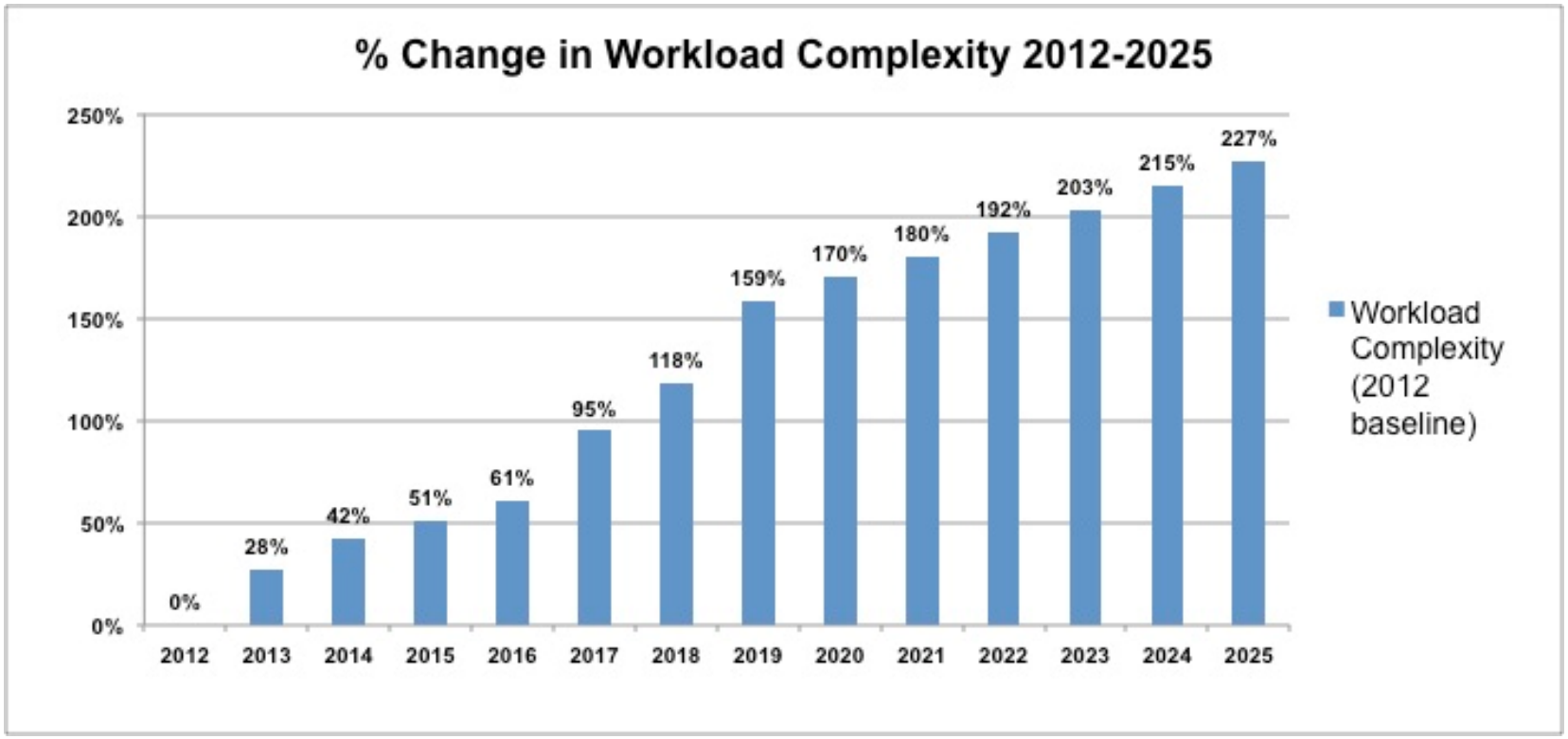
2. WHY DOES DHS PROPOSE THIS POP?

From 2012-2015, BCU has experienced a 41% increase in the total number of background checks. Workload complexity, as measured by the average time required to perform various tasks resulting in a fitness determination and annual background checks per year, has increased in the same period 51% due to new federal and state requirements. During that time BCU underwent a 15% decrease in total permanent staffing. As of 2017, complexity will have increased 95% over 2012.

Numerous process improvements have been attempted without success in stemming growing backlog. As of March 2016 DHS has partially met this workload gap by hiring an additional fifteen (15) limited duration AS1 positions and one (1) PEM-C position for the 2015-17 biennium. However these positions meet only the workload needs of BCU through the 2015-17 biennium.

Due to ongoing program growth and federal statutory changes implementing in the 2017-2019 biennium, BCU workload complexity is expected to increase 159% over 2012 numbers by 2019. Without sufficient permanent staffing increases for 2017-19, delays in processing background checks will begin increasing again.

The following chart relates increasing complexity from 2012 through 2025 based on current background check growth and known federal and state program changes occurring during the 2017-19 biennium. This chart does not include complexity per background check added by the expansion options. It does include the effects of process improvements such as the Long Term Care Registry.



In terms of the expansion portion, each option increases the depth of the background check provided for each subject individual, thereby increasing the likelihood of identifying past history that might affect the health and safety of vulnerable Oregonians. In addition, as noted, the CMS exclusion lists are a requirement of the CMS National Background Check Program grant.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

Comprehensive background checks promote the following:

- Safety and independence of those aging, disabled and intellectually/developmentally disabled Oregonians receiving services from DHS and OHA.
- Safety and wellness for children and youth served by DHS and OHA providers.
- Qualified staff and volunteers successfully passing background checks are able to support themselves and their families as providers through stable living wage employment.

Timely background checks due to matching workload versus staffing means that:

- Vulnerable Oregonians receiving care services from DHS and OHA acquire safe care and support more quickly, improving quality of life for especially those Oregonians requiring emergent in-home services.
- Employers of facilities are able to maintain staffing levels and provide better care to vulnerable Oregonians receiving care and support in facilities.
- Employers in residential care, nursing, adult foster home, skilled nursing, and child care facilities and centers are able to attract and keep top recruits due to faster hiring processes. In addition, they are able to meet licensing requirements for staffing more easily.
- Many licensing and certification processes are affected, thereby extending their timelines. Such processes include but not limited to licensing of facilities for APD, DD and mental health, and certification of home care workers and personal support workers, Traditional Health Workers, and exempt and subsidized Child Care centers and providers.
- Oregonians who may be seeking employment, licensure or certification for their own or their family's independence and quality of life are able to acquire jobs faster.

4. IS THIS POP TIED TO A DHS PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS MEASURE THE SUCCESS OF THIS POP?

Quality Service Engagement – increased speed of quality of background checks performed on providers in support of effective, safe employment, certification and licensing processes for vulnerable Oregonians and Oregon employers.

Safety – Re-abuse rates reduced through more timely identification of provider history.

People Living as Independently as Possible – Faster quality checks on in-home providers leading to safer care, more independence, and better support of Oregonians receiving in-home services. Enhanced checks on in-home and other long term care providers leading to safer care and better support of Oregonians receiving in-home services.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

N/A.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

A variety of internal solutions to meet service delivery agreements have been attempted by BCU to match increases in raw numbers and workload complexity.

- Ongoing work with IT vendor Tailored Solutions and the Oregon State Police (OSP) to achieve numerous process improvements via technology solutions. While useful in automating many time-consuming manual tasks it did not eliminate time spent on core fitness determination work.

- Day-long background check 'events' where all teams in the unit contribute to processing background checks. Assisted fitness determination work, but caused backlogs in Hearings, Compliance and Fingerprint teams' processes.
- Consistent monthly overtime work from October 2014 to August 2016. During that period BCU staff worked 1407.5 overtime hours and processed 25,227 background checks.

  To maximize the quantity processed, BCU staff working overtime focused on "cleans", background checks that had no criminal or abuse history. Cleans are the quickest and easiest checks to complete. Useful in eliminating cleans, but did not address the core fitness determination work of the majority of cases requiring careful research and evaluation of criminal and abuse history.

- Implemented the Long Term Care Registry (LTCR) in January 2015.

  To become active on the LTCR, a provider of long term care must pass an LTCR-related background check. Active status avoids redundant background checks between employers as subject individuals change roles within or between LTCR-covered facilities throughout Oregon.

  Since implementation, 73,961 providers of long term care have achieved active status. As of December 2016, employers have been able to bypass over 33,000 redundant background checks.

  In addition to savings of time for employers and clients in need of services, the LTCR has saved BCU approximately $1.478 million as of December 2016 in labor and fingerprint processing costs for duplicative background checks.

  The LTCR is expected to create a 17% reduction on long term care-related checks. However, per DAS population statistics, the long term care population in Oregon will have exceeded 18% growth between 2014 and 2018, eliminating that gain by 2019.

Despite these efficiencies, background check numbers and complexity have continued to increase beyond what staffing and process improvements could complete, leading to growing backlogs.

The final alternative is to not expand background check staffing despite backlogs. This alternative has been rejected for the following reasons:

1. Potential health and safety factors from vulnerable Oregonians not receiving support from vetted, safe providers sooner.
2. Providers already on the job with new, unreported history not being caught earlier due to delayed recertification background checks.
3. Employers being unable to meet license-related staffing requirements established to maintain client safety and wellbeing.
4. Employers having staffing delays or losing quality candidates due to delays in background check processing.
5. Potentiality of increased tort claims due to compromised health and safety, and financial abuse

For the background check expansion options, the alternative is to not expand background check criteria. This alternative was rejected for potential health and safety factors to those receiving DHS and OHA providers.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Adverse effects of not funding the workload-related section of this POP are as follow:

1. Without timely background checks, vulnerable Oregonians requiring emergent in-home care or facility-provided care may not have providers hired or facilities staffed sufficiently nor quickly for their health and safety needs.
2. Without timely review of background checks for currently working providers, providers with new, unreported history may not be removed from work for extended periods of time. Such an extension of review periods may lead to ongoing or repeated abuse and neglect of vulnerable clients, and causing harm or sometimes death.
3. Employers requiring certain staffing levels for licensing purposes may encounter licensing problems which affect the health, safety and wellness of the vulnerable clients they serve, and the financial

security of the employees and their families who depend on the viability of the facility or center being licensed.

4. Employers serving DHS and OHA clients may lose highly competitive candidates to other facilities or centers that are not regulated by the Background Check Unit (i.e., facilities not serving Medicare and Medicaid-dependent clients) due to delays in background check processing.
5. Potentially escalating tort claims due to compromised health and safety, and financial abuse.

Adverse effects of not funding the background check expansion sections of this POP are as follow, by recommended expansion option:

1. Without sharing adverse actions and terminations between DHS units, providers terminated for health, safety or fraud concerns in one provider unit may successfully transfer to another provider unit without communication of the circumstances of the initial adverse action. This may in turn affect the health, safety or financial wellness of vulnerable Oregonians.
2. While BCU utilizes APS information when completing fitness determinations for all APD, DD, and addictions and mental health providers, some providers from those groups have not historically received CPS checks per agreements with Oregon community stakeholders initiated by the HB2175 (2007) Workgroup.

   This gap affects over 100,000 background checks per year performed by BCU, each check representing a subject individual serving at least one if not multiple vulnerable Oregonians. Not funding this option will continue this gap for increasing numbers of long term care providers.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Other agencies may be affected as necessary to create intergovernmental agreements in support of information sharing on adverse actions.

Currently providers certified by the Office of Child Care (Department of Education) are able under rule, interagency agreement and state plan can bypass our background check process. There have been ongoing concerns with this process. The Office of Child Care also automatically approved providers under age 18 while DHS will background check providers age 16 and older. Office of Child Care providers also do not have the requirement to report new abuse substantiations or criminal history.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Adults and People with Disabilities Program
Child Care Unit
Child Welfare Program
Intellectual/Developmental Disabilities Program
Human Resources
Office of Adult Abuse Protection and Investigation
Office of Licensing and Regulatory Oversight

10. WHAT IS YOUR EQUITY ANALYSIS?

Timely background checks provide greater equity of:

1. Care and service to vulnerable Oregonians;
2. Hiring for Oregon employers;
3. Employment, licensure or certification for Oregonians employed or seeking employment in BCU-regulated programs.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): 22 staff July 1, 2018
End Date (if applicable): Permanent

a. Will there be new responsibilities for DHS? Specify which Program Area(s) and describe their new responsibilities.

☒ Background Check Unit
☒ APD/DD Provider Relations Unit
☒ Office of Licensing and Regulatory Oversight
☒ Child Care Unit/Direct Pay Unit
☒ APD/DD
☒ Child Welfare
☒ Office of Adult Abuse Prevention and Investigation

The majority of new responsibilities will lie with the Background Check Unit.

For the cross-communication portion of the POP, APD/DD Provider Relations Unit, OLRO, CCU, DPU, APD/DD, OAAPI and Child Welfare may all have new cross-reporting duties.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
Background Check Unit will receive the majority of impacts. Currently BCU's facilities are at maximum occupancy. New facilities and work stations will be required for current and additional staff. Training will be required for veteran and new staff on administrating the new background check options. Updates to the Criminal Records Information Management System may be necessary to implement all additions.

Additional positions for Background Check Unit will increase impact for Records, FMLA/OFLA, Recruitment, Human Resource Analyst and Payroll units.

There will also be workload for Facilities and the Office of Information Services.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No changes to client caseloads or direct client services.

However DHS, OHA, Allied Agencies on Aging, DD Brokerage, and other direct service staff assisting clients to find qualified, safe providers or assisting providers with enrollment processes will be beneficially affected by faster turnaround on background checks. Enrollment processes dependent on background checks will be completed more quickly leading to faster connections of clients with needed service providers.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

The staff required for permanent positions (24 months per biennium) are as follow:

- Workload-Related: 5.0 FTE permanent Administrative Specialist 1 (Fitness Determiner) and 1.0 FTE permanent Principle Executive/Manager C (BCU Supervisor) positions
- Communication Option: 1.0 FTE permanent Administrative Specialist 1
- CPS Expansion Option: 4.0 FTE permanent Administrative Specialist 1 (Fitness Determiner) and 1.0 FTE Compliance Specialist 2 (Hearings Representative) positions

The staff required for permanent positions (21 months per biennium) are as follow:

- Workload-Related: 10.0 FTE permanent Administrative Specialist 1 (Fitness Determiner) positions

Additional positions for Background Check Unit will increase impact for Records, FMLA/OFLA, Recruitment, Human Resource Analyst and Payroll units. There will also be workload for Facilities and the Office of Information Services.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Training would be required for all new staff.

Automatic URL access of OIG, SAM, and out-of-state exclusion lists by state(s) required for CMS grant-related checks will require one-time IT costs.

f. What are the ongoing costs?

Current 2015-17 costs in Services & Supplies are expected to increase to a total $8,842,569 for the 2017-19 biennium. These costs are expected to increase due to the following factors:

- +$5,335,316 from Oregon State Police and FBI fingerprint processing fees
- +$37,739 total for Adam Walsh and Child Care out-of-state CPS check costs.
- +$12,000 total for background check research site costs.
- +$307,514 total for agency-paid fingerprint capture for DHS and OHA employees and volunteers, Criminal Justice Information Services (CJIS) clearance, and Child Welfare foster and adoptive parents.
- +$50,000 for annual maintenance on the Criminal Records Information Management System (CRIMS).

Remaining S&S costs would be consistent with trends from the 2015-2017 biennium.

g. What are the potential savings?

Potential savings from timely, quality background checks are based on reductions in risks to health and safety for vulnerable Oregonians served by DHS and OHA. There are savings for clients who receive more timely care, thereby preventing additional medical or support costs that might be

incurred. By increasing health, safety and wellness, money will also be saved through prevention of investigations, hearings, and potential tort claims.

Employers will receive savings due to more timely hiring processes, fewer qualified staff lost due to waits on background checks, and potential fines or other licensing problems for not retaining statutorily-mandated staffing levels.

Approved subject individuals seeking work will be employed more quickly, which may preclude those who are currently unemployed from continuing to receive unemployment benefits or other State-provided support services.

h. Based on these answers, is there a fiscal impact?
Yes.

TOTAL FOR THIS PACKAGE (DHS+OHA)

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	1,353,317	0	1,353,317	22	11.00
Services & Supplies	316,365	5,898,483	61,446	6,276,294		
Special Payments	5,915,435	19,214	1,202,301	7,136,950		
Total	**$6,231,800**	**$7,271,014**	**$1,263,747**	**$14,766,561**	**22**	**11.00**

DHS/OHA - Fiscal Impact Summary by Program Area:

	DHS Shared Services	DHS SAEC	OHA SAEC	Total
General Fund	**$0**	**$6,118,266**	**$113,534**	**$6,231,800**
Other Fund	**$7,251,800**	**$0**	**$19,214**	**$7,271,014**
Federal Funds- Ltd	**$0**	**$1,221,826**	**$41,921**	**$1,263,747**
Total Funds	**$7,251,800**	**$7,340,092**	**$174,669**	**$14,766,561**
Positions	**22**	**0**	**0**	**22**
FTE	**11.00**	**0.00**	**0.00**	**11.00**

What are the sources of funding and the funding split for each one?
For purposes of this analysis, the cost allocation and fund splits for DHS/OHA are based on the 15-17 Cost Allocation model where we have applied the aggregate DHS/OHA fund splits of GF, OF and FF. Available revenue sources are based on Grants which are entitlement grants that are matched and grants that are not federally capped and are available to program or office within DHS/OHA.

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Public Health Division Center for Health Protection
Program Name: Environmental Public Health
Policy Option Package Title: Cleaner Air Oregon Initiative
Policy Option Package Number: 401
Related Legislation: N/A

Summary Statement:

This POP would improve the capacity of the Environmental Public Health Section of the Public Health Division to protect Oregon communities from emissions of industrial air toxics and other environmental health risks. Preventing environmental exposures can reduce the rates of illness and decrease the overall costs of health care in Oregon. Currently, Oregon applies a federal regulatory "floor" that sets pollution control requirements based on type of equipment and volume of emissions (i.e., "technology based" standards). Funding this POP would give Oregon Health Authority (OHA) the capacity to work with the Oregon Department of Environmental Quality (DEQ) to design and implement a health-risk-based industrial air toxics permitting program, as 33 other states have. OHA would provide the expertise needed to set scientifically-supported emissions limits and pollution control requirements based on health risks to protect the health of all Oregonians, and particularly reduce exposures to populations with low-incomes, people of color, children, and others who bear elevated health burdens and geographic proximity to pollution sources.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$720,290**	**$32,124**	**-$476,673**	**$275,741**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP will address gaps in the capacity of the Environmental Public Health (EPH) Section of the OHA Public Health Division (PHD). EPH is funded primarily through federal grants, which have strict requirements on how they can be spent. There is little flexibility to perform work that is outside the scope of the grant. When situations arise such as the recent metals emissions from glass manufacturers, this rigid funding system makes it challenging to implement an appropriately resourced response. In order to address recent air quality issues, in April 2016 the Governor launched a "Cleaner Air Oregon" initiative directing OHA to partner closely with DEQ to overhaul the state's current industrial air toxics regulations to better protect people's health and promote health equity. In addition to sustaining the Cleaner Air Oregon effort, this POP will also augment existing limited capacity within EPH to address other pressing environmental health actions related to lead, radon, pesticides, brownfields, harmful algal blooms, climate change, and more.

2. WHY DOES OHA PROPOSE THIS POP?

This POP would provide Environmental Public Health Section capacity to ensure DEQ's new industrial air toxics rules and implementation strategies align with health protection and equity and environmental justice considerations. DEQ's expertise is identifying, measuring, and regulating sources of pollution; it is able to implement the current federal industrial air toxics technology-based standards without information about localized health impacts. OHA's expertise is needed to formulate a regulatory scheme that considers health impacts to people generally and as they may disproportionately affect people with low income, communities of color, children, the elderly, and other sensitive populations. OHA also brings public health education expertise to communicate to the public where there is – and is not – a public health concern. It is important to develop rules that appropriately balance health protection and a healthy economy, and is in keeping with best practice of public health that considers a full range of determinants of health.. As part of the regulatory overhaul, DEQ is exercising existing authority to require that facilities submit substantial new data and information about their actual emissions; which will generate significant interest from the public. OHA will

interpret the data to provide information about what the information means for people's health. Examples of this joint agency collaborative work has already occurred at multiple sites where U.S. Forest Service analysis of metals in moss samples led DEQ to conduct air monitoring at nearby industrial facilities. OHA is the state agency appropriate to provide this expertise.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

The Public Health Division's vision is: Lifelong health for all people in Oregon. Our mission is: Promoting health and preventing the leading causes of death, disease and injury in Oregon. House Bill 3100 (2015) directed OHA to conduct an assessment to identify priorities for modernizing the state's public health system. The assessment identified capacity to protect the public from environmental health threats as one of the three modernization priorities. Providing EPH with the capacity envisioned by this POP would improve capacity to prevent environmental exposures from industrial air toxics that cause disease and injury in Oregon, especially among populations at higher risk of adverse effects from industrial emissions. This effort also directly supports the Governor's strategic focus area of Responsible Environmental Stewardship.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

This POP is not tied to an existing performance measure. OHA will measure the success of this effort by tracking the number of health-based regulations adopted, the increased number of primary prevention activities performed and the improved health outcomes of Oregonians as a whole.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

EPH may be targeted for increased resources through public health modernization in future biennia. However, staff are stretched extremely thin because of recent events concerning lead in school drinking water, radon in schools, general air quality concerns in a variety of locations around Oregon, metals emissions from glass manufacturers, and the development of health-based air quality standards in coordination with DEQ. Additional support is required to continue these immediate efforts.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

If this POP is not funded, DEQ and OHA will not be able to meet the timeline set by the Governor to complete the industrial air toxics rulemaking. More generally, EPH will continue to have an inadequate capacity to effectively respond to existing and emerging environmental health concerns in Oregon.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Expanding EPH's capacity would benefit DEQ by increasing capacity to develop health-based air quality standards and to respond to the concerns of Oregonians about environmental health threats.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

DEQ and the Governor's Office.

10. WHAT IS YOUR EQUITY ANALYSIS?

Industrial air toxics, like many environmental health risks, disproportionately affect low-income and minority populations. For example, recent research findings show childhood lead poisoning rates are higher in children with low socioeconomic status because malnutrition, specifically inadequate calcium, results in higher uptake of lead into the body. Low-income housing is commonly located near industrial areas or highways, where air quality is typically poor. Asthma rates among low-income and minority populations are

higher than the general population. In the context of the Cleaner Air Oregon rulemaking, EPH expertise has been essential to identifying and informing policy proposals that address environmental justice concerns, such as assessing cumulative risks to people exposed to multiple pollutants and to pollutants from multiple facilities, and setting risk-based concentrations of allowable pollutants. These approaches prioritize environmental health concerns using a lens of health equity and environmental justice. Increasing the capacity of EPH to proactively address health concerns will decrease illness and the overall cost of health care in Oregon.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

This POP includes pricing for five positions (5.00 FTE). Existing position authority is repurposed to fulfill the staffing needs identified in this POP. No new position authority is requested.

Implementation Date(s): Ju1y 1, 2017

End Date (if applicable): Ongoing

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

EPH will be performing a new role in partnering with DEQ to develop and guide implementation of health-based regulation. Other responsibilities will see a significant expansion of efforts.

☒ Public Health Division
☒ Environmental Public Health (PHD)

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
Contract support will be required if sub-contracting occurs.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
Additional capacity would allow EPH to extend its reach to additional population groups.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.
Yes. The table below details the existing position authority that is repurposed for this POP.

Action	Position#	Class Title	Type	Pos	FTE	GF	OF	FF	TF
Abolish	0000848	Chemist 3	PF	-1	-1.00	$0	-$174,293	$0	-$174,293
Abolish	1000692	OS 2	PF	-1	-1.00	$0	$0	-$112,166	-$112,166
Abolish	0000723	OS 2	PF	-1	-1.00	$0	-$112,166	$0	-$112,166
Abolish	0000369	Epidemiologist 2	PF	-1	-1.00	$0	$0	-$181,102	-$181,102
Abolish	0000902	RA 3	PF	-1	-1.00	$0	-$13,390	-$148,500	-$161,890
Establish	1015059	PHP 2	PF	1	1.00	$304,969	$0	$0	$304,969
Establish	1015060	NRS 4	PF	1	1.00	$70,610	$117,681	$0	$188,291
Establish	1015061	PHE 2	PF	1	1.00	$80,947	$80,947	$0	$161,894
Establish	1015062	PA 3	PF	1	1.00	$181,102	$0	$0	$181,102
Establish	1015358	PH Toxicologist	PF	1	1.00	$45,276	$135,828	$0	$193,067
Total				0	0.00	$682,904	$34,607	-$441,768	$717,511

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

f. What are the ongoing costs?
Salary, administrative overhead.

g. What are the potential savings?
Decreased health care costs, educational costs, and costs from repercussions of behavioral issues are areas of potential savings. Many air toxics, such as lead or hexavalent chromium, are potent neurotoxins that adversely affect cognition, behavior, and other aspects of physical and mental development, particularly in children. Other emissions may represent environmental triggers for adverse respiratory or cardiovascular episodes; preventing such episodes can prevents a costly visit to the emergency room. Yet others are carcinogens, so preventing exposure can reduce the incidence of cancer.

h. Based on these answers, is there a fiscal impact?
Yes.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$###	$###	$###	$###	0	0.00
Services & Supplies	$###	$###	$###	$###		
Total	**$720,290**	**$32,124**	**-$476,673**	**$275,741**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	EPH	Total
General Fund	**$720,290**	**$720,290**
Other Fund	**$32,124**	**$32,124**
Federal Funds- Ltd	**-$476,673**	**-$476,673**
Total Funds	**$275,741**	**$275,741**

What are the sources of funding and the funding split for each one?
Funding for this POP will include a combination of State General Fund and a transfer of Other Fund fee revenue from DEQ. This POP also includes Other Fund and Federal Fund reductions for empty limitation.

EPH Revenue Impact:

Description of Revenue	GF	OF	FF	TF
State General Fund (Comp Srce 0050)	720,290	0	0	720,290
Other Revenue (Comp Srce 0975)	0	-385,361	0	-385,361
Federal Revenue (Comp Srce 0995)	0	0	-476,673	-476,673
Transfer in from DEQ (Comp Srce 1340)	0	417,485	0	417,485
Total	**$720,290**	**$32,124**	**-$476,673**	**$275,741**

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name:	**Oregon Health Authority**
Program Area Name:	**OHA Fiscal and Operations Division**
Program Name:	**Office of Program Integrity**
Policy Option Package Title:	**Enhance OHA Office of Program Integrity**
Policy Option Package Number:	**402**
Related Legislation:	**Senate Bill 1577 (2014 Regular Session); federal regulation**

Summary Statement:

The purpose of the OHA Program Integrity POP is to build a successful and cost-effective program to detect, prevent and investigate fraud, waste and abuse. This POP would add seven new governmental auditor (GA 2) positions to the Provider Audit Unit. This would enable OHA to:

- Improve its program to detect, prevent and investigate Medicaid and non-Medicaid fraud, waste and abuse
- Audit and investigate the coordinated care organizations and their provider networks for fraud, waste and abuse
- Comply with the Centers for Medicare and Medicaid Services (CMS) new and enhanced program integrity requirements for managed care organizations
- Increase oversight of provider types and practices that are vulnerable to fraud, waste and abuse. These include home- and community-based services; long-term care services and supports; durable medical equipment; behavioral health; pharmacy billing; contracted services; and waiver-based services
- Work with contractors to investigate and audit fraud, waste and abuse leads provided by data analyses and discoveries
- Augment Medicaid beneficiary fraud investigations

- Strengthen program integrity principles throughout Medicaid rules

The staffing enhancements are critical to the additional fraud, waste and abuse strategies proposed in this POP.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$1,566,735**	**$2,050,000**	**$3,614,761**	**$7,231,496**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Comprehensive oversight and monitoring of the entire Medicaid investment would create great efficiencies for OHA and increase the amount of inappropriate payments returned to OHA.

The Centers for Medicare and Medicaid Services noted the ***lack of a centralized program integrity oversight program*** in OHA in its 2010 and 2013 program integrity reviews. (In 2010, OHA programs were part of the single agency DHS). CMS strongly recommended Oregon identify a central unit to oversee federally mandated comprehensive program integrity activities, and to develop and manage a formal program integrity work plan. With existing resources OHA created the Office for Program Integrity under the chief financial officer, and transferred the Provider Audit Unit from Shared Services to this office.

As the Single State Medicaid Agency under ORS 413.032(1)(g), OHA has the obligation and responsibility to provide a comprehensive program to prevent, detect and investigate Medicaid fraud, waste and abuse. The POP would fund seven new governmental auditor (GA 2) positions for the Provider Audit Unit. This would allow the unit to provide better oversight and monitoring of provider types and practices that are vulnerable to fraud, waste and abuse, including home and community based services; long-term care services and supports; durable medical equipment (DME); behavioral health; pharmacy billing; contracted services; and waiver-based services. It also would bring program integrity practices to OHA rule making, contracting and

operations. One of the positions would be specifically focused on issues of the Medicaid Management Information System (MMIS) that can cause inappropriate payments.

The POP also includes contracting with a data-analytic contractor to perform advanced and innovative analytics on Medicaid data. The new positions would incorporate these analytics into their fraud, waste and abuse prevention and investigation activities.

Based on existing audit operations, the seven new permanent FTE are projected to have an annual return on investment (ROI) of approximately $3 for each $1 spent (including savings that accrue directly to CMS). This ROI would essentially self-fund the positions.

2. WHY DOES OHA PROPOSE THIS POP?

OHA is held accountable to CMS for all program integrity operations, and retains the ultimate administrative authority and responsibility for the operation and oversight of the Medicaid program. OHA is specifically responsible to ensure that all Medicaid funds expended under its authority (the entire Medicaid investment) are spent appropriately and in accordance with federal and state law, federal and state regulations, the State Plan, State Plan Amendments and all waivers. Strengthening program integrity will bring consistency to the auditing of all Medicaid providers; will enhance auditing and oversight of certain Medicaid-funded operations; and will expand fraud, waste and abuse auditing and oversight of all Medicaid providers and operations. In addition, the inclusion of a data-analytic contractor would build a more robust analytic operation within Medicaid, but would require additional government auditing staff to follow up on the results, findings and leads that the contractor discovers.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

This POP will further OHA's goals of transparency, stewardship and accountability by coordinating federally mandated program integrity operations. The agency's auditing of Medicaid providers currently is limited to fee-for-service (FFS) providers, and the resource base further limits our ability have a highly effective FWA program. The additional GA2 staff and the data analytic contractor will allow for a more comprehensive effort to audit managed care Medicaid operations and the long-term care services and supports (LTCSS) system and the home- and community-based systems. The rapid growth of the Medicaid populations (nearly doubled membership), coupled with the magnitude of OHA's CCO program and the aging population present significant vulnerabilities over which we currently have limited independent audit and oversight capacity.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

OHA is required to report on recoveries, savings and return on investment (ROI). This POP would include the development, monitoring and reporting of consistent and appropriate metrics with stakeholders, CMS and other agencies. These metrics will allow OHA to develop recovery-based budgeting; understand and incorporate cost-avoidance impacts; and have a clear line-of-sight to return on investment.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The alternative would be to leave program integrity operations in their current state. The Oregon Medicaid program and population are growing and OHA's accountability, monitoring and oversight responsibilities

must keep pace with this growth. The POP will allow for OHA oversight and monitoring of the significant Medicaid investment made through the CCOs, OHA and DHS. It also would ensure compliance with CMS's new MCO program integrity rules.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Not funding the POP would continue the limited scope and function of the OHA program integrity FWA operations. OHA would continue to face challenges in monitoring the largest Medicaid investments through the CCOs, OHA and DHS. Lack of a data analytics contractor would limit OHA's ability to look for FWA leads. Lack of funding for the new auditor positions would limit OHA's scope of auditing in areas of substantial Medicaid expenditures.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

The POP, by increasing FWA audit activities, may affect other state agencies that receive substantial Medicaid funds such as DHS, and to a minor extent tribal and local governments.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Agencies, programs and stakeholders that work with Medicaid (as with other federal and state funding streams) widely understand that such work includes FWA oversight and monitoring. They recognize OHA's role as the single state Medicaid agency. OHA has worked and will continue to collaborate with these partners in developing the appropriate FWA program for Oregon Medicaid.

10. WHAT IS YOUR EQUITY ANALYSIS?

There are no known racial or ethnic inequalities associated with this POP.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?
Adding seven GA 2 positions (entering at step 2 or 3)

Implementation Date(s): October 1, 2017

End Date (if applicable): N/A

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

☒ Administrator of Program Integrity
☒ Chief Financial Officer

The Administrator of Program Integrity will assume the responsibilities for all aspects of the Program Integrity Unit, and the operations and functions of the OHA Medicaid PI program as described in the POP.

The CFO will have responsibility for ensuring the effective management and oversight of the Program Integrity Unit as described in the POP.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
Hiring cost of new auditing staff are fully loaded. Offices affected by the hire are: HR, facilities, OIS, training and onboarding.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

New staff: seven total

GA 2, seven positions = 21 months for 2017-2019 biennium; continuous for subsequent biennium; permanent full time

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Start-up costs would be negligible. The new staff would be incorporated into the existing audit unit. No new or significant modifications are anticipated.

f. What are the ongoing costs?

Typical per FTE for classification (see financials below).

g. What are the potential savings?

Based on existing, and limited audit operations, the seven new permanent FTE are projected to have an ROI of approximately $3:$1 per year (including savings that accrue directly to CMS), essentially self-funding the positions. Efficiencies will be gained and inappropriate payments will be returned to OHA.

The ROI for the data analytic contractor may not be fully realized in 2017-2019; however, ROI estimates for the 2019-2021 biennium would be similar to the audit positions.

h. Based on these answers, is there a fiscal impact?
Yes, as a result of the funding request for new positions and the data analytic contractor.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$495,782	0	$495,796	$991,578	7	6.16
Services & Supplies	$3,120,953	0	$3,118,965	$6,239,918		
Special Payments	($2,050,000)	$2,050,000	0	0		
Total	**$1,566,735**	**$2,050,000**	**$3,614,761**	**$7,231,496**	**7**	**6.16**

OHA - Fiscal Impact Summary by Program Area:

	HSD Admin	HSD Medicaid	Total
General Fund	**$3,616,735**	**$(2,050,000)**	**$1,566,735**
Other Fund	**$0**	**$2,050,000**	**$2,050,000**
Federal Funds- Ltd	**$3,614,761**	**$0**	**$3,614,761**
Total Funds	**$7,231,496**	**$0**	**$7,231,496**
Positions	**7**	**0**	**7**
FTE	**6.16**	**0.00**	**6.16**

What are the sources of funding and the funding split for each one?
State General Fund. The Other Funds represent funding recovery and the Federal Funds are Medicaid Admin.

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: OHP Pharmaceutical Benefit Program
Program Name: Medicaid Population Hepatitis C Treatment
Policy Option Package Title: Hepatitis C (HCV) Treatment Coverage Expansion
Policy Option Package Number: 403
Related Legislation: N/A

Summary Statement:

Hepatitis C is a viral infection that primarily affects the liver and progresses through several stages of increasing severity. Higher stages of the disease result in chronic liver disease, liver failure and possibly liver cancer. Direct-acting antiviral medications, known as DAAs, are available to treat Hepatitis C infection and frequently result in a cure. In general, DAAs are expensive compared to other prescription drugs. The Oregon Health Plan offers treatment for the diseases at stages F3 and F4, and is limited at earlier stages. This POP would provide funds to cover treatment to OHP members beginning at stage F2.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$31,962,732**	**$14,345,088**	**$150,188,333**	**$196,426,153**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP would provide additional targeted funding to expand access to direct-acting antiviral (DAA) drugs to OHP members at stage F2 of hepatitis C.

DAA drugs, a new type of hepatitis C (HCV) treatment, came to market in December 2013. OHA worked with a coalition of patient care advocates, physicians, pharmacists, and CCO representatives through the Oregon Health Plan Pharmacy and Therapeutics Committee to design appropriate, conservative coverage criteria for the costly new drugs. Hepatitis C patients who receive OHP benefits on a fee-for-service basis are covered primarily for stages F3 and F4. (The "F" stands for fibrosis, which describes damage to liver tissue.) FFS clients have access to the treatment at earlier stages only under certain circumstances. OHA requires coordinated care organizations (CCOs) to provide coverage that is substantially similar or better.

In the past two years some states' Medicaid programs have moved to include coverage before F3. The reasons include shifting standards of care, lower costs from competition with newer drugs, specific guidance from the Centers for Medicare and Medicaid Services (CMS), litigation and threats of litigation.

After consideration of clinical evidence, OHA concluded it would be appropriate to expand current coverage criteria to treat the disease at the F2 stage.

2. WHY DOES OHA PROPOSE THIS POP?

Deaths from HCV in Oregon rose steadily over the past decade, averaging more than 400 annually from 2009 to 2013. The HCV mortality rate was six times higher than that of HIV in Oregon during that five-year period, and in 2013 was twice the national average.

This POP will expand the current OHP program coverage guidelines to treat stage F2 HCV in FFS and CCO populations. It would not create any completely new programs. It would affect OHP members with HCV, including FFS clients and CCO members. It would also affect specialists and primary care providers who

care for clients and members with HCV by offering expanded treatment options to patients. It would improve health by functionally curing disease and preventing some spread of HCV. Legal cases recently filed in other states, including Washington, argue federal law requires state Medicaid programs to cover DAAs without regard to staging and in some cases resulted in federal court orders requiring expanded treatment of the disease beyond F2.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

OHA's mission is "Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care." Expanding HCV treatment to F2 provides increased access to a high-quality treatment for Oregonians affected by this disease. Additionally, expanded coverage would address prevention by decreasing the pool of infected individuals who could potentially spread disease to others.

OHA, in consultation with OSU pharmacy subcontractor staff, clinical staff, and the Oregon Department of Justice, concluded that it is necessary to expand coverage to stage F2 to ensure that state policy does unreasonably restrict coverage of effective treatment. This was in response to guidance letter 172 from the Centers for Medicare and Medicaid Services. That letter stated, in part, "CMS is concerned that some states are restricting access to DAA HCV drugs contrary to the statutory requirements in section 1927 of the Act by imposing conditions for coverage that may unreasonably restrict access to these drugs."

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

The success of HCV treatment with DAAs can be monitored at the patient level with a blood test known as the Sustained Virologic Response (SVR). OHA contracts with a third party to track the SVR in the FFS population, and SVR also is tracked at the CCO level. OHA will work to develop a model to track SVR results of Medicaid treated patients to monitor the success of treatment.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

OHA considered not expanding coverage to F2. Reasons for rejecting this include risk of litigation, risk of noncompliance with CMS directive, and limited clinical justification.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

There are three primary adverse effects of not funding this POP.

First, OHA would incur HCV treatment costs that could have been avoided by providing earlier DAA access. Treatment at later stages may require specialist oversight, also at an additional cost, and could even result in a need for a liver transplant.

Second, the disease will continue to spread if infected individuals are not treated. This in turn will result in additional affected individuals with associated health conditions and treatment costs.

Third, OHA would face a significant risk of litigation. At least two class action lawsuits have been filed in other states (Washington and Indiana) over restriction of DAA coverage to stages F3 and F4. Litigation could result in a federal injunction that severely limits OHA's ability to manage coverage of medically appropriate care.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Tribal populations would be affected by expanded treatment of HCV, as their members would receive this benefit. In Oregon, American Indians and Alaska Natives are twice as likely as whites to die from HCV, according to Oregon Public Health data.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None.

10. WHAT IS YOUR EQUITY ANALYSIS?

Significant racial disparities exist in Oregon: the burden of HCV disproportionately affects African Americans and American Indians/Alaska Natives compared to whites. Rates of reported cases of chronic HCV infection are more than twice as high; cases of liver cancer are 50 percent higher, and HCV-related deaths are twice as high in African American and American Indians compared to whites (see table and figure below).

Condition	Incidence Rates (cases per 100,000)		
	Whites	Blacks	AI/AN
Chronic HCV infection	57.5	124.4	127.7
Liver cancer due to HCV	3.1	5.1	4.1
HCV deaths	8.9	16.1	17.4

Please see the OHA's Viral Hepatitis in Oregon report from May 2015, available online at: https://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/AdultViralHepatitis/Documents/Viral_Hepatitis_Epi_Profile.pdf

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 2017 – based on approximately 3,300 currently enrolled OHP members who are likely in Stage 2 of Hepatitis C. This POP assumes the approximately 3,300 would receive treatment during the 2017-2019 biennium. The cost per treatment is based on current cost of pharmaceuticals for CCO members and fee-for-service members.

End Date (if applicable): N/A

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

OHA will be responsible for expanded monitoring and oversight of CCOs to ensure CCOs provide appropriate access to treatment in accordance with federal regulations, and are not more restrictive than FFS in terms of scope, duration and amount of treatment. This will be new work in terms of oversight of F2 treatment.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.

None.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

Expanded treatment to stage F2 disease will result in the need for more intense medical management of F2 individuals while they undergo treatment for a limited time, typically no longer than 12 weeks.

This would potentially involve more frequent physician office visits and working with a designated case worker. For the FFS population this work would be conducted by a third party medical management entity that already does this work for F3 and F4 members. CCOs would use locally developed resources to conduct this work. The estimated number of OHP members with stage F2 is 3,300.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

No new staff or and no modifications to existing positions will be required.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

Not applicable – the costs in the POP are the costs to provide the treatment to eligible OHP members. Currently, OHP covers the costs for OHP members in stage 3 and 4. This does not require any changes to existing systems.

f. What are the ongoing costs?

Ongoing costs will include treatment for OHP clients in Stage 2 as part of the OHP benefit.

g. What are the potential savings?

Potential savings would include long-term better health outcomes for those with Hepatitis C. those with the disease presumably would not progress to higher stages of the disease that lead to chronic liver disease, liver failure and possibly liver cancer. Given the uncertainty around other cost factors related to treating the Hepatitis C population, OHA is cautious about pricing a long-term saving; however, it is likely that OHP would realize an avoidance of future costs because this population would not need to receive higher-cost future treatment.

h. Based on these answers, is there a fiscal impact?
Yes – see below.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Special Payments	$31,962,732	$14,345,088	$150,118,333	$196,426,153		
Total	**$31,962,732**	**$14,345,088**	**$150,118,333**	**$196,426,153**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	HSD Medicaid	Total
General Fund	**$31,962,732**	**$31,962,732**
Other Fund	**$14,345,088**	**$14,345,088**
Federal Funds- Ltd	**$150,118,333**	**$150,118,333**
Total Funds	**$196,426,153**	**$196,426,153**

What are the sources of funding and the funding split for each one?
Other Funds will be funds received from Drug Rebates and will offset General Fund and Medicaid Fund.

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division – Non Medicaid
Program Name: Child and Family Behavioral Health
Policy Option Package Title: Juvenile Fitness to Proceed
Policy Option Package Number: 404
Related Legislation: Juvenile Fitness to Proceed Legislative Concept

Summary Statement:

This policy option package corresponds to the Juvenile Fitness to Proceed (Aid and Assist) legislative concept, which would change Oregon Revised Statutes in the area of what is known as juvenile fitness to proceed. If these changes become law, youth who are receiving behavioral health services with the aim of restoring their fitness to assist with their legal defense would receive those services in a non-residential setting in their community. This would reduce the burden on the youth mental health residential system and generate General Fund savings by decreasing inappropriate use of residential treatment for these youth.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**($438,984)**	**$0-**	**$0-**	**($438,984)**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Under the current Juvenile Fitness to Proceed (Aid and Assist) statute, youth who need "restorative services" or a fitness to proceed evaluation can be placed in a secure facility under certain circumstances. OHA has designated the Secure Adolescent Inpatient Program (SAIP) at the Children's Farm Home as the facility to be used in these cases. Youth are being referred to this facility with increasing frequency, at times inappropriately. This can result in youth being served at a level of care that does not meet their needs, extra costs to OHA, and further delays for other youth who are waiting for a residential placement.

2. WHY DOES OHA PROPOSE THIS POP?

Restorative services are most effective when they accompany medically necessary behavioral health services and supports. The SAIP facility may be inappropriate for youth who need restorative services. A better option is for the youth to receive treatment through existing local programs. This also allows youth who do require residential services at SAIP to have access to those services.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

This POP would create savings in the area of secure residential services by changing the process for referring youth to residential treatment. The combined legislative concept and POP direct the judicial system and the youth behavioral health system to serve youth in the most appropriate setting, and address the children's residential system capacity issues. It also will put more responsibility on the community mental health programs (CMHP) to provide for the needs of the youth in their counties.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

This POP will save money, be a step toward providing medically necessary behavioral health services in the least restrictive environment possible, and reduce part of the strain on the youth mental health residential system—especially at the highest levels of care.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

OHA has developed a corresponding legislative concept to amend ORS 419C.378-398 (juvenile fitness to proceed statute). The legislative concept and POP should be considered a package. One should not move forward without the other.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

N/A

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

This POP does not require funding. If it is not enacted, our processes will remain the same. This will likely result in courts continuing to order youth into an inappropriate level of care at the SAIP.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

DHS Child Welfare: Many of the youth that are ordered to participate in restorative services are in DHS custody. When these youth experience placement struggles, DHS may seek placement at SAIP for restorative services.

County juvenile departments: County probation staff are responsible for community supervision of youth who receive restorative services in the community. When community safety is a concern, juvenile justice departments may seek a placement at SAIP.

CMHPs: County mental health programs will be expected to provide appropriate placement recommendations.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None.

10. WHAT IS YOUR EQUITY ANALYSIS?

This POP brings the juvenile statute more closely in line with medically necessary treatment and serving youth in the least restrictive environment available.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): 1/1/18

End Date (if applicable): NA

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

No new Responsibilities for OHA.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
No

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No. We will still serve the same amount of youth in restorative services, but may serve them in different environments.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.
No changes for staffing or modification of duties.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
No start-up costs. The program is up and running.

f. What are the ongoing costs?
No ongoing costs, only anticipated savings.

g. What are the potential savings?
Serving fewer youth with restorative services in SAIP creates potential savings (see worksheet).

h. Based on these answers, is there a fiscal impact?
There are potential and likely savings.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Special Payments	($438,984)	0	0	($438,984)		
Total	**($438,984)**	**$0**	**$0**	**($438,984)**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	Child and Family Behavioral Health	Total
General Fund	($438,984)	**($438,984)**
Total Funds	**($438,984)**	**($438,984)**

Department of Human Services / Oregon Health Authority
2017-2019 Policy Option Package

Agency Name:	**Oregon Health Authority (OHA)**
Program Area Name:	**Office of Information Systems/Health Systems Division**
Program Name:	**Office of Information Systems/Health Systems Division**
Policy Option Package Title:	**Medicaid Management Information System (MMIS) Strategic Plan for Modularization**
Policy Option Package Number:	**405**
Related Legislation:	**N/A**

Summary Statement:

The Centers for Medicare and Medicaid Services (CMS) requires all states to move toward a modular design on their information systems that support the Medicaid program. This will allow the systems to be upgraded as programs and technology evolve. They have to use a competitive process to plan and implement these modular solutions. Oregon's current Medicaid Management Information System (MMIS) is a monolithic system implemented in 2008. MMIS was designed primarily to support a fee for service-based model. It later was extensively modified to support Oregon's capitation-based coordinated care organization (CCO) model. This POP requests state funds to secure 90 percent federal participation funds to: define Oregon's Medicaid service delivery strategic plan, assess the approaches other states have taken toward modularization; identify options for modular solutions; define certification requirements as required by CMS; and begin the procurement process.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$367,739**	**$2,022,391**	**$3,241,513**	**$5,631,643**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP supports OHA and DHS as they begin planning to comply CMS requirements for delivery of Medicaid services in Oregon. CMS is requiring that all states use interconnected modules or components to create a system of services, software, data and interfaces.
These modules will be inter-operable, scalable, reusable and relatively independent of other application modules, allowing them to be updated or even replaced without an impact on the whole.

OHA and DHS anticipate a five-year effort to re-align the systems that support Oregon's Medicaid program to a modular business and technical architecture. For the 2017-2019 biennium, emphasis will be on defining the strategy, roadmap and approach.

Activities this POP will fund include:

- Development of a Medicaid service delivery strategic plan. It would outline Oregon's alignment to the Affordable Care Act (ACA) and business architecture that supports the CCO capitation model and other value-based payment models. It also would still support the fee-for-service payment model. Oregon plans to use an independent consulting organization as a strategic technology advisor to help with planning efforts at three levels:
    - An executive-level trusted advisor helping leadership define Oregon's Medicaid service delivery strategy
    - A program-level guide to help define functional requirements, capture operational business needs, define and refine business processes, and optimize workflow
    - An industry expert to help Oregon identify the best acquisition strategy and approach by examining industry best practices, other states' approaches and lessons learned. . This entity will also help Oregon determine the optimal project structure and staffing model.
- Update Oregon's Medicaid Information Technology Architecture (MITA) five-year plan in accordance with CMS requirements

- Incorporate CMS certification requirements into Medicaid solution alternative requirements to ensure compliance with certification criteria
- Define an overall technical architecture that ensures modular components will work together to support Medicaid business operations
- An acquisition approach, roadmap and detailed plan recommending the optimal sequence for procuring and implementing components
- Develop a request for proposal to solicit modular solutions meeting Oregon requirements, and a request for proposal to solicit system integrator services
- An policy option package in the 2019-2021 Agency Request Budget for implementation
- Quality assurance throughout the planning and implementation lifecycle to help manage project risk through the review of project related processes and deliverables

2. WHY DOES DHS/OHA PROPOSE THIS POP?

This POP provides the funding match necessary to secure 90 percent enhanced federal funding from CMS to support the planning efforts outlined above. A rigorous planning process is necessary to ensure Oregon's roadmap meets CMS requirements, considers continued stability of the existing mission-critical MMIS system during the planning and implementation, and supports Oregon's health care transformation.

It is essential that OHA and DHS begin planning efforts now. Planning and implementation are expected to take five years. OHA's current contract with the existing MMIS solution provider is undergoing a five-year extension, which will expire by the year 2022. Oregon needs to be prepared to start implementation with enough lead-time before that extended contract expires.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

CMS currently funds maintenance and operational costs of the MMIS system at a 75 percent Federal Fund match rate. Oregon General Funds are used for the state's 25 percent portion. Annually, the contract for supporting MMIS totals over $20 million with Oregon contributing approximately $5 million. CMS has

recently indicated that continued eligibility for this level of federal funding depends on compliance with CMS mandates and evidence of a state's commitment to a thorough planning effort supporting a modular future state. Oregon risks loss of CMS enhanced funding for maintenance and operations, which would result in the state assuming 100 percent of responsibility to fund operations and maintenance of the MMIS with General Funds.

CMS recognizes that shifting to a modular environment will require careful planning and incremental implementation over several biennia. CMS is supportive of Oregon's intent to leverage a strategic technology consultant to aid the planning efforts and has signaled that it would provide enhanced federal funding at the 90 percent level to support these efforts. This translates into substantially lower investment costs for Oregon to transform its existing Medicaid systems. Access to enhanced funding will allow Oregon to incrementally implement modular solutions over the next five to seven years while shouldering only 10 percent of the primary costs and 25 percent of any hardware expenditures. At an anticipated total cost of $150 million, the estimated cost in Oregon General Funds will be under $20 million.

4. IS THIS POP TIED TO AN OHA OR DHS PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS MEASURE THE SUCCESS OF THIS POP?

Although this POP does not tie to a DHS performance measure directly, success will be measured by having a strategy that reduces both DHS and OHA's dependency on a single MMIS vendor, supporting overall health care transformation. For OHA, this POP ties to KMP #31, OHA's triple aim measure.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Two alternatives were considered:

1. Do nothing – continue to extend the existing support contract with HPE.
   - The current MMIS was implemented with a maintenance and operations contract of five years with a three-year extension for a total of eight years. Those eight years end February 27, 2017. OHA is seeking an extension of three years with an optional two-year extension to develop and execute the modularization plan.
   - While CMS is supportive of Oregon's need for time and funding to plan for the future, they will not be supportive if Oregon does not demonstrate a commitment to plan and execute a solution that complies with CMS mandates. Non-compliance with CMS mandates will lead to significant negative financial ramifications for Oregon – doubling of the general funds needed for existing maintenance and operations costs and loss of enhanced funding for enhancements or renewal of the system.
   - OHA and DHS have several Medicaid sub-systems not currently integrated with the core MMIS[1]. Maintaining the current state leaves Oregon with siloed Medicaid systems and misses the opportunity to update and streamline Medicaid-related functions.

2. Develop and issue a procurement RFP without the support and planning efforts outlined above.
   - Oregon could choose to skip doing its own planning efforts and adopt the planning approach of another state, leveraging their planning outcomes and RFP to procure new solutions. While this approach would save less than $100,000 in General Funds for the cost of a consultant strategic technology advisor, choosing to circumvent an Oregon-specific planning effort will likely result in increased project risk through lack of a cohesive roadmap and executable plan to meet Oregon's needs. It is also likely the solutions used by another state either would require substantial

[1] Includes Customer Employed Provider (CEP), Express Payment and Reporting (eXPRS), Relational Statewide Accounting & Reporting System (RStars) and Oregon Automated Computer Capture Storage System (Oregon Access).

modifications to address Oregon requirements or significant business process and operational workflow reengineering.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

- Potential significant financial impact due to loss of CMS enhanced funding support for maintenance and operations. The current annual maintenance and operations cost is approximately $20 million per year. CMS funds 75 percent or approximately $15 million. If Oregon lost CMS enhanced funding, the federal funding level will drop from 75 percent to 50 percent. This would increase Oregon's General Fund expenditures for annual maintenance and operations from $5 million to $10 million per year.
- Potential significant financial impact due to loss of CMS enhanced funding support for system change requests and for major enhancement projects. System change requests average $10 million annually. Major enhancement projects range between $5 million and $20 million. CMS currently pays 75 percent of the cost of system change requests and 90 percent of the cost of major enhancements. If Oregon lost CMS enhanced funding, the federal funding level would drop to 50 percent. This would increase Oregon's typical annual general fund change request and enhancement projects cost from under $4 million to over $11 million
- Lost opportunity to develop a modern, sustainable and scalable Medicaid support system for Oregon
- Lost opportunity to leverage CMS enhanced 90 percent funding for future replacement of Medicaid supporting technology. In five more years, the current MMIS solution will be 13 years old and will be past its expected lifespan. The typical cost to replace MMIS systems is in the $110-150 million range. Without enhanced funding, the general fund share of a replacement would be $55-75 million, compared to $11-15 million.
- Lost opportunity to negotiate competitive maintenance and operations vendor support as a result of increased competition. The current contract with HPE for maintenance and operations increases by 2 percent annually.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Coordinated Care Organizations will be positively affected by this POP. A modular system built for a capitation model would address current system challenges in supporting CCOs. Tribes could be positively affected as this will improve the system they use to submit claims to OHA for payment.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

The Oregon Health Authority Health Systems Division, the coordinated care organizations, tribal providers, DHS Aging & People with Disabilities, DHS Developmental Disabilities, and Oregon State Hospital all support this POP. All of these entities are stakeholders and users of the current MMIS and will benefit from modularization.

10. WHAT IS YOUR EQUITY ANALYSIS?

Strategic planning activities will better allow OHA and DHS to include all stakeholders in the planning for the replacement, including the OHA Office of Equity and Inclusion and the DHS Office of Multicultural Services.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation date(s):

Pre-planning will start in 2016-2017; planning and procurement activities will occur through the 2017-2019 biennium and implementation of modular components will begin in the 2019-2021 biennium.

End date (if applicable):

The transition to a modular architecture is currently estimated to require at least three years of initial implementation and may require up to five years to be fully realized. End date ranges from 2022 to 2024.

a. Will there be new responsibilities for DHS? Specify which Program Area(s) and describe their new responsibilities.

☒ Integrating existing disparate systems into a more comprehensive Medicaid modular solution set will require engagement and support of program and policy resources for DHS and OHA together. Governance overseeing prioritization of system changes will need to be informed by program or system impacts.
☒ Contract administration of multiple implementation and then on-going maintenance and operations support performed by different solution vendors will be far more complex than it is today. This will require additional dedicated resourcing to support and manage effectively.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
Yes. Until the MMIS environment is fully modularized and the existing monolithic system replaced, additional funding will be needed to continue support of the existing system, hardware, software and resources.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No changes anticipated.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.
New staff will be necessary to support this effort. Because this is expected to span for five years or more, permanent positions are requested to support and manage modularization efforts, leaving existing resources in place to continue their work supporting on-going maintenance and operations.

The level of new staffing is modest, although the need for permanent positions will continue beyond full implementation. The new environment will require more resources to manage multiple contracts, provide oversight and support for governance efforts, ensure interfaces and integration integrity are sustained and support emerging opportunities to capitalize on the modular environment.

Proposed staffing:

Personal Services	Position Type	Classification	Duration
Project Director	PEM F (I) MS	35x	P
Medicaid Program Architect	OPA4 MMN	32	P
Contract Administrator	OPA4 MMN	32	P
Senior Analyst	OPA4	32	P
Analyst - BSA	OPA3	30	P
Analyst - BA	OPA3	30	P
Analyst - BA	OPA3	30	P
Sr Project Manager	PM3	31	P
Project Coordinator	PM2	29	P
TOTAL			9

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

For 2017-2019, the primary costs are to support the planning efforts. They are estimated at $5.6 million total cost with a state General Fund cost of $367,739. In the 2019-2021 biennium, new solutions will be purchased and implemented using the services of one or more system integrators. Training of staff and other end-users will be necessary, communications and new materials will be needed to support adoption and business process changes to fully leverage the new solutions.

f. What are the ongoing costs?

Ongoing costs for operations and maintenance will be higher during the implementation cycles of this effort since the existing MMIS system will continue to be operational and will require continued support. Once Oregon has fully migrated to a new modular architecture, the ongoing vendor-related costs should be comparable to or less than the existing funds paid for maintenance and operations.

g. What are the potential savings?

DHS will have the potential to sunset several systems or portions of systems. This will ultimately yield savings and enable use of the technical staff who support those systems to support the new systems.

h. Based on these answers, is there a fiscal impact?

Yes.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	**0**	**$1,887,534**	**0**	**$1,887,534**	**9**	**9.00**
Services & Supplies	**$164,935**	**$129,205**	**$1,416,274**	**$1,710,414**		
Special Payments	**$202,239**	**$5,652**	**$1,825,239**	**$2,033,695**		
Total	**$367,739**	**$2,022,391**	**$3,241,513**	**$5,631,643**	**9**	**9.00**

OHA - Fiscal Impact Summary by Program Area:

	Health Systems Division	Office of Information Services	OHA Statewide Assessments & Enterprise-wide Costs	Total
General Fund	**$344,538**	**$0**	**$23,201**	**$367,739**
Other Fund	**$0**	**$2,022,391**	**$0**	**$2,022,391**
Federal Funds- Ltd	**$3,032,701**	**$0**	**$208,812**	**$3,241,513**
Total Funds	**$3,377,239**	**$2,022,391**	**$232,013**	**$5,631,643**
Positions	**0**	**9**	**0**	**9**
FTE	**0.00**	**9.00**	**0.00**	**9.00**

What are the sources of funding and the funding split for each one?

The Other Funds in this Policy Option Package are non-add Other Funds limitation necessary to perform Office of Information Systems functions. The Federal Funds is Medicaid at Development match rate of 90/10.

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name:	**Oregon Health Authority (OHA)**
Program Area Name:	**Health Systems Division/Office of Information Systems**
Program Name:	**Health Systems Division/Office of Information Systems**
Policy Option Package Title:	**Enhancement and Support Services for ONE System**
Policy Option Package Number:	**406**
Related Legislation:	**N/A**

Summary Statement:

The Centers for Medicare and Medicaid Services (CMS) offers funding for updating eligibility systems. This policy option package requests authority to fund enhancements to Oregon's Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination system (called ONE). The plan is to update the system several times per year as prioritized by Health Systems Division. This POP also would support anticipated necessary changes when CMS issues new requirements for MAGI Medicaid eligibility systems.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$1,283,680**	**$0**	**$11,516,320**	**$12,800,000**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP will allow Oregon to enhance the ONE system to better serve its users. These enhancements would include, for example:

- Updates to implement new CMS requirements such as security upgrades and account transfer changes
- Ongoing support of the OHP renewal and redetermination process
- Annual changes in the federal poverty level
- System changes requested by Member Services to eliminate manual workarounds or to further automate their work

2. WHY DOES DHS/OHA PROPOSE THIS POP?

This enhanced federal match would fund ongoing eligibility, maintenance and operation, and enhancement and support work. Existing funds cover the current eligibility work, but OHA requires additional funding to allow for the ongoing maintenance and operation of the ONE system and enhancements necessary to serve clients and coordinate their care. Without this funding, OHA's ability to use and maintain the ONE system to serve almost 1 million Oregonians through MAGI would be put at risk.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

This project would improve OHA's timely and effective determination and renewal of benefits, improving Oregonians' access to health care through Medicaid coverage. It also would improve effective use of state funds. This federal-state ratio of this enhanced funding is 90:10 for enhancements and 75:25 for maintenance and operation, rather than the normal 50:50 for administration. This would significantly reduce the amount of state General Funds necessary to make ongoing enhancements.

4. IS THIS POP TIED TO A DHS/OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL DHS MEASURE THE SUCCESS OF THIS POP?

OHA tracks and reports on the accuracy, timeliness, and number of new applications and redeterminations processed. This POP allows the system and funding to continue this work and meet federal and state guidelines.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

The other option considered was for the Office of Information Services to take on the system's maintenance and operation. However, due to the rapid lack of position authority and specialized skills necessary to support some components of the system, this was not seen feasible without risk to the system. It would not be cost effective to add staff with the specialized skills and knowledge.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

OHA's ability to maintain and update the ONE would be put at risk due to reliance on General Funds for that ongoing work. Lack of maintenance and updates would place the state's Medicaid funding in jeopardy, placing at risk the health coverage of more than $1 million Oregonians.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

DHS, local governments that process eligibility, coordinated care organizations, and Medicaid providers who need to know if their patients are covered by OHP. This POP allows the system to operate, providing eligibility to Oregonians and data to MMIS and to approved providers.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Department of Human Services

10. WHAT IS YOUR EQUITY ANALYSIS?

The ONE system was modified at initial implementation to support the REAL+D requirements and the enhancements will allow for better communication and equity measures as identified by the Office of Inclusion and Equity.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

This POP assumes the approval of the Advanced Planning Document and enhanced funding from CMS.

a. Will there be new responsibilities for DHS? Specify which Program Area(s) and describe their new responsibilities.

N/A

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
None anticipated.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
None anticipated.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.
Existing positions that were created in OIS to support modernization will be used to support this effort. Approximately 32 positions are involved in supporting the ONE system or working with DHS's integrated eligibility expansion to the ONE system.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None.

f. What are the ongoing costs?
Costs for maintenance and operations of the ONE system average approximately $1.1 million per month. After the DHS' IE project enhances the ONE system to become Integrated ONE, total maintenance and operation cost will rise, but it will be a shared cost with OHA, resulting in a likely annual cost decrease.

g. What are the potential savings?
Enhanced funding and enhanced Medicaid match for eligibility determination**.**

h. Based on these answers, is there a fiscal impact?
Yes.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Services & Supplies	$1,283,680	0	$11,516,320	$12,800,000		
Total	**$1,283,680**	**$0**	**$11,516,320**	**$12,800,000**	**0**	**0.00**

OHA - Fiscal Impact Summary by Program Area:

	Health Systems Division - Admin	Total
General Fund	**$1,283,680**	**$1,283,680**
Other Fund	**$0**	**$0**
Federal Funds- Ltd	**$11,516,320**	**$11,516,320**
Total Funds	**$12,800,000**	**$12,800,000**
Positions	**0**	**0**
FTE	**0.00**	**0.00**

What are the sources of funding and the funding split for each one?
The Federal Funds is a mixture of Medicaid at Development match rate of 90/10 and Medicaid Admin rate of 50/50.

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division
Program Name: Oregon Health Plan
Policy Option Package Initiative: OHP Coverage for All Kids
Policy Option Package Title: N/A
Policy Option Package Number: 407
Related Legislation: N/A

Summary Statement:

This POP would provide the Oregon Health Plan (OHP) benefit package to children who do not qualify for full OHP benefits solely because they do not meet federal citizenship and immigration status requirements under Medicaid and the Children's Health Insurance Program (CHIP). Income eligibility would be up to 300 percent of the federal poverty level. Coverage would be for children through 18 years of age.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$55,030,483**	**$0**	**$0**	**$55,030,483**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP supports Oregon families by covering all low-income children regardless of immigration status through the Oregon Health Plan. The intent is to enroll them in coordinated care organizations (CCOs).

Currently, children who are ineligible for the Oregon Health Plan due to immigration status can receive coverage only through the Citizen Alien Waived Emergent Medical (CAWEM) program, which provides coverage for life-threatening medical emergencies that are treated in an emergency department. CAWEM is a federally funded program. On average, nearly 6,000 children have been enrolled in CAWEM in 2015-2016.

This POP will cover the cost of providing full Medicaid benefits to children through 18 years of age who are otherwise eligible except for immigration status. The coverage and benefits will be identical to those provided to children currently eligible for federal Medicaid and Children's Health Insurance Program (CHIP) coverage in Oregon. Children would still need to qualify for coverage through an income assessment that places them below 300 percent of the Federal Poverty Level, which would mirror Oregon's existing eligibility requirements for OHP.

The Oregon Health Plan program is, governed and funded in part by federal Medicaid program rules. Due to federal restrictions in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, undocumented immigrants are barred from participation in any federally funded assistance programs. However, states are able to fund these assistance programs with state dollars, without any federal match. The Centers for Medicaid and Medicare Services (CMS) currently funds 75 percent of the maintenance and operational costs of Oregon's MMIS system. With this program, Oregon would need to fund 100 percent of all costs attributed to determining eligibility and enrolling the new coverage population into OHP. In addition to expanding the Oregon Health Plan to all low-income children in Oregon, this POP will also provide funding for any staff needed for program operations.

As requested in SB 5701 (2016 regular session), the Oregon Health Authority is currently planning for development of a program that would allow for enrollment of all children, regardless of immigration status, in the Oregon Health Plan through the ONE Eligibility System. From a consumer perspective, there would be no discernible difference when enrolling in OHP. Internally, these populations would need to be distinguished in order to correctly allocate federal and state funding sources.

2. WHY DOES OHA PROPOSE THIS POP?

The Oregon Health Authority requests this funding to ensure that all children in Oregon, regardless of immigration status, have access to health care. Building on the success of Oregon's Healthy Kids initiative in 2009, which expanded OHP coverage to more than 100,000 children; the Medicaid expansion in 2014; and success of the state's 16 CCOs and the coordinated care model, the state is well positioned to expand coverage to the remaining children that are still uninsured due to federal law. Providing health insurance benefits to children can have a significant impact on Oregon's future economy and society. California, Illinois, Massachusetts, New York, Washington, and the District of Columbia have extended health insurance benefits to all eligible children aged 0-18 years. Evidence indicates that children who receive coverage benefit in ways that go beyond health improvements, including improved social and emotional functioning and better educational outcomes.[1] Children with health insurance coverage do better in school and miss fewer school days[2] [3], are more likely to graduate high school and go to college[4], have fewer emergency room visits and hospitalizations as adults[5], and earn more money as adults[6].

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[1] Kaiser Family Foundation Issue Brief: "The Impact of Children's Health Insurance Program (CHIP): What Does the Research Tell Us?" (2014) http://kff.org/report-section/the-impact-of-the-childrens-health-insurance-program-chip-issue-brief/

[2] The Healthy Families Program Health Stats Assessment (PedsQL) Final Report," Managed Risk Medical Insurance Board, (2004);

[3] Yeung, R. et al., "Can Health Insurance Reduce School Absenteeism?," Education and Urban Society (2011), http://eus.sagepub.com/content/43/6/696

[4] Cohodes, S., et al., "The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions," National Bureau of Economic Research (2014)

[5] Wherry, L. R., et al., "Childhood Medicaid Coverage and Later Life Health Care Utilization," National Bureau of Economic Research (2015), www.nber.org/papers/w20929.pdf

[6] Brown, D. W., et al., "Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?," National Bureau of Economic Research (2015), www.nber.org/papers/w20835.pdf.

Most of these children can receive health services only through an often fragmented system of safety net clinics. Federally qualified health centers (FQHCs), some school-based health centers, community health clinics and free clinics are the only reliable place for many children to receive care in Oregon. Although these clinics provide vital support by truly acting as a "safety net," many are under-resourced or under-staffed, cannot provide care beyond primary physical health care, and have limited hours. Most do not provide oral and dental health care, behavioral or mental health care, vision care, pharmacy support, or any specialist care.

This program is a necessary step to reduce the statewide uninsurance rate. It would provide essential services to one of Oregon's most vulnerable populations: children. Currently, children who are undocumented immigrants cannot participate in any state-funded assistance programs, even if they would otherwise qualify. The benefits package provided to this new population would be identical to the benefit package currently provided to children on OHP. Work is already underway to design and develop the program in the Medicaid Management Information System (MMIS) so that any funding from this POP can immediately go to implementation.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS?

Oregon is in the midst of significant health system transformation, guided by a vision of improving health for all Oregonians. The agency's mission is: "helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care."

Oregon has been at the forefront of innovation since the creation of the Oregon Health Plan in 1994. Since then, it has created the Oregon Health Authority and a statewide network of organizations, implemented an 1115 waiver and a substantial State Innovation Model, expanded Medicaid, and significantly lowered the uninsurance rates across the state. Even so, thousands of children remain uninsured. Funding would ensure access to care and help set up some of Oregon's most vulnerable children for a lifetime of better health and well-being.

Oregon's health system transformation has focused on care coordination, which improves health outcomes and the quality of care, and can lower costs. These children are unable to experience coordinated care's

benefits such as disease management, and the health system is unable to provide them with evidence-based care that could prevent future costs.

Finally, expanding coverage would allow OHA to directly address persistent health inequities experienced by some of Oregon's most vulnerable children, and immediately start to close a major gap in health equity between those who have access to health insurance and those who don't.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP? Although this POP is not directly related to specific performance measures. However, undocumented children covered through OHP would likely be enrolled in coordinated care organizations, which report quality and access test measures. Should this POP be implemented, these children would have an impact on the following measures:

- Adolescent well-care visits
- All-cause readmissions
- Ambulatory care: emergency department utilization
- Child and adolescent access to primary care practitioners
- Childhood immunization status
- Dental sealants
- Developmental screening in the first 36 months of life
- Immunization for adolescents
- Timeliness of prenatal care: prenatal and postpartum (if the mother is under age 19)
- Well child visits in the first 15 months of life

Hospitals could potentially see fewer undocumented children in the emergency departments, assuming that these children would be able to more readily access primary care and preventive care services.

Because this POP would create a distinct program (from a state regulatory perspective), it will be possible to track health outcomes and health care claims for this population, allowing for robust data analysis that can be useful in measuring the success of this POP.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

Yes. A change is required to ORS 414.231(3), which states that "a child is eligible for assistance under subsection (2) of this section if the child is **lawfully present** in this state and…" This POP would require that the statute language be changed to allow all children, regardless of immigration status, to be eligible for coverage.

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 USC section 1621(a) provides that an alien who is not (1) a qualified alien as defined by 8 USC section 1641, (2) a nonimmigrant under the Immigration and Nationality Act (8 USC 1101 et seq), or (3) an alien who is paroled into the US under section 212(d)(5) of such Act (8 USC 1182(d)(5) for less than one year, is NOT eligible for any state or local public benefit (as defined by 8 USC section 1621(c)). There are, however, certain exceptions to this prohibition. The relevant exception for this POP is 8 USC section 1621(d) which provides:

"A State may provide that an alien who is not lawfully present in the United States is eligible for any State or local public benefit for which such alien would otherwise be ineligible under subsection (a) of this section only through the enactment of a State law after August 22, 1996, which affirmatively provides for such eligibility."

Thus, in order to cover all children in Oregon, the state legislature would need to "affirmatively provide" for such eligibility.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Without new funding, OHA has no alternatives.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

- Missed opportunity to improve equity for children in Oregon; 2 percent of Oregon's children would remain uninsured and unable to access most health care services including behavioral, mental, oral and dental, vision, pharmacy, and specialty services, beyond those available in the limited safety net system.
- Missed opportunity to improve the health of thousands of children in Oregon, including in ways that could have direct impacts on other children (e.g., attending school while sick or being out of date with the recommended vaccination schedule).
- Missed opportunity to improve the well-being and future educational attainment of uninsured children in Oregon, who will continue to have inconsistent health care and will suffer the consequences by missing school days and having trouble focusing in school while sick.
- FQHCs, free clinics, school-based health centers, and other community based clinics that currently provide services would not be able to rely on reimbursement for services. Beyond reimbursement, it can be especially challenging to provide coordinated care for these children due to their inconsistency in visiting the doctor or in being connected to the system.
- Missed opportunity to improve care coordination, case management and disease management for these children, all of which can lead to future cost savings.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

A number of local government agencies, non-profit and private organizations would be affected by the POP. In Oregon, the state's health care safety net provides primary care services to undocumented children who are not eligible for any federal or state funded coverage programs. A sizable portion of the Oregon's safety net providers are community clinics and federally qualified health centers operated by local area health

authorities. County health agencies and school-based health centers, which offer primary and preventive services, would be able to receive financial reimbursement for these services. They also would be able to coordinate among local health care and specialty providers to ensure children receive coordinated, comprehensive health care services. Similarly, a number of health care service providers including migrant health clinics and non-profit health care organizations would be able to receive reimbursement for health-related services. And these organizations would be able to expand service delivery beyond primary care to include behavioral, oral, and ancillary care as well as care coordination and case management services, particularly for children with special health care needs.

If this program offers OHP benefits to these children through the CCOs, the CCOs and their network of providers and community-based partnerships across the state would be affected.

The Department of Education may see improvements in absenteeism rates and high school graduation rates, both of which have been positively linked to children who have health insurance coverage.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Within the Oregon Health Authority, this POP has been jointly proposed by the Health Policy and Analytics Division, the Health Systems Division, the Chief Financial Office, Division of Equity and Inclusion, and the Public Health Division.

10. WHAT IS YOUR EQUITY ANALYSIS?

This POP would offer a significant improvement in health inequities facing low-income, undocumented immigrant children in Oregon. Children in this population have very little control over their circumstances and often have to suffer the consequences of decisions made by adults. Expanding OHP to all children in Oregon would be a step toward helping these children achieve greater success during their lifetime.

Covering all children in Oregon through this POP also would significantly improve OHA's data collection and analysis capability. Knowing more about the health needs and utilization patterns of these children can help to improve access and care, and ensure that Oregon is on track toward improving the health of all Oregonians. OHA will be able to use REAL+D data to track inequities in health outcomes for this specific population and determine how their health outcomes change over time after children are covered.

Health equity for specific populations will be tracked in OHA's new 1115 Waiver renewal submitted to the Centers for Medicare and Medicaid Services (CMS) for review in the summer of 2016. Undocumented children could be one of the specific populations tracked, which would allow for even greater understanding of any disparities experienced by children in Oregon.

This POP also would support the Oregon Health Authority's Health Systems Division in ensuring that outreach activities to this population are culturally and linguistically appropriate.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

The pricing was based on a gradual increase of caseload that would cover a total of 14,928 children by the end of the biennium, with a monthly biennial average of 12,239. Pricing assumptions were based on what Medicaid currently pays for OHP-eligible children minus $187 per member per month for emergent care. States that have expanded benefits to this same population have seen actual costs that were less than projected. OHA is continuing to research this experience and as more is known, will share this information as requested. The expansion requires two human services specialists at 0.5 FTE.

Implementation Date(s): July 1, 2017

End Date (if applicable): N/A

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.
Health Systems Division would be responsible to implement this new program as an added population to those covered under the Oregon Health Plan.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected. See Addendum A – Shared, OIS and Central Offices Services LC/POP Impact Questionnaire.
No.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
This POP is projected to increase the OHP caseload by a biennial average of 12,239 children.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.
The expansion requires two permanent human services specialists at 0.5 FTE.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
The POP includes staffing costs for the initial eligibility determination for the expansion of OHP.

f. What are the ongoing costs?
The costs associated with the ongoing health benefit coverage for this OHP expansion population.

g. What are the potential savings?
OHA would not incur savings.

h. Based on these answers, is there a fiscal impact?

Yes – see below chart for detail of projected costs associated with the Special Payments.

CAWEM kids expansion estimates

			Up to 300% FPL		
		Total	**Ages 0-1**	**Ages 2-5**	**Ages 6-18**
Biennial Avgs 2017-19		**12,239**	**388**	**1,683**	**10,168**
PMPM *			$607	$162	$182
Total Cost w/ total PMPM:	$192	$56,483,828	$5,652,805	$6,527,791	$44,303,232
Reduced by Current cost of Emergent:	$5	$1,521,537	$48,215	$209,257	$1,264,065
Current cost of State Share:	$187	$54,962,291	$5,604,590	$6,318,534	$43,039,167

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services		0	0		2	0.50
Services & Supplies	68,192	0	0	68,192		
Capital Outlay	0	0	0	0		
Special Payments	54,962,291	0	0	54,962,291		
Total	**$55,030,483**	**$0**	**$0**	**$55,030,483**	**2**	**0.50**

OHA - Fiscal Impact Summary by Program Area:

	Oregon Health Plan-Cover all kids	Program Area 2	Program Area 3	Program Area 4	Total
General Fund	$55,030,483	**$0**	**$0**	**$0**	**$55,030,483**
Total Funds	**$55,030,483**	**$0**	**$0**	**$0**	**$55,030,483**
Positions	**2**	**0**	**0**	**0**	**0**
FTE	**0.50**	**0.00**	**0.00**	**0.00**	**0.50**

What are the sources of funding and the funding split for each one?

(Program Area 1) Revenue Impact:

Description of Revenue	OF	FF	TF
Licensing fees (Comp Srce 0975)	0	0	0
Medicaid (Comp Srce 0995)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Total	**$0**	**$0**	**$0**

(Program Area 2) Revenue Impact:

Description of Revenue	OF	FF	TF
Licensing fees (Comp Srce 0975)	0	0	0
Medicaid (Comp Srce 0995)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name: **Oregon Health Authority**
Program Area Name: **Health Systems Division and Public Health Division**
Program Name:
Policy Option Package Initiative:
Policy Option Package Title: **OHA Other Fund Revenue Shortfall (Package 070 Reductions)**
Policy Option Package Number: **070 (See corresponding Policy Option Package 409)**
Related Legislation:

Summary Statement:

This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure authority to revenues available at current service level. This POP reduces Other Fund authority to align with the projected:

- **Tobacco Master Settlement Revenue** for Health Systems Division (-$3,301,600) and Public Health (-$850,200);
- Other Fund revenue shortfall from Public Health's **Oregon Environmental Laboratory Accreditation Program (ORELAP)** fees (-$16,417);
- Other Fund revenue shortfall from Public Health's **Newborn Screening** program fees (-$11,170); and,
- Other Fund revenue shortfall from fees for programs administered by Public Health's **Health Care Regulation and Quality Improvement (HCRQI)** programs (-$936,475).

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:		**$(5,115,862)**		**$(5,115,862)**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure authority to current service level available revenues. This POP reduces Other Fund authority to align with the projected:

- **Tobacco Master Settlement** Revenue for Health Systems Division (-$3,301,600) and Public Health (-$850,200);
- Other Fund revenue shortfall from Public Health's **Oregon Environmental Laboratory Accreditation Program (ORELAP)** fees (-$16,417);
- Other Fund revenue shortfall from Public Health's **Newborn Screening** program fees (-$11,170); and,
- Other Fund revenue shortfall from fees for programs administered by Public Health's **Health Care Regulation and Quality Improvement (HCRQI)** programs (-$936,475).

In POP #409, the Oregon Health Authority requests Public Health proposed fee and Other Fund authority increases to cover program operating costs.

- The Oregon State Public Health Laboratory is proposing to add four new fees and increase 12 existing fees relating to **ORELAP** by 20 percent. This POP removes the 2017-2019 impact of those fees (-$16,417) in the event the Legislature does not approve the fee increase for 2017-2019 in POP #409.
- The **Newborn Screening** program is proposing to increase in-state fees to the same level as out-of-state fees. This package removes the 2017-2019 impact of those fees (-$11,170) in the event the Legislature does not approve the fee increase for 2017-2019 in POP #409.
- The **HCRQI** program is proposing to increase licensing fees for hospice agencies and in-home care agencies. It also would increase fees charged by the Certificate of Need program and Facility Planning and Safety Construction program. This package removes the 2017-2019 impact of those fees (-$936,475) in the event the Legislature does not approve the fee increase for 2017-2019.

2. WHY DOES OHA PROPOSE THIS POP?

This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

No.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

No.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

None.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

None.

10. WHAT IS YOUR EQUITY ANALYSIS?

Not applicable.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): July 1, 2017

End Date (if applicable): _____

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

No.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.

No.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

No.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

No.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

None.

f. What are the ongoing costs?

Not applicable. This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

g. What are the potential savings?

Not applicable. This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

h. Based on these answers, is there a fiscal impact?

Yes. This POP is required by the Department of Administrative Services budget instructions to reduce Other Fund expenditure limitation to current service level available revenues.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	$0	$(617,188)	$0	$(617,188)	(2)	(2.91)
Services & Supplies	$0	$(346,874)	$0	$(346,874)		
Capital Outlay	$0	$0	$0	$0		
Special Payments	$0	$(4,151,800)	$0	$(4,151,800)		
Other	$0	$0	$0	$0		
Total	**$0**	**$(5,115,862)**	**$0**	**$(5,115,862)**	**(2)**	**(2.91)**

OHA - Fiscal Impact Summary by Program Area:

	HSD Tobacco Master Settlement	PH Tobacco Master Settlement	ORELAP	Newborn Screening	HCRQI	Total
General Fund	$0	$0	$0	$0	$0	$0
Other Fund	$(3,301,600)	$(850,200)	$(16,417)	$(44,170)	$(936,475)	$(5,115,862)
Federal Funds- Ltd	$0	$0	$0	$0	$0	$0
Total Funds	$(3,301,600)	$(850,200)	$(16,417)	$(44,170)	$(936,475)	$(5,115,862)
Positions	0	0	0	0	(2)	(2)
FTE	0.00	0.00	(0.04)	(0.08)	(2.79)	(2.91)

What are the sources of funding and the funding split for each one?

(Program Area 1) Revenue Impact:

Description of Revenue	OF	FF	TF
Licensing fees (Comp Srce 0975)	0	0	0
Medicaid (Comp Srce 0995)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Total	**$0**	**$0**	**$0**

(Program Area 2) Revenue Impact:

Description of Revenue	OF	FF	TF
Licensing fees (Comp Srce 0975)	0	0	0
Medicaid (Comp Srce 0995)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0
Other (Comp Srce XXXX)	0	0	0

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name:	**Oregon Health Authority**
Program Area Name:	**Public Health Division Center for Public Health Practice and Center for Public Health Protection**
Program Name:	**Oregon State Public Health Laboratory, Environmental Public Health, Immunization and Health Care Regulation and Quality Improvement**
Policy Option Package Title:	**Public Health Fee Changes**
Policy Option Package Number:	**409 Part A**
Related Legislation:	**Legislative Concept 26**

Summary Statement:

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
This POP requests ratification of the ORELAP fee establishments and increases that were adopted in June 2016. Fee authority is authorized under ORS 438.620, ORS 475B.560 and implemented under OAR 333-064-0060.

Newborn screening fee change:
This POP requests approval to increase the newborn screening fees. The fee increase will allow all Oregon newborns to be tested for the current panel of disorders, as well as two additional disorders that were recently added to the recommended panel, and improve cystic fibrosis screening. Fee authority is authorized under ORS 431A.750, ORS 433.285 and implemented under OAR 333-024-0240.

Toxic Free Kids Act (TFKA) fee changes:
This POP requests ratification of the TFKA fee establishments that were adopted in January 2017. Fee authority is authorized under ORS 431A.270 and implemented under OAR 333-016-2080.

Immunization ALERT Registry and Tracking System fee changes:
This POP requests approval to decrease the current individual client fee, and establish a maximum fee per user. The fee provides revenue to support the statewide ALERT immunization registry. Fee authority is authorized under ORS 433.100 and implemented under OAR 333-049-0065.

Health care facility construction plan review fee changes:
This POP requests fee increases for construction plan review fees for certain health care facilities licensed by OHA or DHS. Fee authority is authorized under ORS 441.060 and implemented under OAR 333-675-0050.

Hospice and in-home care licensing fee changes:
This POP requests increases for annual hospice agency licensure fees and in-home care agency licensure fees to fund personal services and operating expenses for inspection, licensure, and complaint investigation. Fee authority is authorized under ORS 443.860 and ORS 443.315.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$0**	**$2,471,662**	**$(1,163,402)**	**$1,308,260**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
This POP requests ratification of the ORELAP fee establishments and increases that were made in Oregon Administrative Rule (OAR) in June 2016. The ORELAP fee changes have allowed the program to accredit cannabis testing labs under ORS 475B.550 to 485B.590, establish additional technologies that labs can be accredited for, and increase fees on out-of-state labs. No new services are proposed and no new position authority is requested.

Newborn screening fee change:
The Oregon State Public Health Laboratory (OSPHL) newborn screening tests to prevent metabolic disorders detectable at birth. This POP increases test fees. It will allow the lab to continue to test Oregon newborns for the current panel of disorders, as well as improve cystic fibrosis screening and add two other disorders that were recently added to the recommended panel. No new position authority is requested.

Toxic Free Kids Act (TFKA) fee changes:
This POP requests ratification of the TFKA fee establishments that were made in Oregon Administrative Rule (OAR) in January 2017. The TFKA fee establishments will allow the program to implement the requirements of SB 478 (2015) as authorized under ORS 431A.250 to 431A.280 in accordance with the timelines established in statute. No new services are proposed and no new position authority is requested.

Immunization ALERT Registry and Tracking System fee changes:
This POP requests approval to decrease the current ALERT individual client record fee from $10 to $5, and approval to establish a maximum fee of $75,000 per user in Oregon Administrative Rule (OAR) effective July 1, 2017. The rule changes will also strengthen and clarify fee payor definitions and services provided.

Health facility construction plan review fee changes:
ORS 441.060 directs the Health Care Regulation and Quality Improvement program (HCRQI) to review proposals to alter, expand or build certain types of health care facilities licensed by the Oregon Health Authority or the Department of Human Services prior to construction. These construction plans are reviewed for compliance with applicable state licensure requirements and federal National Fire Protection Association (NFPA) standards if the facility is to be Medicare or Medicaid certified. This POP increases construction plan review fees. It will allow HCRQI to continue to meet its statutory mandate to review and approve health care facility construction plans in a timely manner. No new services are proposed and no new position authority is requested.

Hospice and in-home care licensing fee changes:

HCRQI also is responsible for the licensure, inspection, certification, complaint investigation and oversight of multiple non-long term care facilities, including those defined in ORS 442 and 443. This includes hospitals, ambulatory surgery centers, hospice agencies, in-home care agencies and home health agencies. This POP requests approval to increase annual hospice agency and in-home care agency licensing fees to support the current requirements defined in statute. No new services are proposed and no new position authority is requested.

2. WHY DOES OHA PROPOSE THIS POP?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
Ratification of the ORELAP fee changes enables the program to fulfill its legislative mandate and accredit cannabis testing labs.

Newborn screening fee change:
OSPHL uses Oregon newborn screening fees to cover the cost of providing this testing service. The current newborn screening fee does not cover the actual costs of providing current testing services and costs will increase with the addition of two disorders recently added to the recommended screening panel, plus improved cystic fibrosis screening. The program will not generate sufficient revenue to cover the cost of providing this testing service without the fee increase. The fee increase will cover the actual costs of providing the tests and bring the Oregon fee into better alignment with the amount other states charge for this service. The increase allows all Oregon newborns to be tested for the full panel of recommended disorders.

Toxic Free Kids Act fee changes:
Ratification of the TFKA fee changes enables the Environmental Public Health Program to fulfill the statutory requirements to: 1) establish and maintain a list of designated high priority chemicals of concern for children's health used in children products sold in Oregon, 2) establish procedures and a process for manufacturers to request exemptions, and 3) establish procedures and a process for manufacturer's requests for exemption review and determination. The fee ratification will provide revenue to cover the actual associated costs for these requirements. No new services beyond those specified in SB 478 (2015) are proposed and no new position authority is requested.

Immunization ALERT Registry and Tracking System fee changes:
In Oregon immunization data on all Oregonians is collected, tracked, and reported with the ALERT Immunization Information System. Oregon Administrative Rule 333-049-0065 (4) currently authorizes a fee of $10 per client record to be charged to each authorized user for each client specific immunization data

request, but also provides authorization to waive the fee and instead utilize a system of voluntary contributions from users of the system. In earlier biennia the program was the successful recipient of numerous federal grants specifically designated for Immunization Information System (IIS) development, improvement, and maintenance allowing the program to waive the $10 per client fee and instead ask users of the system to provide voluntary contributions. Federal grant support ends July 2017, and the voluntary contributions will no longer cover the costs to collect data and provide the data requests to both public and private health care providers. In order to maintain the current level of service to users, it will be necessary to retract the earlier waiver, reduce the per client fee to $5, and establish a maximum fee of $75,000 per user. The program requests approval of this proposal effective July 1, 2017. No new services are proposed and no new position authority is requested.

Health facility construction plan review fee changes:
The current health facility construction plan review fees do not cover the actual costs of providing these services. The increase will allow HCRQI to continue its timely review of health facility construction plans and assure that proposed health care facility construction projects throughout Oregon are not delayed.

Hospice and in-home care licensing fee changes:
HCRQI uses annual licensing fees to cover the direct cost of operational and administrative functions related to the regulation of hospice agencies and in-home care agencies. However, revenues generated from current hospice agency and in-home care agency licensure fees no longer support the cost of associated regulatory work.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
ORELAP ensures that cannabis testing laboratories follow scientifically sound principles so that they produce correct test results. These results are used to ensure that cannabis products sold for both recreational

and medical purposes are not contaminated by pesticides or solvents and that the product strength is correctly stated. This proposal will sustain the program's existing regulatory and oversight function.

Newborn screening fee change:
Newborn screening identifies conditions that can affect a child's long-term health or survival. Early detection, diagnosis and intervention can prevent death or disability. This proposal will ensure that this cost-effective early diagnosis continues to be available to all Oregon infants regardless of their ability to pay and that the fee structure supports actual operating costs.

Toxic Free Kids Act (TFKA) fee changes:
TFKA ensures compliance with SB 478 (2015) requirements, and ensures that manufacturers of children's toys that are sold in Oregon that contain one or more high-priority chemicals report all chemicals to the Oregon Health Authority (OHA) by January 1, 2018. It further meets the statutory requirement to establish an exemption request, review and determination process for product manufacturers. Without the establishment of fees OHA will not have funding to pay for the costs associated with accepting and processing notifications from manufacturers of children's toys sold in Oregon that contain one or more high-priority chemicals, or process, review or conduct a determination on requests for exemption from manufacturers.

Immunization ALERT Registry and Tracking Systems fee changes:
This proposal furthers the agency's mission by establishing a fee structure that will provide revenue to support the collection, tracking and reporting of complete immunization records for all Oregonians. The ALERT Immunization Information System provides a single source repository for all Oregon immunization information. ALERT collects immunization data from both public and private health care providers to create complete immunization records for Oregonians. The data is accessible by authorized users, and both public and private health care providers utilize this data to help measure performance on important dimensions of care and services.

Health facility construction plan review fee changes:
This proposal furthers the agency's mission by continuing to provide regulatory oversight of various health care facilities licensed by OHA or DHS. These activities directly improve the health and safety of all patients by ensuring that regulated facilities meet minimal physical environment standards, which directly affect patient safety and infection control. The proposal will ensure the program's regulatory and oversight functions continue at current service levels.

Hospice and in-home care licensing fee changes:
HCRQI furthers the agency's mission by providing regulatory oversight of prospective and licensed hospice and in-home care agencies. These activities directly improve the health and safety of all Oregonians receiving these services by ensuring that hospice and in-home care services are safe, equitable and comply with current regulatory standards. Oregon hospice and in-home care agencies provide services to some of our most vulnerable and fragile citizens. Most frequently those services are provided to clients in their most private space: their homes. This proposal will sustain the program's regulatory and oversight functions at current service levels.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?
This POP is not tied to OHA key performance measures. However, OHA can use several metrics to measure success including:

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
Success will be measured by the number of cannabis testing labs that are accredited and can apply for licensure through the Oregon Liquor Control Commission.

Newborn screening fee change:

Success will be measured by providing testing for all recommended disorders and meeting standards for timely testing, analysis and reporting for Oregon newborn babies.

Toxic Free Kids Act (TFKA) fee changes:
Success will be measured by the number of manufacturers that comply with the requirement to report high-priority chemicals in children's toys sold in Oregon, and the number of exemption requests that meet review and determination requirements and timelines.

Immunization ALERT Registry and Tracking System fee changes:
Success will be measured by the number of Healthcare Effectiveness Data and Information Set (HEDIS) data requests that are fulfilled timely. HEDIS is a tool consisting of 81 measures across five important dimensions of healthcare and service, and is used by more than 90 percent of America's health plans to measure performance.

Health facility construction plan review fee changes:
HCRQI will measure the success of this POP by the percentage of construction plan review projects that satisfy state and federal construction and fire safety requirements.

Hospice and in-home care licensing fee changes:
HCRQI will measure the success of this POP by the percentage of completed surveys that satisfy applicable state and federal requirements.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
No statutory change is needed. This fee change will continue through OAR 333-064-0060.

Newborn screening fee change:
No statutory change is needed. This fee change request will be implemented through OAR 333-024-0240.

Toxic Free Kids Acts (TFKA) fee changes:
No statutory change is needed. This fee change will continue through OAR 333-016-2080.

Immunization ALERT Registry and Tracking System fee changes:
No statutory change is needed. This fee change will be implemented through OAR 333-049-0065.

Health facility construction plan review fee changes:
No statutory change is needed. This fee change request will be implemented through OAR 333-675-0050.

Hospice and in-home care licensing fee changes:
Yes, this fee change request will require statutory changes to ORS 443.860 and ORS 443.315.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
ORELAP considered adding the necessary technologies into the existing fee categories with no fee increase. This did not generate enough revenue to cover the additional expenditures associated with the work required to accredit cannabis testing labs.

Newborn screening fee change:

In addition to providing newborn screening for Oregon babies, the program contracts with a number of other states to provide these services. Fees to other states have been increased over the past 18 months as new contract periods were negotiated. The agency considered increasing other states' fees even more in order to avoid raising the Oregon fee. The agency rejected this because Oregon would not have remained competitive with other states that offer the service. Oregon receives the benefit of volume discounts by contracting with other states. This reduces the overall costs of the program and generates revenue that can defray laboratory infrastructure and operations costs and enhance services to Oregonians. The program also rejected the idea of screening for fewer disorders or capping the number of disorders at current levels. Finding these disorders soon after birth can help prevent serious problems and it would not be fair to infants and their families to screen for fewer than the recommended number of disorders. Timely identification and intervention furthers Oregon Health Authority's triple aim of improving lifelong health of all Oregonians, increasing the quality of health care, and lowering the cost of care to ensure that it is affordable for everyone.

Toxic Free Kids Act (TFKA) fee changes:
The TFKA statutory requirements contained in SB 478 (2015) are new to Oregon law. The agency did review existing fee authority and structures to determine if the requirements of the legislation could be accomplished through existing fee authority. The agency also carefully evaluated what specific elements of the requirements needed to be funded with fee revenue. It was determined that a separate and distinct fee structure would be necessary to meet the requirements of the act.

Immunization ALERT Registry and Tracking System fee changes:
The Immunization program considered keeping the $10 per client fee and notifying authorized users the waiver was discontinued. The agency rejected this because imposing the $10 fee per client generated more revenue than was necessary to meet the costs associated with collecting the data, maintaining the ALERT system, and timely response to data output requests from authorized users. The program determined that reducing the current client fee to $5 and establishing a maximum fee of $75,000 per authorized user will generate revenue adequate to maintain the current service level through 2019-2021.

Health facility construction plan review fee changes:
HCRQI considered several alternatives in lieu of the proposed construction plan review fee increase, including: (1) Suspending all construction plan review services under ORS 441.060(2); (2) Imposing a limit on physical environment constraints applicable to regulated health care facilities; (3) Suspending on-site inspections of construction plan review projects; (4) Imposing a limit on the type of on-site inspections that the program would agree to investigate, and (5) All recommendations developed as a result of 2015 SB 886 post-legislative session stakeholder discussions. Each of these alternatives was determined to jeopardize the state's ability to ensure that regulated health care facilities meet minimum physical environment standards, which directly affect patient safety and infection control measures.

Hospice and in-home care licensing fee changes:
HCRQI considered the following alternatives: (1) Limiting the type of regulatory requirements reviewed during required relicensure and initial licensure surveys; (2) Limiting the type of complaint investigations that the program would agree to investigate; (3) Reducing the frequency of required relicensure surveys in violation of statutory requirements; (4) Reducing the frequency of complaint investigations; (5) Reducing the scope of regulatory activities performed for other types of health care facilities regulated by the program; and (6) Increasing travel and workload requirements for existing staff. The program determined that each of these alternatives either jeopardized the program's ability to ensure that licensed hospice and in-home care agencies meet regulatory standards or failed to reduce the program's overall hospice agency operational costs.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
ORELAP would not be able to assess and accredit cannabis testing labs. By statute, cannabis products must be tested by an ORELAP accredited lab before they can be sold. This could effectively remove cannabis from the market.

Newborn screening fee change:
The program would not be able to cover the costs of screening Oregon babies for the full recommended panel. Babies with these disorders might not be identified in time to receive prompt treatment and prevent severe health consequences or even death.

Toxic Free Kids Act (TFKA) fee changes:
The agency would not be able to implements the requirements identified in SB 478 (2015). The agency and manufacturers of children's toys sold in Oregon that contain high-priority chemicals would be out of compliance with the act.

Immunization ALERT Registry and Tracking System fee changes:
The Immunization program would not be able to collect Oregon immunization data, support clinical, school and public health partners, maintain the ALERT data system, or respond to requests from public and private health care providers regarding complete individual immunization records for Oregonians.

Health facility construction plan review fee changes:
If this POP is not funded the program will be unable to satisfy statutory requirements. It would not be able to maintain the current level of service, which would delay construction of proposed health care facilities throughout the state. Construction delays will adversely impact health care facilities and patients and could restrict the overall availability of new or improved health care services in some communities.

Hospice and in-home care licensing fee changes:
If this POP is not funded HCRQI will perform fewer hospice and in-home care agency relicensure surveys, slower in-home care agency initial licensure surveys, and fewer hospice and in-home care agency complaint investigations. This may place clients at an increased risk of unsafe or ineffective care and jeopardize the quality of health care services available to citizens.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
Oregon Liquor Control Commission (OLCC) would not have accredited labs to license. Cannabis products would not be available for sale.

Newborn screening fee change:
If the recommended screening panel is not performed, early diagnosis for some disorders will not occur. That will result in delayed diagnosis and treatment, and increased costs for the health care system.

Toxic Free Kids Act (TFKA) fee changes:
If this proposal is not approved state, tribal, local government, and the public will not have access to a website and database that contains information about high-priority toxins in children's toys sold in Oregon.

Immunization ALERT Registry and Tracking System fee changes:
The Oregon Health Authority, Oregon Department of Human Services, local school districts, local public health agencies, tribes and public and private health care providers will no longer have access to complete individual immunization records for Oregonians.

Health facility construction plan review fee changes:
The program provides plan review services for the Department of Human Services, which is the licensing entity for long-term care facilities that fall within the program's jurisdiction; and contracts with the Office of the State Fire Marshall to ensure applicable health care facilities comply with National Fire Protection Association requirements. The program relies on the local authorities to ensure regulated facilities meet applicable building code requirements necessary for occupancy.

Hospice and in-home care licensing fee changes:

No other agencies would be affected by this portion of the POP.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
The program worked closely with the ORELAP Technical Advisory Committee (OTAC) and the Oregon Environmental Laboratory Association (OELA), both of which submitted written comments and support the fee changes. Additionally, a rules advisory committee meeting was held March 2, 2016, with representatives from two marijuana testing laboratories attending; and representatives from 17 marijuana testing laboratories attended a presentation on October 5, 2015, where methods and analysis and the accreditation application process were discussed.

Newborn screening fee change:
Public Health has not yet collaborated with other agencies, programs or stakeholders on the newborn screening fee increase proposal. The program plans to engage stakeholders in the fall of 2016 to review the proposal and provide input.

Toxic Free Kids Act (TFKA) fee changes:
The program established a rule advisory committee (RAC) for this rulemaking consisting of thirteen primary members and four alternates. The RAC members include representatives from business and industry affected by the requirements of TFKA, as well as representation from other states and interested parties. The program plans to continue to engage the RAC throughout the full implementation of TFKA.

Immunization ALERT Registry and Tracking System fee changes:
The program is in the process of establishing a rule advisory committee (RAC) that will include representation from other state and local agencies, as well as the ALERT IIS Advisory Council which includes a variety of members including public and private health care providers and authorized users.

Health facility construction plan review fee changes:
In December of 2014 the program convened a rules advisory committee for proposed construction plan review fee changes. Representatives from key stakeholder groups and almost every type of health care facility subject to health facility construction plan review provided feedback.

In the spring of 2016, stakeholders met extensively to discuss proposals for SB 886 (2015 session). Representatives from key stakeholder groups subject to plan review participated in these discussions.

The Office of the State Fire Marshal and the Department of Human Services Office of Licensing and Regulatory Oversight have been included in discussions about program operating costs and work load with performance measures for all plan review services.

Hospice and in-home care licensing fee changes:
Public Health has not yet collaborated with other agencies, programs, or stakeholders on the hospice agency or in-home care agency licensing fee increase portion of this POP. The program plans to engage with stakeholders in the fall of 2016 to review the proposal and provide input.

10. WHAT IS YOUR EQUITY ANALYSIS?

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
ORELAP assesses any lab that completes an application and pays the appropriate fees. Race and gender are not part of the application.

Newborn screening fee change:
OSPHL provides testing regardless of race or economic status. Families can decline newborn screening based on religious objections. No baby is denied testing due to the family's inability to pay.

Toxic Free Kids Act (TFKA) fee changes:
There are no know racial or ethnic inequities associated with this proposal. The fee establishment requested in this proposal would apply equally to all.

Immunization ALERT Registry and Tracking System fee changes:
ALERT collects, tracks and reports immunization data on all Oregonians. The fee changes requested in this proposal would apply equally to all.

Health facility construction plan review fee changes:
There are no known racial or ethnic inequities associated with this POP. The proposed fee increase described in this document would apply equally to all construction plan review projects.

Hospice and in-home care licensing fee changes:
There are no known racial or ethnic inequities associated with this POP. HCRQI will apply the proposed fee increase described in this document equally to all hospice and in-home care agencies licensed by and operating within the state.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

In all cases the pricing for this POP was established by applying the principles and standards required by the Oregon Department of Administrative Services Budget and Management Division for all Oregon state agencies for 2017-2019 current service level budget development, and comparing those costs to projected 2017-2019 program revenues. Revenue proposals were established through analysis of workload, level of effort and projected costs for each program. The revenue increase proposals are designed to meet program current service costs through 2019-21.

Over the next 12 months the agency will be working to establish a fee methodology strategy that is more granular and transparent, demonstrates sensitivity to economic indicators, and ensures the integrity and high quality of fee-supported programs and services provided.

Implementation Date(s): July 1, 2017

End Date (if applicable): N/A

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

☒ (2) OHA's Medicaid program might need to slightly increase the amount of reimbursement for birth packages to include the increased cost of newborn screening.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected.
No for all components.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No for all components.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

This POP includes two position modification actions: Fund switch of positions/FTE from Federal Funds to Other Funds and "buy back" of positions/FTE eliminated in Package 070.

Oregon Environmental Laboratory Accreditation Program (ORELAP) fee changes:
Buy back from Package 070: Compliance Specialist 3 – permanent – 0 position/0.04 FTE

Newborn screening fee change:
Buy back from Package 070: Office Specialist 2 – permanent – 0 positions/0.08 FTE

Toxic Free Kids Act (TFKA) fee changes:
Fund switch from Federal Funds to Other Funds: Program Analyst 2 – permanent - 1 position/1.00 FTE, Research Analyst 3 – permanent – 1 position/1.00, and Office Specialist 2 – permanent – 1 position/1.00 FTE

Immunization ALERT Registry and Tracking System fee changes:
Fund switch from Federal Funds to Other Funds: Operations and Policy Analyst 3 – permanent – 2 positions/2.00 FTE, Operations and Policy Analyst 1 – permanent – 1 position/1.00 FTE, Administrative Specialist 1 – permanent – 1 position/1.00 FTE, and Principal Executive Manager D – permanent – 1 position/1.00 FTE

Health facility construction plan review fee changes:
Buy back from Package 070: Health Facilities Consultant – permanent – 2 positions/2.0 FTE

Hospice and in-home care licensing fee changes:

Buy back from Package 070: Client Care Surveyor – 0 position/0.79 FTE

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?
None for all components.

f. What are the ongoing costs?
Ongoing costs are for providing continuing program services as authorized in ORS or OAR at current service levels. There are no new costs.

g. What are the potential savings?
None for all components.

h. Based on these answers, is there a fiscal impact?
Yes, for all components.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	$1,646,776	-$1,022,639	$624,137	2	2.91
Services & Supplies	0	624,886	-$140,763	484,123		
Capital Outlay	0	200,000	0	200,000		
Total	**$0**	**$2,471,662**	**-$1,163,402**	**$1,308,260**	**2**	**2.91**

OHA - Fiscal Impact Summary by Program Area:

	OSPHL	HCRQI	EPH	IMMY	Total
Other Fund	$27,587	$936,475	$294,238	$1,213,362	**$2,471,662**
Federal Fund	$0	$0	-$153,679	-$1,009,723	**-$1,163,402**
Total Funds	**$27,587**	**$936,475**	**$140,559**	**$203,639**	**$1,308,260**
Positions	**0**	**2**	**0**	**0**	**2**
FTE	**0.12**	**2.79**	**0.00**	**0.00**	**2.91**

What are the sources of funding and the funding split for each one?

OSPHL Revenue Impact:

Description of Revenue	OF	FF	TF
Charges for Services (Comp Srce 0410)	11,170	0	11,170
Other Nonbusiness License and Fees (Comp Srce 0210)	16,417	0	16,417
Total	**$27,587**	**$0**	**$27,587**

HCRQI Revenue Impact:

Description of Revenue	OF	FF	TF
Licensing fees (Comp Srce 0975)	936,475	0	936,475
Total	**$936,475**	**$0**	**$936,475**

EPH Revenue Impact:

Description of Revenue	OF	FF	TF
Other Business Licenses and Fees (Comp Srce 0205)	294,238	0	294,238
Federal Revenue (Comp Srce 0995)	0	-153,679	-153,679
Total	**$294,238**	**-$153,679**	**$140,559**

IMMY Revenue Impact:

Description of Revenue	OF	FF	TF
Charges for Services (Comp Srce 0410)	1,213,362	0	1,213,362
Federal Revenue (Comp Srce 0995)	0	-1,009,723	-1,009,723
Total	**$1,213,362**	**-$1,009,723**	**$203,639**

Oregon Health Authority
2017-2019 Policy Option Package

Agency Name:	**Oregon Health Authority (OHA)**
Program Area Name:	**Health Policy & Analytics**
Program Name:	**Office of Health Information Technology (OHIT)**
Policy Option Package Title:	**Office of Health Information Technology Fee**
Policy Option Package Number:	**409 Part B**
Related Legislation:	**Oregon Law 2013, Ch. 603 (Senate Bill 604); Oregon Law 2015, Ch. 243 (House Bill 2294)**

Summary Statement:

This policy option package is necessary to obtain Other Fund authority that will enable OHA to collect fees to support two health information technology efforts in Oregon: the Oregon Common Credentialing Program as mandated by Senate Bill 604 and the statewide Provider Directory. Other Fund authority allows OHA to collect fees and spend those funds to cover these programs' operating costs.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**$0**	**$12,983,343**	**$0**	**$12,983,343**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP will enable OHA to collect fees to sustainably fund two statewide health information technology programs in Oregon. They are:

- The **Oregon Common Credentialing Program** (hereafter common credentialing). This will streamline the credentialing process by providing a centralized, web-based repository of verified health care practitioner information. Common Credentialing will increase the efficiency of the process for credentialing organizations and allow health care providers to focus less on administration and more on patient care.
- A statewide **Provider Directory**. This will provide health care organizations and state and local agencies with an accurate and comprehensive directory of providers. It will have their contact information, health information exchange addresses and clinic affiliations. It will facilitate care coordination and referrals, analytics and quality improvement activities, health information exchange, and other administrative efficiencies.

Fees paid by users of these systems will help pay for vendors or contractors to implement and operate the programs. Each program's fees will be administered differently (see table). OHA has legislative authority to charge these fees. This POP seeks Other Fund authority to spend the revenue from these fees, and legislative approval of the fee structure and amounts for each program.

Program	Fee Structure Summary
Common Credentialing	Credentialing organizations: A one-time set up and annual subscription fees for access. It will be tiered based on practitioner panel size. An optional expedite fee will also be available. Practitioners: A one-time application fee.

Provider Directory	Subscription fees for non-Medicaid users. Fees will be tiered based on level of use and method of access (web portal, static extracts, customized extracts, and interfaces).

Note: *Fee structure and amount details are being developed. They will reflect vendor costs identified after procurement and vendor selection, which is underway. Further detail will be incorporated into this POP at a later date.*

2. WHY DOES OHA PROPOSE THIS POP?

Common credentialing

As mandated by Senate Bill (SB) 604 (2013), the Oregon Common Credentialing Program is established as a new program in OHA to make health care practitioner information centrally available to credentialing organizations.

Common Credentialing will greatly benefit credentialed health care providers in the state, and it will create efficiencies for credentialing organizations.

Provider directory

The statewide Provider Directory is a new centralized program that will collect and route reliable health care practitioner information to health care organizations and state and local agencies. It will connect existing provider directories and will leverage key provider information from Common Credentialing. Centralized, validated provider information will create administrative efficiencies and improve the quality of provider information for care coordination and referrals, health information exchange, health care operations, analytics and quality improvement.

Specifically, the directory will:

- Include all types of providers and organizations
- Include core provider and organization information in a central database
- Act as a "router," and a centralized point of query for provider information

- Allow user searches via a certified electronic health record, a health information exchange, a web portal or through exchange of flat files
- Use national standards for such directories

OHA is using significant federal investment and state matching funds to develop the directory for state Medicaid operations. This POP will allow OHA to extend the use of the Provider Directory beyond Medicaid enterprise.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

The mission of OHA is "helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care." The two programs supported by this POP will indirectly affect all Oregonians by supporting improved quality of care, better care coordination, and lowered costs.

Common Credentialing will help to lower the costs of health care administration. It also will work in tandem with the Provider Directory to support care coordination and create data analytics.

4. IS THIS POP TIED TO AN OHA PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OHA MEASURE THE SUCCESS OF THIS POP?

These two programs contribute to OHA's goal of aligning systems and tools at all levels of the organization to improve health outcomes and customer service. Through these programs, patients will have greater access to culturally appropriate providers. Providers will have greater access to their patients' most current health information. Systems will save time and resources due to the streamlined processes these programs will enable, which will translate to efficient, coordinated, and more cost-effective patient care.

Implementing fees for these programs and services will enable OHA to provide some of the same services to non-Medicaid providers that will be available to Medicaid providers, which will allow us to expand our ability to affect the following key performance indicators beyond the Medicaid program:

- Access to care
- Member experience of care
- Member health status
- Customer service

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

The Provider Directory program is linked to Oregon Law 2015, Ch. 243 (House Bill 2294) and requires no change. Common Credentialing is mandated by existing Oregon Law 2013, Chapter 603 (Senate Bill 604) and requires no change.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Common credentialing

This POP is requesting Other Fund authority to collect fees to implement and operate Common Credentialing. No other funding alternative is identified. The fees are the intent of the legislation as authorized under Oregon Law 2013, Chapter 603.

Provider Directory

An alternative to charging fees for the statewide Provider Directory would be to continue the status quo of offering the Provider Directory to Medicaid users only. This alternative would fail to leverage for all Oregon health care entities the considerable federal and state resources that have been invested in building a statewide provider directory for Medicaid purposes.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Not funding this POP would result in the inability to collect and use fees to support the administration of Common Credentialing and the Provider Directory. OHA would be unable to meet the mandate enacted by Oregon Law 2013, Chapter 603 for Common Credentialing. State and federal investments in CareAccord and Provider Directory would not be leveraged into sustainable models for the benefit of statewide stakeholders.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

County health programs, county mental health providers, school-based health centers, tribal clinics, and other local government entities would benefit from the services and operational efficiencies provided by the programs associated with this POP.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

OHA staffs the Health Information Technology Oversight Committee (HITOC) and the CCO Health Information Technology Advisory Group (HITAG). HITOC advises OHA on its HIT strategies and policies, per existing law (ORS § 413.301). In 2013, OHA convened a health information technology (HIT) Task Force to synthesize stakeholder input and develop an HIT Business Plan Framework to chart a path for statewide efforts over the next several years. The HIT Task Force outlined specific steps in creating a statewide provider directory to support a goal of statewide direct secure messaging as a component to OHA's statewide HIT strategic plan. HITOC endorsed the plan and monitors OHA's progress in these areas. HITAG advises OHA on the implementation of this service from a CCO perspective, to ensure value for Medicaid's health system transformation and alignment with CCO and community efforts.

In 2014, OHA composed a subject matter work group to inform the scope, functions and parameters of a statewide provider directory. This group included representatives from health plans, CCOs, provider groups,

and the Oregon Medical Association. Since 2015, OHA has convened a Provider Directory Advisory Group made up of stakeholders who inform the OHA on the technical, programmatic, and policy aspects associated with the Provider Directory.

OHA has a Common Credentialing Advisory Group made up of stakeholders including health care practitioners, credentialing organizations and HCRBs in place since October 2013 to advise the agency on the implementation of SB 604 and continue beyond. The agency also convenes a credentialing subject matter expert workgroup.

10. WHAT IS YOUR EQUITY ANALYSIS

The technology solutions described in this POP are focused on solving problems inherent to the health care delivery system in Oregon. As such, these problems affect all Oregonians regardless of race or ethnicity. Enhancing the delivery system using these solutions will have a positive impact on all provider types and their patients.

The Provider Directory will specifically address the issue of culturally and linguistically appropriate care by allowing users to identify languages spoken by providers. This will increase the use of appropriate referrals for patients who have limited English proficiency to ensure they receive high quality care from a language concordant provider.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Operational Date(s):

Common credentialing:

January 1, 2018: OHA anticipates the common credentialing program and related fee collection to be operational January 1, 2018.

Provider directory:

January 1, 2018: OHA anticipates the provider directory to be operational in a pilot phase beginning in January 1, 2018. OHA expects fees for optional enhancements to begin in October 1, 2018, with full fees for non-Medicaid users to begin in October 1, 2018.

End Date (if applicable): Not applicable.

a. Will there be new responsibilities for OHA? Specify which Program Area(s) and describe their new responsibilities.

OHA's responsibility to operate these programs has already been established. Common Credentialing was established by Oregon Law 2013, Ch. 603, the Provider Directory is approved to be developed for Medicaid uses, and CareAccord is an existing program. Oregon Law 2015, Ch. 243 requires OHA to establish the Oregon HIT program, and allows OHA to charge fees to ensure the sustainability of services within the program, such as the Provider Directory. This POP will enable the collection of user fees for these programs.

b. Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected. See Addendum A - Shared Services LC/POP Impact Questionnaire (at the end of this document).

None identified.

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.

This POP will not affect client caseloads.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

No.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

	Common Credentialing	Provider Directory
COST CATEGORY	October 1, 2014 – June 30, 2018	n/a
Professional Services (includes technology/operations, QA, consulting)	$8,395,249	$0
Total Implementation Cost:	**$8,395,249**	**$0**

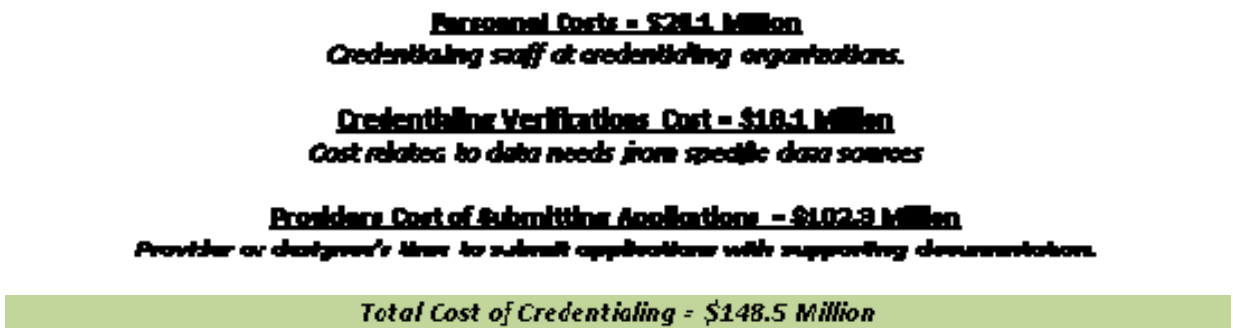
f. What are the ongoing costs?

	Common Credentialing	Provider Directory
COST CATEGORY	July 1, 2018 – June 30, 2019	January 1, 2018 – June 30, 2019
Professional Services (includes technology/operations, outreach, consulting)	$4,388,094	$200,000
Total Ongoing Cost:	**$4,388,094**	**$200,000**

g. What are the potential savings?

These programs have the potential for significant cost savings in health care across Oregon. Common Credentialing. The cost to Oregon of the current credentialing system is estimated at $150 million annually (see Diagram 1).[1] While this cost may not be substantially reduced at least initially, there will be savings based on the benefits described below.

Diagram #1: SB 604 Savings Estimates from Legislative Testimony



Notes: *Personnel cost estimates are based on a limited number of credentialing organizations that include Independent Physician Associations, Health Plans, Hospitals, and ambulatory surgical centers. As many of these staff will remain employed and possibly be reassigned to other functions, that state may not see savings in this area. However, savings related to drastically reduced redundancy of verifications and provider time spent providing the same information to numerous organizations will result in a large savings.*

Provider Directory. A centralized, common provider directory will allow health plans and CCOs to reduce the FTE dedicated to maintaining their own individual directories – between one and four FTE

[1] Written Testimony provided by Mike R. Bond, MBA, President and CEO of PrimeCare, Inc. before the Senate Committee on Health Care and Human Services, Oregon Legislature. March 26, 2013. Available at: https://olis.leg.state.or.us/liz/2013R1/Measures/Exhibits/SB604.

for each entity. Providers and CCOs also will save money by having one point of data entry for this information.

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h. Based on these answers, is there a fiscal impact?
Yes.

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Services & Supplies	0	$12,983,343	0	$12,983,343		
Total	**$0**	**$12,983,343**	**$0**	**$12,983,343**	**0**	**0.00**

Office of HIT, OHA - Fiscal Impact Summary by Program Area:

	Common Credentialing	Provider Directory	Total
Other Fund	**$12,783,343**	**$200,000**	**$12,983,343**
Total Funds	**$12,783,343**	**$200,000**	**$12,983,343**
Positions	**0**	**0**	**0**
FTE	**0.00**	**0.00**	**0.00**

What are the sources of funding and the funding split for each one?
All Other Funds are assumed to be credentialing fees.

Common Credentialing Revenue Impact:

Description of Revenue	OF	FF	TF

Other (Comp Srce 0210)	$12,783,343	0	$12,783,343
Total	**$12,783,343**	**$0**	**$12,783,343**

Provider Directory Revenue Impact:

Description of Revenue	OF	FF	TF
Other (Comp Srce 0210)	$200,000	0	$200,000
Total	**$200,000**	**$0**	**$200,000**

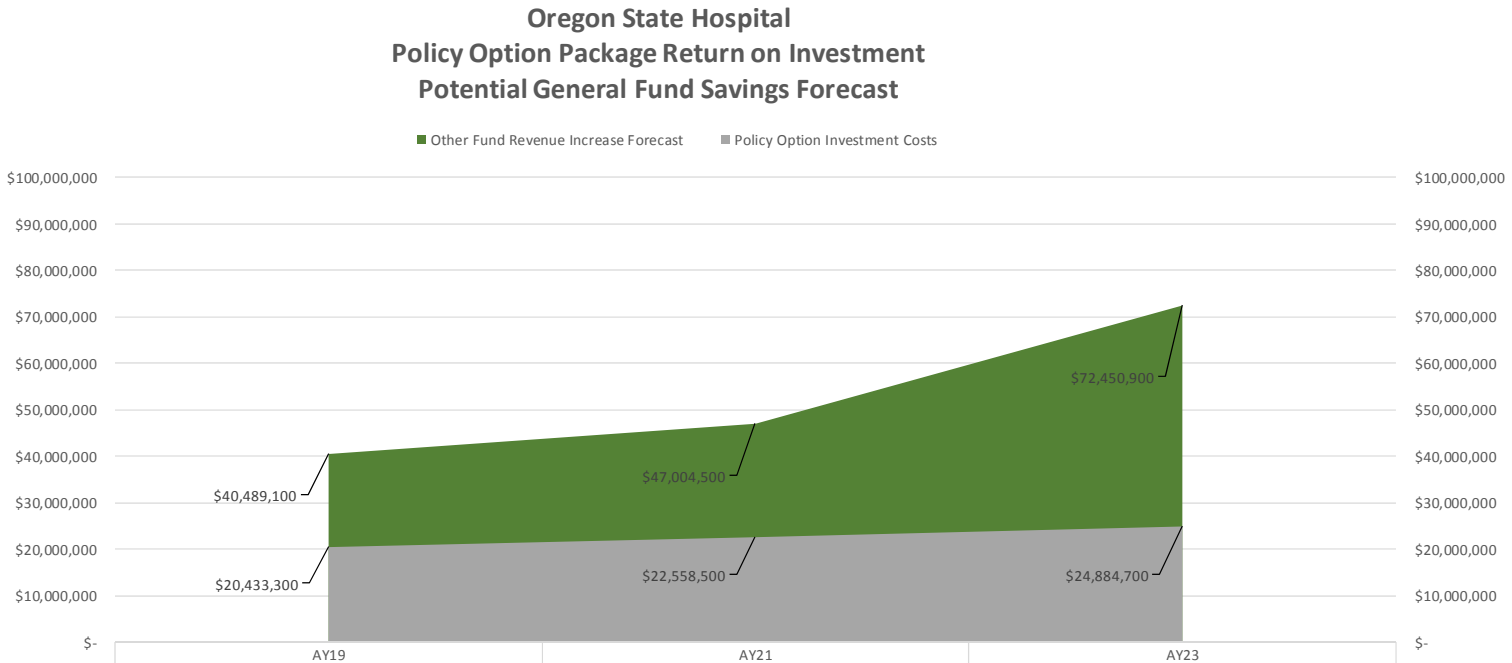
2017-2019 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Oregon State Hospital
Program Name: Oregon State Hospital
Policy Option Package Title: Oregon State Hospital Improvements
Policy Option Package Number: 410
Related Legislation: Not applicable

Summary Statement:

Oregon State Hospital seeks to reduce its reliance on state General Funds by increasing Other Fund reimbursement. By investing in infrastructure improvements, the hospital has certified an additional 454 beds with the Centers for Medicare and Medicaid Services (CMS), which has enabled it to bill all hospital beds for Medicare, third-party insurances, and Medicaid.

With recent improvements completed in 2016, OSH has certified an additional 454 hospital-licensed beds with CMS, this additional certification has brought the total of CMS-certified beds for OSH to 569. CMS certification means the hospital can bill insurance plans for patients covered under Medicare, third party (commercial) insurance, and Medicaid. With the certification of additional beds, the estimate is a $40.5 million increase in Other Fund revenues for 2017-2019 and $47-$75 million or more in subsequent biennia. However, to prevent loss of these Federal Funds, the hospital must invest $20.4 million of this new revenue in utilization management, safety improvements that address treatment and staffing levels to maintain compliance with CMS regulations. This leaves a potential net General Fund reduction of $20.1 million in 2017-2019, $24.4 million in 2019-2021, and $47.6 million in 2021-2023 (see chart below).



	AY19	AY21	AY23
Other Fund Revenue Increase Forecast	$40,489,100	$47,004,500	$72,450,900
Policy Option Investment Costs	$20,433,300	$22,558,500	$24,884,700
Potential General Fund Savings	$20,055,800	$24,446,000	$47,566,200

2017-19 Funding	GF	OF	FF	TF	Positions	FTE
Revenue Fund Shift	-20,055,765	20,055,765	0	0	0	0.00
Revenue Cycle Management	0	8,617,322	0	8,617,322	25	25.00
Accreditation and Compliance	0	5,667,474	0	5,667,474	24	24.00
Limited Duration Nursing Float Pool	0	6,148,468	0	6,148,468	34	34.00
Total	**-20,055,765**	**40,489,029**	**0**	**20,433,264**	**83**	**83.00**

1. WHAT WOULD THIS POLICY OPTION PACKAGE (POP) DO AND HOW WOULD IT BE IMPLEMENTED?

This POP funds four key investments needed to maximize revenues and maintain CMS certification for 569 beds at Oregon State hospital. The certification of all hospital-licensed beds will generate increased Other Funds, resulting in a potential net General Fund savings of approximately $20 million during the next biennium. These key investments are in **infrastructure** – revenue cycle management and accreditation and compliance – and in **safety** – and nursing float pool.

Infrastructure – revenue cycle management

This POP provides the necessary administrative infrastructure to expand the capacity of the hospital's ability to bill Medicare and other third-party insurances for inpatient hospital care. The hospital already has initiated several improvements during the current biennium; however, in order to expand the billing operations capacity from 115 hospital beds to 569 hospital beds, additional resources are needed to meet the stringent conditions of participation that are required by the Centers for Medicare and Medicaid Services (CMS).

Improving safety – limited duration nursing float pool

This POP will improve treatment and safety at OSH by expanding the position authority of the nursing float pool by providing up to 34 float pool positions. These positions will be used to rotate limited duration float staff to expand the OSH float pool capacity. As other full-time program-specific positions become available, float pool staff can transfer to those, freeing up the float position for rehire. This will better enable OSH to meet staffing requirements necessary to maintain compliance with CMS standards and sustain CMS certification without excessive reliance on overtime or the use of agency staff, and reduced need for multi-filling limited duration float positions.

Infrastructure – accreditation and compliance

It is essential that OSH maintain its compliance with these standards to reduce the risk of audits and settlement reviews leading to potential paybacks on the estimated $40.5 million increase in Other Funds that this POP would generate. This POP improves and expands the hospital's accreditation and compliance

processes and provides the additional staff required to ensure compliance for an additional 454 beds. CMS certification will require compliance support in all of the following areas:

- Environment of care
- Emergency management
- Human resources
- Infection prevention and control
- Information management
- Leadership
- Life Safety
- Medication management
- Medical staff
- National Safety Patient Goals
- Nursing
- Provision of care, treatment, and services
- Performance improvement
- Record of care, treatment, and services
- Rights and responsibilities of the individual
- Waived testing

2. WHY DOES OREGON STATE HOSPITAL PROPOSE THIS POP?

Oregon State Hospital proposes this POP because it:

- Reduces the financial burden on patients
- Reduces uncompensated care
- Frees General Fund dollars to be reinvested in the community behavioral health system
- Improves care and treatment for patients
- Improves safety for both patients and staff

Infrastructure – revenue cycle management

In order to take expand and maximize revenues from Other Funds, all of OSH's hospital-licensed beds must maintain continuous CMS-certification. OSH has been working to address known compliance risks and achieve a level of operational excellence necessary to maintain CMS certification and Joint Commission accreditation for all hospital licensed beds. With the improvements over the past six years, verified by the Joint Commission in 2015, OSH was able to obtain CMS approval to certify all 569 hospital-licensed beds, increasing its ability to bill Medicare, Medicaid, or third-party insurance for all reimbursable services.

Timeline:

- Early 2000s – OSH had four civil units certified by CMS, and was billing Medicare for the cost of care for the patients on these units. None of the remaining 16 units were CMS certified, and none of the services provided within these units were reimbursed by Medicare.
- 2008 – CMS surveyed OSH, determined that three of the four certified units were not providing adequate active treatment and decertified three of the four units. Only one unit remained certified. Medicare billing was very limited, and the hospital had only conditional accreditation from The Joint Commission to operate.
- 2014 – Hospital leadership focused on improving billing and reimbursement processes.
- 2015 – With the construction of the new facilities complete and all prior deficiencies addressed, OSH began to consider CMS certification for additional units. The Joint Commission surveyed the hospital in March 2015 and issued a very favorable report, fully accrediting the hospital, including the newly opened facility in Junction City. Based on that review, the hospital is actively pursuing CMS certification of the remaining 19 hospital units.
- 2016 – Working with the Oregon Public Health Division, the CMS Regional Office, and with the Medicare Administrative Contractor (Noridian), the hospital was able to use the 2015 Joint Commission survey to obtain certification for all hospital beds, effective as of July 1, 2016.

Improving safety – limited duration nursing float pool

Adequate staffing is fundamental for safety at OSH. Failure to meet established staffing requirements puts OSH at risk of not maintaining CMS certification. The following is the associated Joint Commission 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.*]

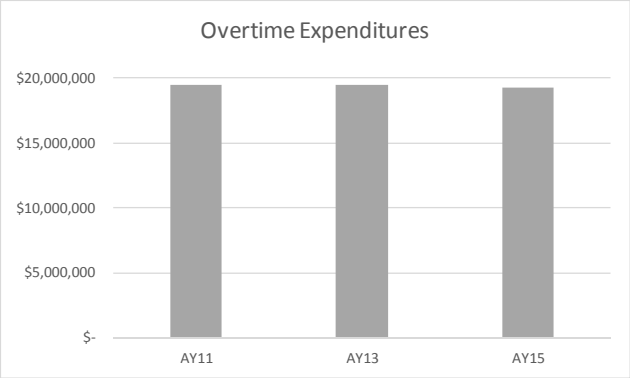
On average, 14 percent of OSH direct care staff (registered nurses, licensed practical nurse, and mental health technicians) are absent each day. This does not include planned absences such as vacation or personal business. In order to meet minimum staffing requirements, direct care staff are asked or mandated to work overtime. But even with overtime shifts, staffing needs are not always met. By expanding the number of float pool positions as needed, the hospital can better ensure staffing levels are met and avoid excessive overtime and mandatory overtime.

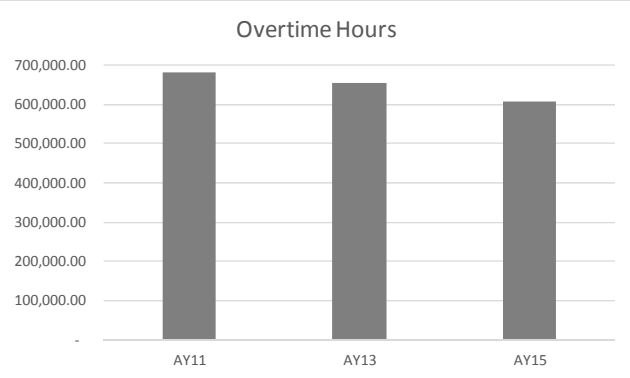
OSH nursing staffing requirements are affected by:

- Acuity – higher staff-to-patient ratios are needed to maintain a safe treatment environment for patients and staff when there is a high acuity related to the patient population.
- Precautions – Additional staff are needed to carry out physician-ordered patient "precautions," in which one or two staff are assigned to watch an individual patient who the physician has assessed as a risk for harming themselves or others.

In 2015, the firm of AKT conducted an independent review of OSH nurse staffing practices. The report concluded that "*the methodology of the calculation appears to be sound. In speaking with our outside counsel, OSH's delivery model is well known and viewed favorably by others in the industry.*" The nurse staffing plan established by OSH will be the standard CMS will expect OSH to maintain as part of certification requirements.

Historically and currently, OSH has relied on overtime as the primary means to meet staffing needs when direct-care staff are absent. Over the past three biennia, OSH has averaged 26,969 hours and $808,767 in monthly overtime to fill planned and unplanned direct care staff vacancies.





To reduce its dependence on overtime, OSH has historically hired limited duration direct-care staff for a nursing "float pool" and multi-filled these staff on one position since limited duration position authority was not budgeted. Recently (June 2015), the Oregon Health Authority initiated steps to reduce or eliminate limited duration positions and stop the practice of multi-filling positions. The related hiring freezes and constraints on limited-duration positions resulted in an insufficient number of float pool staff at OSH, which increased the dependence on overtime. In the fall of 2015, an allowance was made for OSH to multi-fill some limited duration float pool positions. To reduce the risk of future disruption of float pool hiring, additional float pool position authority is needed. Without enough float pool staff to back-fill direct-care absences, the hospital has been unable to keep overtime within the budgeted level.

Currently, there are 122 Limited Duration float pool staff to back-fill staff call-outs and precaution orders; however, all float pool staff are assigned to one position (multi-filled). Although these staff were not a part of the 2015-2017 budget, the cost of the float pool staff has been offset by savings from other vacant

positions. Since OSH is currently operating within the funding provided in its base budget, it is requesting position authority and funding for only 34 float positions. These positions will be used to rotate limited duration staff hired as float staff into other full-time permanent positions assigned to specific programs units (non-float) as available through turnover, then back-filling the float position. This will increase the OSH float staff, reduce the need to multi-fill LD positions, and better enable OSH to consistently staff at required levels.

In 2014 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."*

In 2016 The Joint Commission visited OSH to follow up on concerns of inadequate staffing levels. The surveyor investigated the following standard: *EP 3 §482.62(d)(2) - (B150) - (2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.* Because the surveyor observed the high level of unplanned direct-staff absences at OSH, her finding was: "*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."*

With adequate position authority to establish a robust limited duration nursing float pool, OSH will be able to maintain safe staffing levels, cover unplanned absences without overreliance on overtime, and maintain compliance with regulations necessary for continued CMS certification.

Infrastructure – accreditation and compliance

In 2008 the United States Department of Justice issued a report that the hospital:

A. Inadequately protected patients from harm;

B. Failed to provide adequate mental health care;
C. Inappropriately used seclusion and restraint;
D. Provided inadequate nursing care; and
E. Performed inadequate discharge planning and placement in the most integrated setting.

Hospital leadership has since established a culture of continuous improvement, and it has resolved all of the deficiencies listed above. In addition, many of the hospital's improvement initiatives support proper billing and reimbursement for in-patient services.

During FY2016 several audits and reports were submitted to a variety of federal and state contracted auditors related to past revenue operations. The three most notable financial audits and reports were:

- FY2012 Disproportionate Share audit conducted by Myers and Stauffer
- FY2015 Medicaid Credit Balance audit conducted by Health Management Systems (HMS), and
- FY2015 Cost Report which was submitted to CMS via Noridian Healthcare Solutions.

In each of these audits and reports, OSH was found to be delinquent in submitting the required data in a timely manner. The auditors cited the hospital for the delay in responding to the audit requests, and identified an overpayment of approximately $365,000 for the FY2015 Medicaid Credit Balance because the hospital was not in compliance with the requirement for "coordination of benefits."

As the hospital has expanded CMS certification from 115 certified beds to 569 certified beds, the associated financial risks have also increased proportionately. In order to mitigate these risks and avoid future overpayments, the hospital is requesting to invest in strengthening front-end compliance, to ensure the hospital and OHA are consistently in compliance with the federal regulations and guidance related to billing for Medicare services. This includes establishing the appropriate staffing position levels commensurate with skills and experience required for this work; establishing sufficient staff resources; and enhanced staff training.

3. HOW DOES THIS FURTHER THE AGENCY'S MISSION OR GOALS? HOW DOES THIS FURTHER THE PROGRAM FUNDING TEAM OUTCOMES OR STRATEGIES?

This POP meets the **Oregon Health Authority's OSH "Priority Area" goals and objectives**:

- To provide adults in Oregon who have serious and persistent mental illness with community services that will assist them to live in the most integrated setting appropriate to their needs, achieve positive outcomes, and prevent their unnecessary institutionalization.
- The state will make diligent efforts to obtain the funding, appropriations, limitations, allotments, or other expenditure authority necessary to achieve this goal.

This POP also meets the following Oregon Health Authority 18-month priorities:

- **Priority 1 - Ensure accurate Oregon Health Plan eligibility and enrollment processes for Oregon's Medicaid program**
  This POP enables the hospital to put "front-end eligibility" checks in place for individuals admitted to OSH. This way, the hospital will ensure patients are enrolled in the Oregon Health Plan and maintain their enrollment during their hospitalization so they have continued access to health care upon discharge.

- **Priority 2 – Ensure behavioral health systems work for all Oregonians**
  This POP has a significant impact on the overall behavioral health system. By providing a robust revenue cycle management plan, the hospital will reduce the financial burden to the individual and free up General Fund dollars which can be reinvested in the community system.

- **Priority 9 – Maintain a fiscally sustainable budget**
  By maximizing the hospital's ability to bill Medicare and third-party insurance, this POP implements a "win-win-win" strategy of reducing General Fund expenditures and state taxpayer burden, as well as reducing the financial burden on patients and their families.

- **Priority 10 – Empower and strengthen the skills and capabilities of OHA's employees**
  This POP invests in the staff and training needed to ensure the hospital can meet compliance requirements for maintaining certification of the additional 454 hospital beds and the associated administrative conditions of participation related to bill for inpatient services under the Medicare program.

4. IS THIS POP TIED TO AN OREGON STATE HOSPITAL PERFORMANCE MEASURE? IF YES, IDENTIFY THE PERFORMANCE MEASURE. IF NO, HOW WILL OREGON STATE HOSPITAL MEASURE THE SUCCESS OF THIS POP?

Yes, this POP achieves the following Oregon State Hospital performance measures:

- We are good stewards of hospital resources.
- We ensure regulatory compliance
- Our information technology is efficient and promotes effective decision-making.
- We recruit and retain staff who share our vision and values.
- We are a center of excellence.

5. DOES THIS POP REQUIRE A CHANGE(S) TO AN EXISTING STATUTE OR REQUIRE A NEW STATUTE? IF YES, IDENTIFY THE STATUTE AND THE LEGISLATIVE CONCEPT.

This POP does not require a change to an existing statute or require a new statute.

6. WHAT ALTERNATIVES WERE CONSIDERED AND WHAT WERE THE REASONS FOR REJECTING THEM?

Before submitting this POP, OSH considered several options:

1. Continuing operations as is, with only staff to support the historical 115 CMS-certified hospital beds and billing CMS for reimbursement for only those patients who are eligible for Medicare or Medicaid occupying these specific beds.
2. Requesting CMS certification for additional hospital beds in increments rather than all at once.

3. Outsourcing the operation of the hospital's entire revenue cycle to an outside vendor once the hospital has been fully CMS certified.

These options were not accepted because options 1 and 2 would continue to severely limit OSH's ability to bill our patients' insurance providers, particularly Medicare and Medicaid, for reimbursement of their cost of care, leaving the patient responsible for this cost. Because very little of this cost is ultimately collected from our patients, OSH would continue to require significant state General Fund investments to operate. These options also fail to take advantage of available Other Funds.

Option 3, outsourcing operation of the revenue cycle, has not worked well for other state psychiatric hospitals that have tried it, and most have returned to an in-house approach. Revenue cycle work for state psychiatric hospitals is not the same as acute care hospitals, and many of the rules and regulations are different; thus, finding competent professionals in this area is challenging. Because of the nuances and unique expertise that state psychiatric hospital revenue cycle work entails, the hospital rejected this option. Performing this operation internally provides more control and oversight of the work to ensure all available resources are identified and properly billed.

7. WHAT WOULD BE THE ADVERSE EFFECTS OF NOT FUNDING THIS POP?

Infrastructure – revenue cycle management

If this POP is not funded, the hospital runs the risk of not being able to:

- Maintain certification for all 569 hospital-licensed beds
- Adequately and fully bill Medicare, Medicaid and third-party insurances for all reimbursable in-patient services
- Penalties and repayments to the Medicare program due to insufficient billing, compliance, and administrative processes.

Additionally, the hospital would risk losing revenue cycle improvements made throughout the past 24 months. This POP provides the mechanism to ensure that the gains and improvements already made remain secure.

Improving safety – limited duration nursing float pool

If this POP is not funded, the hospital will struggle to maintain safe staffing levels due to unplanned direct-care staff absences, putting continued CMS certification at risk. In addition, the hospital will continue to excessively rely on overtime and mandatory overtime, putting an undue burden on staff and their families.

Infrastructure – accreditation and compliance

If this POP is not funded, the hospital would be at risk for potential paybacks to the Medicare program for erroneous billing. Under current Medicare guidelines, any errors in billing for services are subject to recovery audits and reviews. If a recovery audit discovers errors, the Medicare contractor may require payback of all amounts paid to the hospital for the past six years, including interest and penalties.

8. WHAT OTHER AGENCIES (STATE, TRIBAL AND/OR LOCAL GOVERNMENT) WOULD BE AFFECTED BY THIS POP? HOW WOULD THEY BE AFFECTED?

The OHA Health Systems Division, which oversees the Medicaid Management Information System (MMIS), may be required to change policies regarding the "coordination of benefits" for those patients who

are dual-eligible for both Medicare and Medicaid. This is due to Medicare's billing requirements, specifically regarding the revenue code structure. The reimbursement mechanism changed when the hospital implemented a new electronic health record system. Because the electronic billing component of this system can accurately capture the various costs and charges related to the routine service cost centers and ancillary cost centers, it is no longer appropriate or cost-effective to use an "all-inclusive" rate for billing Medicare beneficiaries. MMIS still uses an "all-inclusive" rate and revenue code, which means Health Systems Division must either update MMIS to reflect the DRG billing methodology, or establish a "bridge routine" to convert the revenue code and pricing from a DRG method (Rev Code 0124) to the "all-inclusive" method (Rev Code 0100) in order to accurately process claims electronically.

9. WHAT OTHER AGENCIES, PROGRAMS or STAKEHOLDERS ARE COLLABORATING ON THIS POP?

OSH will invite the OHA Health Systems Division to participate in a policy review of MMIS's processing of Medicaid claims submitted on behalf of inpatients at OSH. The goal will be to ensure effective controls are in place to preclude payment of claims that are ineligible for federal financial participation (FFP) under the Medicaid program for all medical services provided at the hospital for patients between the ages of 21 and 64 years. If working properly, MMIS would deny any claims for ineligible services. This would achieve the appropriate coordination of benefits and would document the indigence of those patients who are eligible for Medicaid services. The other impact would be that patients' Medicaid benefits would remain intact during their hospitalization, so that if they require medical services outside of OSH, the facility or physician that renders the service could appropriately bill for it. By ensuring that Medicaid pays for eligible services, the state would realize a General Fund savings through federal financial participation on these outside medical costs.

10. WHAT IS YOUR EQUITY ANALYSIS?

This POP will expand the hospital's participation in federal Medicare and Medicaid programs. These entitlement federal programs have stringent equity requirements that OSH will continue to meet, to ensure it fully complies with all equity requirements and guidelines.

11. WHAT ASSUMPTIONS AFFECT THE PRICING OF THIS POP?

Implementation Date(s): 7/1/2017

End Date (if applicable): N/A

a. Will there be new responsibilities for the Oregon Health Authority? Specify which Program Area(s) and describe their new responsibilities.
No – no new responsibilities.

b. **Will there be new Shared Services impacts sufficient to require additional funding? Specify which office(s) (i.e., facilities, computer services, etc.) and describe how it will be affected. See Addendum A - Shared Services LC/POP Impact Questionnaire (at the end of this document).**
Yes, we added Shared Services positions to cover the increased staffing caseload that will affect HR, OFS, and IRMS. The positions added in this POP are one Human Resource Analyst 3 (HR), one Accountant 2 (OFS), one Accounting Tech 3 (OFS), one Data Entry Operator (IRMS), and one Administrative Specialist 2 (IRMS).

c. Will there be changes to client caseloads or services provided to population groups? Specify how many in each relevant program.
No.

d. Will it take new staff or will existing positions be modified? For each classification, list the number of positions and the number of months the positions will work in each biennium. Specify if the positions are permanent, limited duration or temporary.

Yes, new staff are required and modifications to existing positions are needed as well.

e. What are the start-up costs, such as new or significant modifications to computer systems, new materials, outreach and training?

One-time costs associated with this POP are:

1. Purchase of business intelligence software, $85,000
2. Avatar change request, $75,000
3. Capital related replacement of equipment/material, $526,000

f. What are the ongoing costs?

Ongoing	GF	OF	FF	TF
Personal Services	0	12,736,771	0	12,736,771
Services & Supplies	0	4,850,757	0	4,850,757
Capital Outlay	0	85,000	0	85,000
Special Payments	0	2,069,854	0	2,069,854
Total	**0**	**19,742,382**	**0**	**19,742,382**
Position				**83**
FTE				**83.00**

g. What are the potential savings?

This POP will result in an increase in total expenditure authority, but will provide an overall General Fund reduction in the amount of ($20,055,765).

h. Based on these answers, is there a fiscal impact?

Yes. There is a fiscal impact. Negative GF and a positive OF (to match anticipated revenues).

Policy Option Package Summary					
Fiscal Impact:		20,433,264			
· Program Unit name and SCR number: OSH, 030-06-00-00000					
· Dollars by fund type by category:					
		GF	OF	FF	TF
Personal Services		0	12,741,653	0	12,741,653
Services & Supplies		-20,055,765	25,066,522	0	5,010,757
Capital Outlay		0	611,000	0	611,000
Special Payments		0	2,069,854	0	2,069,854
Total		**-20,055,765**	**40,489,029**	**0**	**20,433,264**
Position					**83**
FTE					**83.00**

TOTAL FOR THIS PACKAGE

Category	GF	OF	FF	TF	Position	FTE
Personal Services	0	$12,741,653	0	$12,741,653	83	83.00
Services & Supplies	($20,055,765)	$25,066,522	0	$5,010,757		
Capital Outlay	0	$611,000	0	$611,000		
Special Payments	0	$2,069,854	0	$2,069,854		
Total	**($20,055,765)**	**$40,489,029**	**$0**	**$20,433,264**	**83**	**83.00**

Oregon Health Authority-Fiscal Impact Summary by Program Area:

	Oregon State Hospital	Total
General Fund	**($20,055,765)**	**($20,055,765)**
Other Fund	**$40,489,029**	**$40,489,029**
Federal Funds- Ltd	**$0**	**$0**
Total Funds	**$20,433,264**	**$20,433,264**
Positions	**83**	**83**
FTE	**83.00**	**83.00**

What are the sources of funding and the funding split for each one?

Revenue Impact:

Description of Revenue	OF	FF	TF
Other (Medicare) (Comp Srce 0975)	$40,489,029	0	$40,489,029
Total	**$40,489,029**	**$0**	**$40,489,029**

Oregon Health Authority
2017-19 Policy Option Package

Agency Name: Oregon Health Authority
Program Area Name: Health Systems Division and Public Health
Program Name: Health Systems Division – Medicaid and Public Health
Policy Option Package Title: Statewide Tobacco Tax change
Policy Option Package Number: 501
Related Legislation: N/A

Summary Statement:

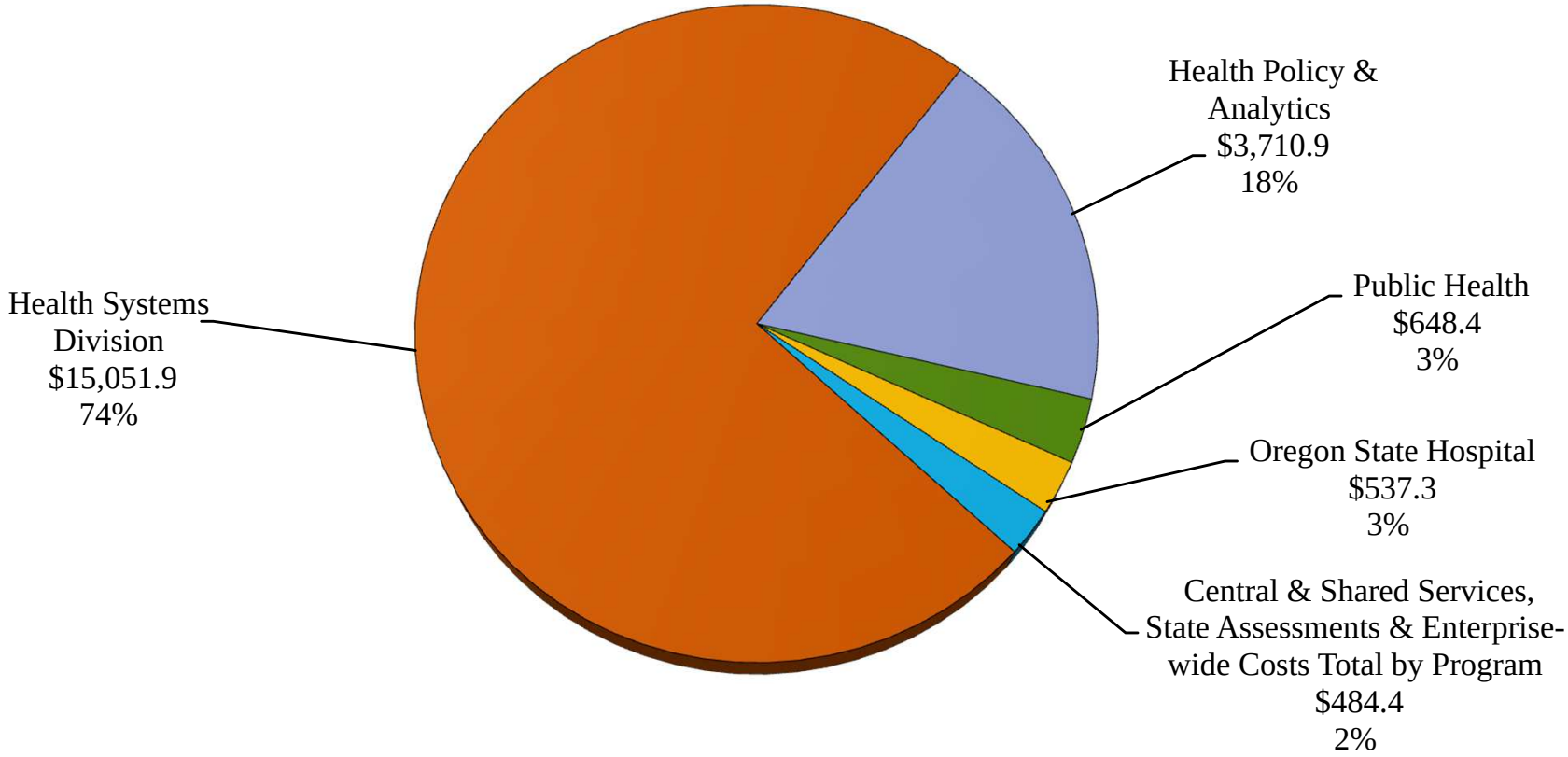
The Governor's Budget proposes to increase the Cigarette Tax from $1.33 per pack to $2.18 per pack effective January 1, 2018. The increase is estimated to generate an estimated $21.5 million for the General Fund per the Department of Revenue. The distribution formula will be in exact proportion to the existing distributions. The Governor's Budget also proposes to increase taxes on Other Tobacco Products, generating an estimated $13.7 million for the General Fund, in the following ways:

- Increase the per cigar cap from $0.50 to $1.00;
- Increase the rate on moist snuff by $0.89 per ounce; and,
- Increase the rate on all other tobacco products from 65 percent of the wholesale price to 75 percent of the wholesale price.

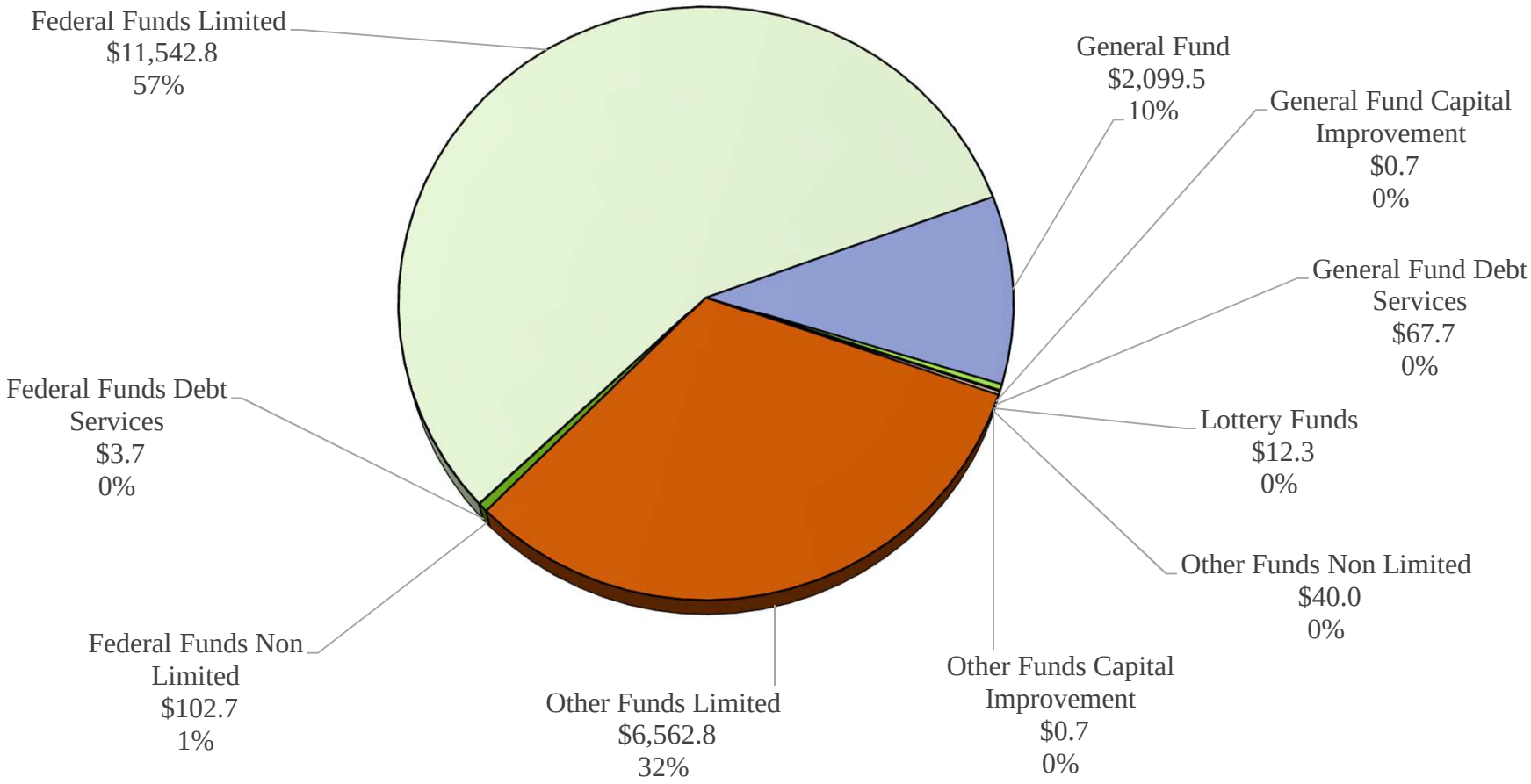
The distribution formula will be in exact proportion to the existing distributions and are proposed to take effect in January 1, 2018.

	General Fund	Other Funds	Federal Funds	Total Funds
Policy Option Package Pricing:	**($109,007,434)**	**$113,523,069**	**$0**	**$4,515,635**

Oregon Health Authority
2017-19 Governor's Budget
Total Funds by Program Area
$20,432.9



Oregon Health Authority
2017-19 Governor's Budget
Total by Fund Type
$20,432.9



Summary of 2017-19 Biennium Budget

Oregon Health Authority | **Governor's Budget**
Oregon Health Authority | **Cross Reference Number: 44300-000-00-00-00000**
2017-19 Biennium

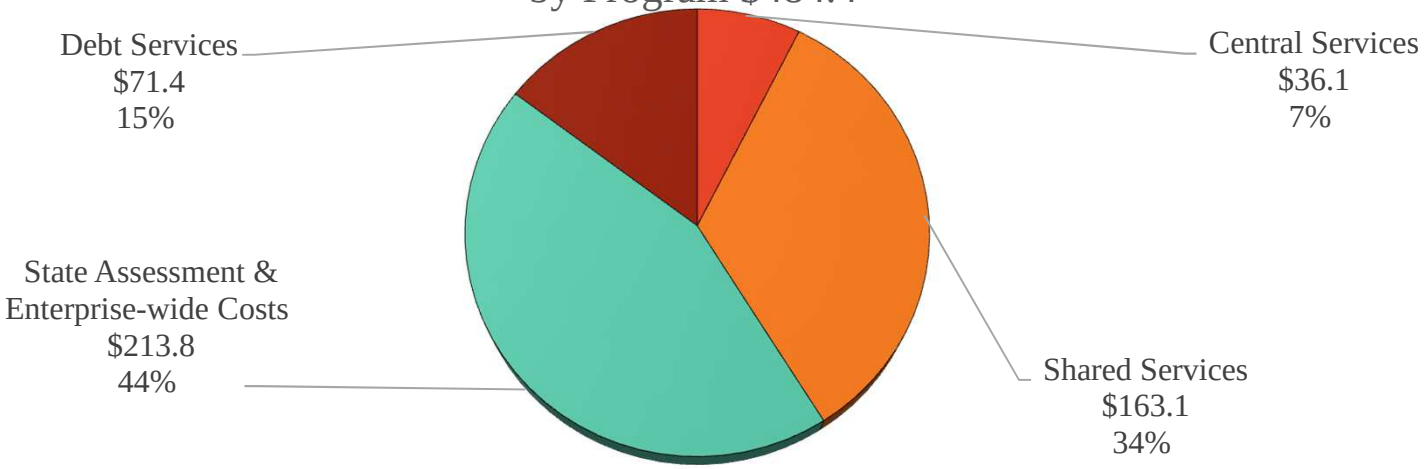
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	4,428	4,361.01	19,466,370,129	2,120,607,875	11,292,544	5,683,377,776	11,400,938,911	143,500,000	106,653,023
2015-17 Emergency Boards	21	22.88	1,106,683,216	19,356,538	56,209	98,917,856	988,352,613	-	-
2015-17 Leg Approved Budget	**4,449**	**4,383.89**	**20,573,053,345**	**2,139,964,413**	**11,348,753**	**5,782,295,632**	12,389,291,524	**143,500,000**	**106,653,023**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(49)	(11.39)	40,995,501	29,836,419	37,785	8,810,019	2,311,278	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(1,707,045)	2,695,030	-	(4,197,413)	-	-	(204,662)
Base Nonlimited Adjustment			(103,500,000)	-	-	-	-	(103,500,000)	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**4,400**	**4,372.50**	**20,508,841,801**	**2,172,495,862**	**11,386,538**	**5,786,908,238**	12,391,602,802	**40,000,000**	**106,448,361**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	9,187,345	6,598,629	(2,661)	1,907,163	684,214	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	5,724,783	3,140,027	7,386	1,572,104	1,005,266	-	-
Subtotal	**-**	**-**	**14,912,128**	**9,738,656**	**4,725**	**3,479,267**	1,689,480	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	380	369.34	98,477,907	77,233,757	684,798	3,571,710	16,987,642	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(167,269,595)	9,601,013	-	(12,799,272)	(164,071,336)	-	-
Subtotal	**380**	**369.34**	**(68,791,688)**	**86,834,770**	**684,798**	**(9,227,562)**	(147,083,694)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,272,802,721	96,208,060	380,543	366,540,431	809,673,687	-	-
State Gov"t & Services Charges Increase/(Decrease)			3,071,302	2,772,818	-	391,503	(93,019)	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal	**-**	**-**	**1,275,874,023**	**98,980,878**	**380,543**	**366,931,934**	809,580,668	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	(1,034,546,416)	50,671,131	-	1,466,179	(1,086,683,726)	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	771,938,129	-	(416,226,914)	(355,711,215)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**4,780**	**4,741.84**	**20,696,289,848**	**3,190,659,426**	**12,456,604**	**5,733,331,142**	11,613,394,315	**40,000,000**	**106,448,361**

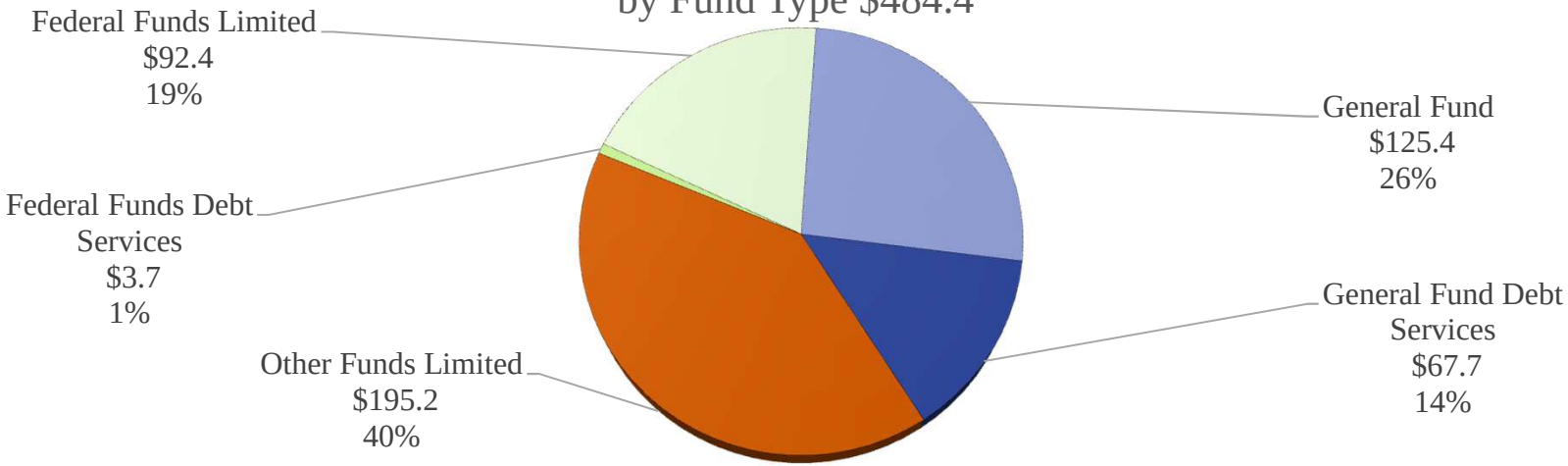
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**4,780**	**4,741.84**	**20,696,289,848**	**3,190,659,426**	**12,456,604**	**5,733,331,142**	11,613,394,315	**40,000,000**	**106,448,361**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	(5)	(5.00)	(4,343,664)	-	-	(4,343,664)	-	-	-
Modified 2017-19 Current Service Level	**4,775**	**4,736.84**	**20,691,946,184**	**3,190,659,426**	**12,456,604**	**5,728,987,478**	11,613,394,315	**40,000,000**	**106,448,361**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	(157)	(333.99)	(583,201,859)	(985,914,942)	(132,108)	642,821,563	(239,976,372)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(7,339,865)	(1,675,469)	(2,371)	(4,447,731)	(1,212,650)	-	(1,644)
092 - Statewide AG Adjustment	-	-	(377,752)	(127,634)	(16)	(223,486)	(26,616)	-	-
095 - December 2016 Rebalance	5	14.50	4,329,032	3,444,069	-	(2,735,974)	3,620,937	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	4,515,635	(109,007,434)	-	113,523,069	-	-	-
201 - Integrated Eligibility	22	19.75	10,762,599	-	-	10,762,599	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	174,669	113,534	-	19,214	41,921	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	275,741	720,290	-	32,124	(476,673)	-	-
402 - Enhance OHA Office of Program Integrity	7	6.16	7,231,496	1,566,735	-	2,050,000	3,614,761	-	-
403 - Hepatitis C Treatment Expansion	-	-	196,426,153	31,962,732	-	14,345,088	150,118,333	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	(438,984)	(438,984)	-	-	-	-	-
405 - MMIS Modularization	9	9.00	5,631,643	367,739	-	2,022,391	3,241,513	-	-
406 - ONE System Enhancements	-	-	12,800,000	1,283,680	-	-	11,516,320	-	-
407 - OHP Coverage for All Kids	-	-	55,030,483	55,030,483	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	5	5.00	14,662,205	-	-	15,825,607	(1,163,402)	-	-
410 - Oregon State Hospital Improvements	83	83.00	20,433,264	(20,055,765)	-	40,489,029	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**(26)**	**(196.58)**	**(259,085,540)**	**(1,022,730,966)**	**(134,495)**	**834,483,493**	(70,701,928)	**-**	**(1,644)**
Total 2017-19 Governor's Budget	**4,749**	**4,540.26**	**20,432,860,644**	**2,167,928,460**	**12,322,109**	**6,563,470,971**	11,542,692,387	**40,000,000**	**106,446,717**
Percentage Change From 2015-17 Leg Approved Budget	6.74%	3.57%	-0.68%	1.31%	8.58%	13.51%	-6.83%	-72.13%	-0.19%
Percentage Change From 2017-19 Current Service Level	-0.65%	-4.25%	-1.27%	-32.05%	-1.08%	14.48%	-0.61%	-	-

Oregon Health Authority
2017-19 Governor's Budget
Central & Shared Services,
State Assessments & Enterprise-wide Costs
by Program $484.4



Central & Shared Services,
State Assessments & Enterprise-wide Costs
by Fund Type $484.4



Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	69	67.43	22,167,236	13,436,943	-	1,278,042	7,452,251	-	-
2015-17 Emergency Boards	52	48.55	13,526,389	6,056,737	-	1,660,578	5,809,074	-	-
2015-17 Leg Approved Budget	**121**	**115.98**	**35,693,625**	**19,493,680**	**-**	**2,938,620**	13,261,325	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	3.63	3,314,056	1,691,704	-	290,215	1,332,137	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**121**	**119.61**	**39,007,681**	**21,185,384**	**-**	**3,228,835**	14,593,462	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	215,232	115,030	-	6,582	93,620	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	548,839	226,398	-	81,786	240,655	-	-
Subtotal	**-**	**-**	**764,071**	**341,428**	**-**	**88,368**	334,275	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(175,000)	(175,000)	-	-	-	-	-
Subtotal	**-**	**-**	**(175,000)**	**(175,000)**	**-**	**-**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	672,676	443,815	-	39,664	189,197	-	-
Subtotal	**-**	**-**	**672,676**	**443,815**	**-**	**39,664**	189,197	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**121**	**119.61**	**40,269,428**	**21,795,627**	**-**	**3,356,867**	15,116,934	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2017-19 Current Service Level	**121**	**119.61**	**40,269,428**	**21,795,627**	**-**	**3,356,867**	15,116,934	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**121**	**119.61**	**40,269,428**	**21,795,627**	**-**	**3,356,867**	15,116,934	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(1,667,009)	(1,356,812)	-	(46,762)	(263,435)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(14,153)	(9,137)	-	(1,729)	(3,287)	-	-
092 - Statewide AG Adjustment	-	-	(13,730)	(7,398)	-	(997)	(5,335)	-	-
095 - December 2016 Rebalance	(12)	(12.00)	(2,471,894)	2,996,326	-	(606,002)	(4,862,218)	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**(12)**	**(12.00)**	**(4,166,786)**	**1,622,979**	**-**	**(655,490)**	(5,134,275)	**-**	**-**
Total 2017-19 Governor's Budget	**109**	**107.61**	**36,102,642**	**23,418,606**	**-**	**2,701,377**	9,982,659	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	-9.92%	-7.22%	1.15%	20.13%	-	-8.07%	-24.72%	-	-
Percentage Change From 2017-19 Current Service Level	-9.92%	-10.03%	-10.35%	7.45%	-	-19.53%	-33.96%	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	482	465.18	137,823,428	-	-	137,823,428	-	-	-
2015-17 Emergency Boards	4	2.20	6,462,868	-	-	6,462,868	-	-	-
2015-17 Leg Approved Budget	**486**	**467.38**	**144,286,296**	**-**	**-**	**144,286,296**	-	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(7)	2.37	4,638,064	-	-	4,638,064	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**479**	**469.75**	**148,924,360**	**-**	**-**	**148,924,360**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,371,904	-	-	1,371,904	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	849,673	-	-	849,673	-	-	-
Subtotal	**-**	**-**	**2,221,577**	**-**	**-**	**2,221,577**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	57,186	-	-	57,186	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**57,186**	**-**	**-**	**57,186**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,336,598	-	-	1,336,598	-	-	-
Subtotal	**-**	**-**	**1,336,598**	**-**	**-**	**1,336,598**	-	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**479**	**469.75**	**152,539,721**	**-**	**-**	**152,539,721**	-	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**479**	**469.75**	**152,539,721**	**-**	**-**	**152,539,721**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**479**	**469.75**	**152,539,721**	**-**	**-**	**152,539,721**	-	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	(4)	(5.24)	(2,167,619)	-	-	(2,167,619)	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(73,660)	-	-	(73,660)	-	-	-
092 - Statewide AG Adjustment	-	-	(862)	-	-	(862)	-	-	-
095 - December 2016 Rebalance	-	9.25	-	-	-	-	-	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	22	19.75	10,762,599	-	-	10,762,599	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	9	9.00	2,022,391	-	-	2,022,391	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**27**	**32.76**	**10,542,849**	**-**	**-**	**10,542,849**	-	**-**	**-**
Total 2017-19 Governor's Budget	**506**	**502.51**	**163,082,570**	**-**	**-**	**163,082,570**	-	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	4.12%	7.52%	13.03%	-	-	13.03%	-	-	-
Percentage Change From 2017-19 Current Service Level	5.64%	6.97%	6.91%	-	-	6.91%	-	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	240,291,422	150,459,407	-	24,762,464	61,145,579	-	3,923,972
2015-17 Emergency Boards	-	-	32,746,496	11,635,584	-	9,002,363	12,108,549	-	-
2015-17 Leg Approved Budget	**-**	**-**	**273,037,918**	**162,094,991**	**-**	**33,764,827**	73,254,128	**-**	**3,923,972**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			(1,707,045)	2,695,030	-	(4,197,413)	-	-	(204,662)
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**-**	**-**	**271,330,873**	**164,790,021**	**-**	**29,567,414**	73,254,128	**-**	**3,719,310**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Non-PICS Personal Service Increase/(Decrease)	-	-	(2,357,991)	(2,069,302)	-	(292,905)	4,216	-	-
Subtotal	**-**	**-**	**(2,357,991)**	**(2,069,302)**	**-**	**(292,905)**	4,216	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	9,007,230	2,243,141	-	200,750	6,563,339	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**9,007,230**	**2,243,141**	**-**	**200,750**	6,563,339	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	10,694,653	5,118,730	-	1,818,881	3,757,042	-	-
State Gov"t & Services Charges Increase/(Decrease)			3,071,302	2,772,818	-	391,503	(93,019)	-	-
Subtotal	**-**	**-**	**13,765,955**	**7,891,548**	**-**	**2,210,384**	3,664,023	**-**	**-**

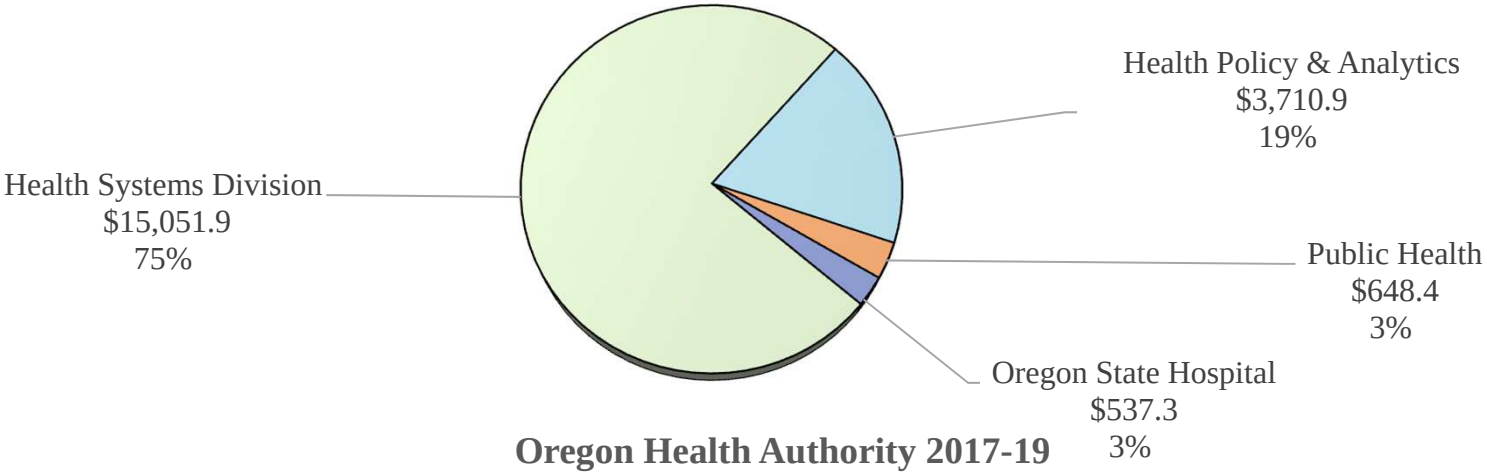
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	40,992	-	-	40,992	-	-	-
Subtotal: 2017-19 Current Service Level	**-**	**-**	**291,787,059**	**172,855,408**	**-**	**31,726,635**	83,485,706	**-**	**3,719,310**

Oregon Health Authority | **Governor's Budget**
State Assessments and Enterprise-wide Costs | **Cross Reference Number: 44300-010-50-00-00000**
2017-19 Biennium

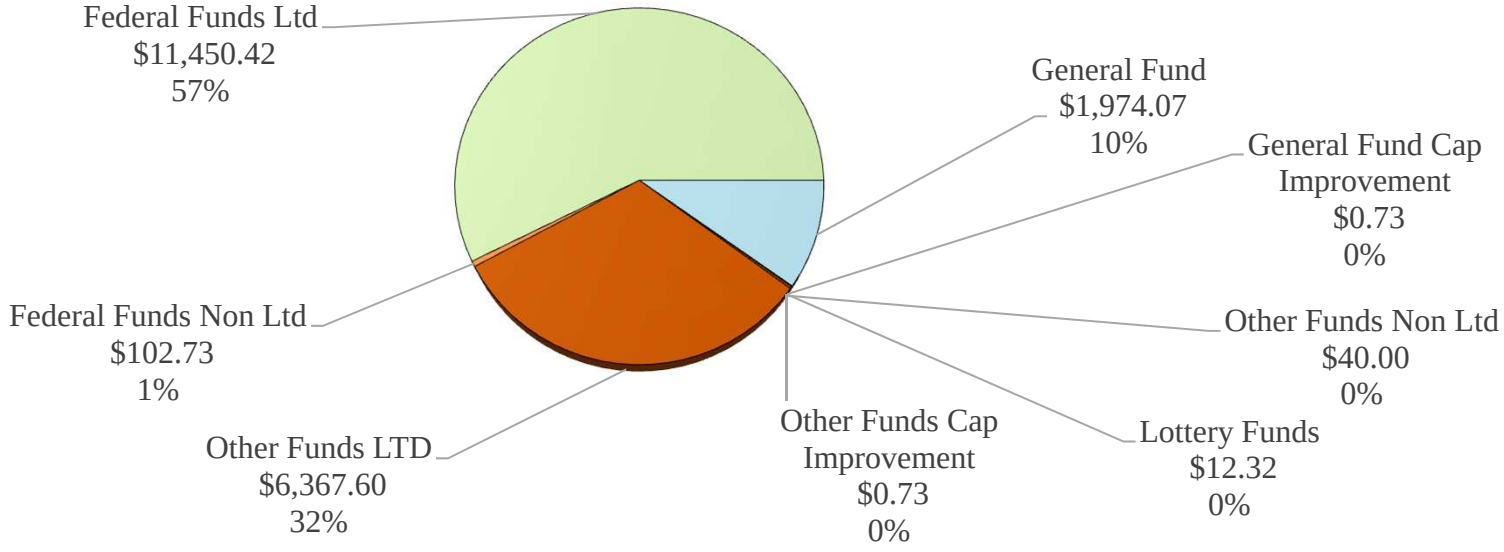
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2017-19 Current Service Level	**-**	**-**	**291,787,059**	**172,855,408**	**-**	**31,726,635**	83,485,706	**-**	**3,719,310**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**-**	**-**	**291,787,059**	**172,855,408**	**-**	**31,726,635**	83,485,706	**-**	**3,719,310**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(4,877,855)	(3,919,522)	-	(285,061)	(673,272)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(2,331,552)	(1,358,978)	-	(255,954)	(716,620)	-	-
092 - Statewide AG Adjustment	-	-	(194)	(91)	-	(25)	(78)	-	-
095 - December 2016 Rebalance	-	-	209,156	2,005,138	-	(1,741,945)	(54,037)	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	174,669	113,534	-	19,214	41,921	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	232,013	23,201	-	-	208,812	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**(6,593,763)**	**(3,136,718)**	**-**	**(2,263,771)**	(1,193,274)	**-**	**-**
Total 2017-19 Governor's Budget	**-**	**-**	**285,193,296**	**169,718,690**	**-**	**29,462,864**	82,292,432	**-**	**3,719,310**
Percentage Change From 2015-17 Leg Approved Budget	-	-	4.45%	4.70%	-	-12.74%	12.34%	-	-5.22%
Percentage Change From 2017-19 Current Service Level	-	-	-2.26%	-1.81%	-	-7.14%	-1.43%	-	-

Oregon Health Authority 2017-19
Governor's Budget
Budget for Health Progams $19,948.5



Oregon Health Authority 2017-19
Governor's Budget
Budget for Health Progams by Fund Type $19,948.5

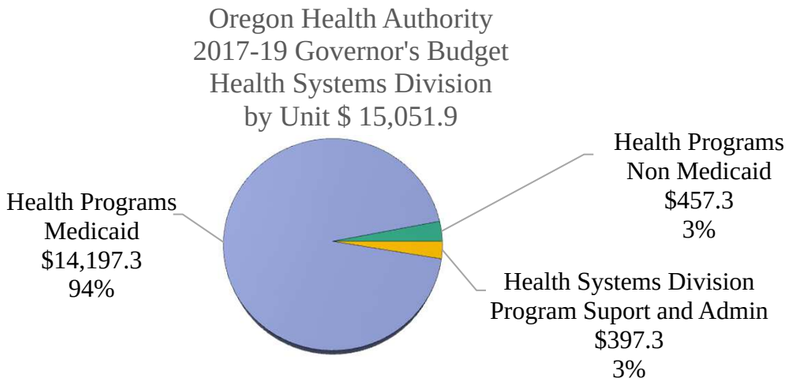


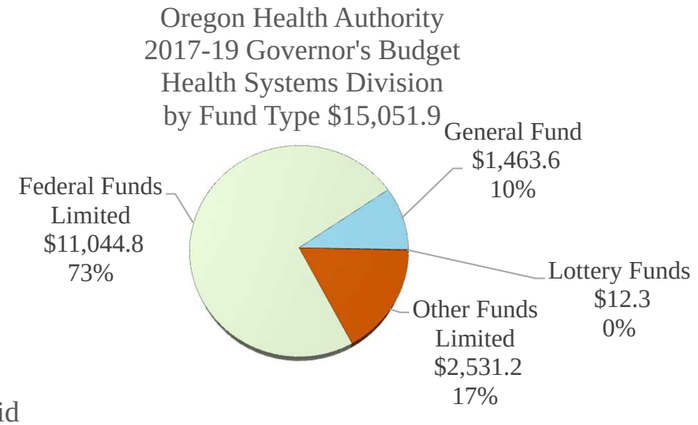
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	3,842	3,800.49	20,120,035,506	1,958,375,742	11,348,753	5,601,305,889	12,302,776,071	143,500,000	102,729,051
2015-17 Leg Approved Budget	**3,842**	**3,800.49**	**20,120,035,506**	**1,958,375,742**	**11,348,753**	**5,601,305,889**	12,302,776,071	**143,500,000**	**102,729,051**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(42)	(17.35)	33,043,381	28,144,715	37,785	3,881,740	979,141	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			(103,500,000)	-	-	-	-	(103,500,000)	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**3,800**	**3,783.14**	**20,049,578,887**	**1,986,520,457**	**11,386,538**	**5,605,187,629**	12,303,755,212	**40,000,000**	**102,729,051**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	7,600,209	6,483,599	(2,661)	528,677	590,594	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	6,684,262	4,982,931	7,386	933,550	760,395	-	-
Subtotal	**-**	**-**	**14,284,471**	**11,466,530**	**4,725**	**1,462,227**	1,350,989	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	380	369.34	89,413,491	74,990,616	684,798	3,313,774	10,424,303	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(167,094,595)	9,776,013	-	(12,799,272)	(164,071,336)	-	-
Subtotal	**380**	**369.34**	**(77,681,104)**	**84,766,629**	**684,798**	**(9,485,498)**	(153,647,033)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,260,098,794	90,645,515	380,543	363,345,288	805,727,448	-	-
Subtotal	**-**	**-**	**1,260,098,794**	**90,645,515**	**380,543**	**363,345,288**	805,727,448	**-**	**-**

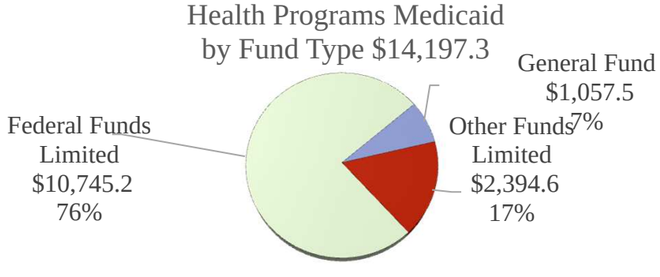
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	(1,034,546,416)	50,671,131	-	1,466,179	(1,086,683,726)	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	771,938,129	-	(416,226,914)	(355,711,215)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	(40,992)	-	-	(40,992)	-	-	-
Subtotal: 2017-19 Current Service Level	**4,180**	**4,152.48**	**20,211,693,640**	**2,996,008,391**	**12,456,604**	**5,545,707,919**	11,514,791,675	**40,000,000**	**102,729,051**

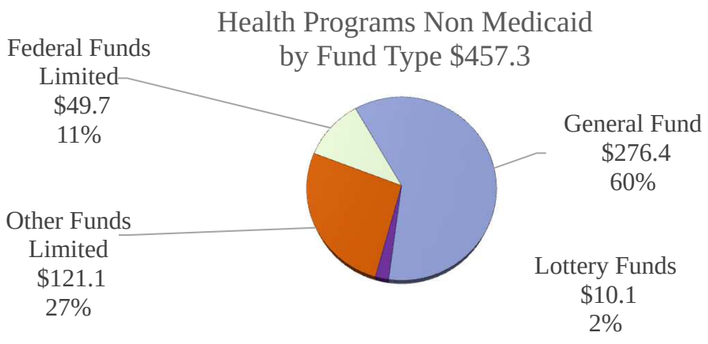
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**4,180**	**4,152.48**	**20,211,693,640**	**2,996,008,391**	**12,456,604**	**5,545,707,919**	11,514,791,675	**40,000,000**	**102,729,051**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	(5)	(5.00)	(4,343,664)	-	-	(4,343,664)	-	-	-
Modified 2017-19 Current Service Level	**4,175**	**4,147.48**	**20,207,349,976**	**2,996,008,391**	**12,456,604**	**5,541,364,255**	11,514,791,675	**40,000,000**	**102,729,051**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	(153)	(328.75)	(574,489,376)	(980,638,608)	(132,108)	645,321,005	(239,039,665)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(4,920,500)	(307,354)	(2,371)	(4,116,388)	(492,743)	-	(1,644)
092 - Statewide AG Adjustment	-	-	(362,966)	(120,145)	(16)	(221,602)	(21,203)	-	-
095 - December 2016 Rebalance	17	17.25	6,591,770	(1,557,395)	-	(388,027)	8,537,192	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	4,515,635	(109,007,434)	-	113,523,069	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	275,741	720,290	-	32,124	(476,673)	-	-
402 - Enhance OHA Office of Program Integrity	7	6.16	7,231,496	1,566,735	-	2,050,000	3,614,761	-	-
403 - Hepatitis C Treatment Expansion	-	-	196,426,153	31,962,732	-	14,345,088	150,118,333	-	-

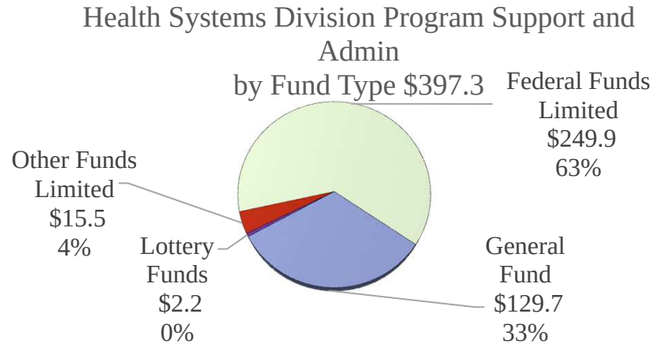
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	(438,984)	(438,984)	-	-	-	-	-
405 - MMIS Modularization	-	-	3,377,239	344,538	-	-	3,032,701	-	-
406 - ONE System Enhancements	-	-	12,800,000	1,283,680	-	-	11,516,320	-	-
407 - OHP Coverage for All Kids	-	-	55,030,483	55,030,483	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	5	5.00	14,662,205	-	-	15,825,607	(1,163,402)	-	-
410 - Oregon State Hospital Improvements	83	83.00	20,433,264	(20,055,765)	-	40,489,029	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**(41)**	**(217.34)**	**(258,867,840)**	**(1,021,217,227)**	**(134,495)**	**826,859,905**	(64,374,379)	**-**	**(1,644)**
Total 2017-19 Governor's Budget	**4,134**	**3,930.14**	**19,948,482,136**	**1,974,791,164**	**12,322,109**	**6,368,224,160**	11,450,417,296	**40,000,000**	**102,727,407**
Percentage Change From 2015-17 Leg Approved Budget	7.60%	3.41%	-0.85%	0.84%	8.58%	13.69%	-6.93%	-72.13%	-
Percentage Change From 2017-19 Current Service Level	-1.10%	-5.35%	-1.30%	-34.09%	-1.08%	14.83%	-0.56%	-	-


Oregon Health Authority
2017-19 Governor's Budget
Health Systems Division
by Unit $ 15,051.9
Health Programs
Medicaid
$14,197.3
94%
Health Programs
Non Medicaid
$457.3
3%
Health Systems Division
Program Suport and Admin
$397.3
3%


Oregon Health Authority
2017-19 Governor's Budget
Health Systems Division
by Fund Type $15,051.9
Federal Funds
Limited
$11,044.8
73%
General Fund
$1,463.6
10%
Lottery Funds
$12.3
0%
Other Funds
Limited
$2,531.2
17%


Health Programs Medicaid
by Fund Type $14,197.3
Federal Funds
Limited
$10,745.2
76%
General Fund
$1,057.5
7%
Other Funds
Limited
$2,394.6
17%


Health Programs Non Medicaid
by Fund Type $457.3
Federal Funds
Limited
$49.7
11%
General Fund
$276.4
60%
Other Funds
Limited
$121.1
27%
Lottery Funds
$10.1
2%


Health Systems Division Program Support and Admin
by Fund Type $397.3
Federal Funds
Limited
$249.9
63%
Other Funds
Limited
$15.5
4%
Lottery
Funds
$2.2
0%
General
Fund
$129.7
33%

Oregon Health Authority
Health Systems Division
2017-19 Biennium

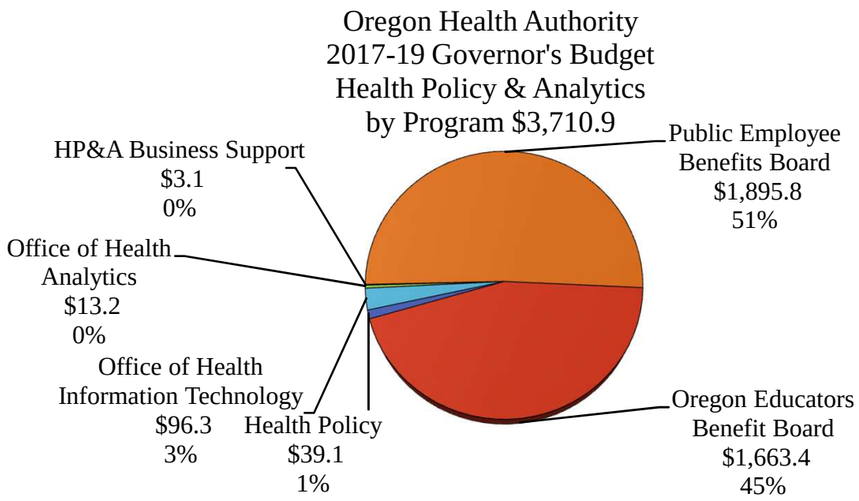
Governor's Budget
Cross Reference Number: 44300-030-01-00-00000

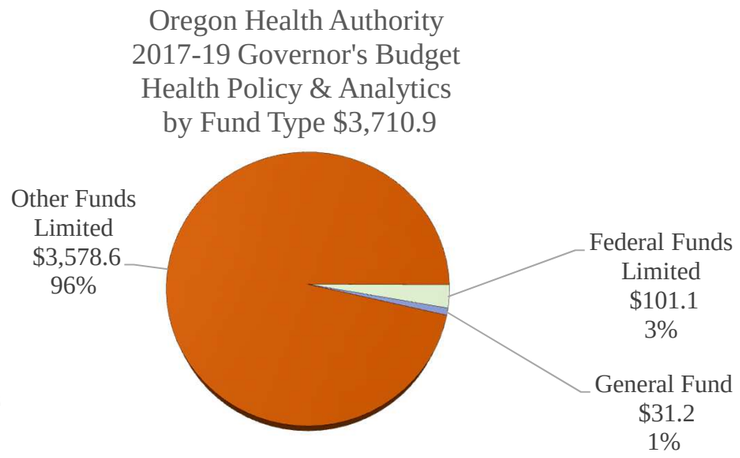
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	612	603.93	15,482,623,094	1,444,762,259	11,348,753	2,050,193,022	11,872,819,060	103,500,000	-
2015-17 Leg Approved Budget	**612**	**603.93**	**15,482,623,094**	**1,444,762,259**	**11,348,753**	**2,050,193,022**	11,872,819,060	**103,500,000**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(2)	(1.83)	653,435	1,605,808	37,785	(644,618)	(345,540)	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			(103,500,000)	-	-	-	-	(103,500,000)	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**610**	**602.10**	**15,379,776,529**	**1,446,368,067**	**11,386,538**	**2,049,548,404**	11,872,473,520	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	(544,068)	(273,274)	(2,661)	7,489	(275,622)	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	700,170	181,082	7,386	(63,827)	575,529	-	-
Subtotal	**-**	**-**	**156,102**	**(92,192)**	**4,725**	**(56,338)**	299,907	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	188	188.00	29,086,673	23,864,073	684,798	2,816,907	1,720,895	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(126,425,041)	13,065,516	-	(11,213,197)	(128,277,360)	-	-
Subtotal	**188**	**188.00**	**(97,338,368)**	**36,929,589**	**684,798**	**(8,396,290)**	(126,556,465)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	1,028,100,378	86,661,787	380,543	138,589,839	802,468,209	-	-
Subtotal	**-**	**-**	**1,028,100,378**	**86,661,787**	**380,543**	**138,589,839**	802,468,209	**-**	**-**

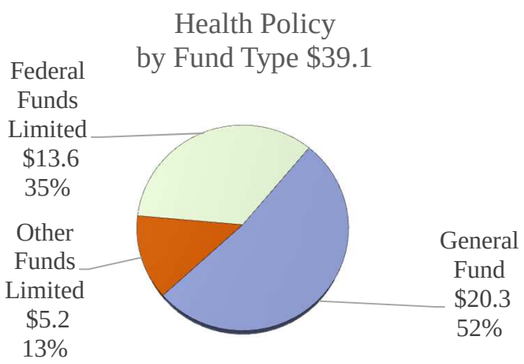
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	(1,034,546,416)	50,671,131	-	1,466,179	(1,086,683,726)	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	771,938,129	-	(416,226,914)	(355,711,215)	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**798**	**790.10**	**15,276,148,225**	**2,392,476,511**	**12,456,604**	**1,764,924,880**	11,106,290,230	**-**	**-**

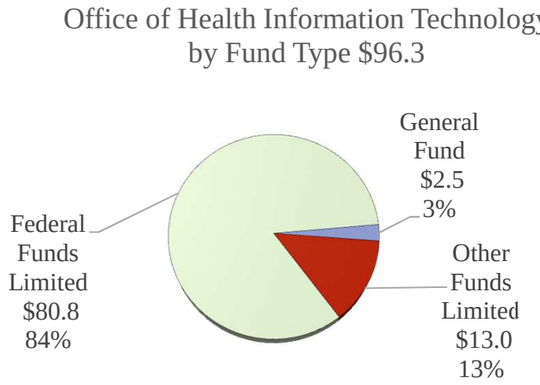
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**798**	**790.10**	**15,276,148,225**	**2,392,476,511**	**12,456,604**	**1,764,924,880**	11,106,290,230	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	(2,158,800)	-	-	(2,158,800)	-	-	-
Modified 2017-19 Current Service Level	**798**	**790.10**	**15,273,989,425**	**2,392,476,511**	**12,456,604**	**1,762,766,080**	11,106,290,230	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(498,425,558)	(907,451,611)	(132,108)	645,751,327	(236,593,166)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(456,752)	(121,300)	(2,371)	(24,889)	(308,192)	-	-
092 - Statewide AG Adjustment	-	-	(45,462)	(12,849)	(16)	(21,650)	(10,947)	-	-
095 - December 2016 Rebalance	11	11.00	2,437,842	(2,080,666)	-	(2,700,000)	7,218,508	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	(109,007,434)	-	109,007,434	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	7	6.16	7,231,496	1,566,735	-	2,050,000	3,614,761	-	-
403 - Hepatitis C Treatment Expansion	-	-	196,426,153	31,962,732	-	14,345,088	150,118,333	-	-

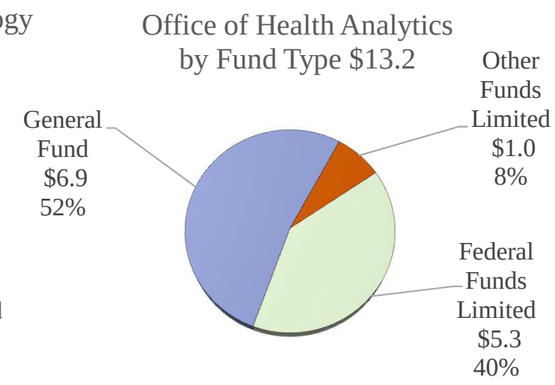
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	(438,984)	(438,984)	-	-	-	-	-
405 - MMIS Modularization	-	-	3,377,239	344,538	-	-	3,032,701	-	-
406 - ONE System Enhancements	-	-	12,800,000	1,283,680	-	-	11,516,320	-	-
407 - OHP Coverage for All Kids	-	-	55,030,483	55,030,483	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**18**	**17.16**	**(222,063,543)**	**(928,924,676)**	**(134,495)**	**768,407,310**	(61,411,682)	**-**	**-**
Total 2017-19 Governor's Budget	**816**	**807.26**	**15,051,925,882**	**1,463,551,835**	**12,322,109**	**2,531,173,390**	11,044,878,548	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	33.33%	33.67%	-2.78%	1.30%	8.58%	23.46%	-6.97%	-100.00%	-
Percentage Change From 2017-19 Current Service Level	2.26%	2.17%	-1.47%	-38.83%	-1.08%	43.42%	-0.55%	-	-

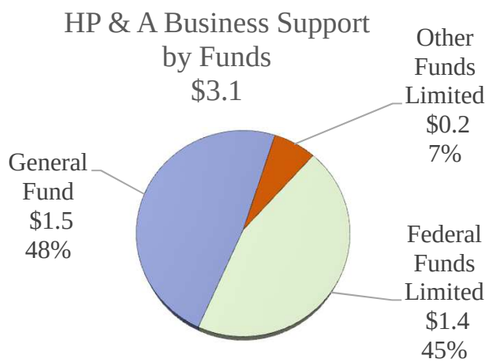

Oregon Health Authority
2017-19 Governor's Budget
Health Policy & Analytics
by Program $3,710.9
HP&A Business Support
$3.1
0%
Public Employee
Benefits Board
$1,895.8
51%
Office of Health
Analytics
$13.2
0%
Office of Health
Information Technology
$96.3
3%
Health Policy
$39.1
1%
Oregon Educators
Benefit Board
$1,663.4
45%

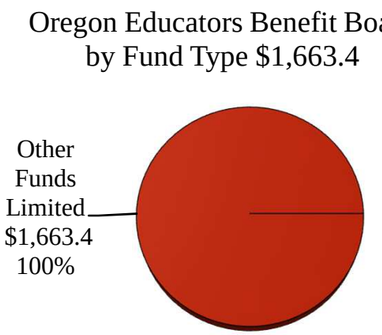

Oregon Health Authority
2017-19 Governor's Budget
Health Policy & Analytics
by Fund Type $3,710.9
Other Funds
Limited
$3,578.6
96%
Federal Funds
Limited
$101.1
3%
General Fund
$31.2
1%

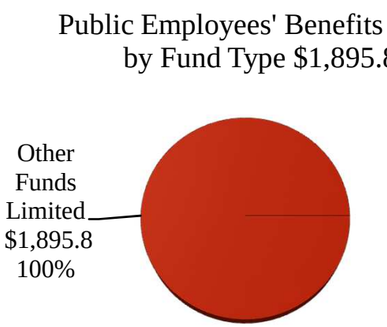

Health Policy
by Fund Type $39.1
Federal
Funds
Limited
$13.6
35%
Other
Funds
Limited
$5.2
13%
General
Fund
$20.3
52%


Office of Health Information Technology
by Fund Type $96.3
General
Fund
$2.5
3%
Federal
Funds
Limited
$80.8
84%
Other
Funds
Limited
$13.0
13%


Office of Health Analytics
by Fund Type $13.2
Other
Funds
Limited
$1.0
8%
General
Fund
$6.9
52%
Federal
Funds
Limited
$5.3
40%


HP & A Business Support
by Funds
$3.1
Other
Funds
Limited
$0.2
7%
General
Fund
$1.5
48%
Federal
Funds
Limited
$1.4
45%


Oregon Educators Benefit Board
by Fund Type $1,663.4
Other
Funds
Limited
$1,663.4
100%

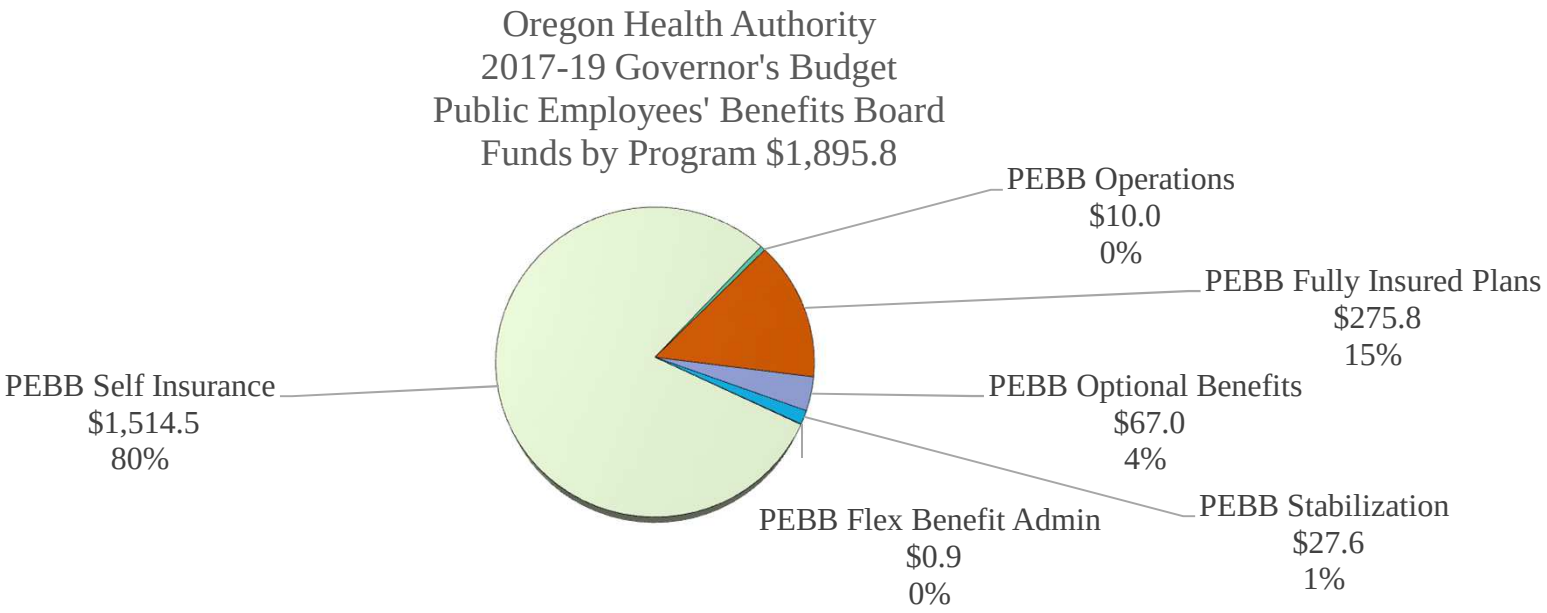

Public Employees' Benefits Board
by Fund Type $1,895.8
Other
Funds
Limited
$1,895.8
100%

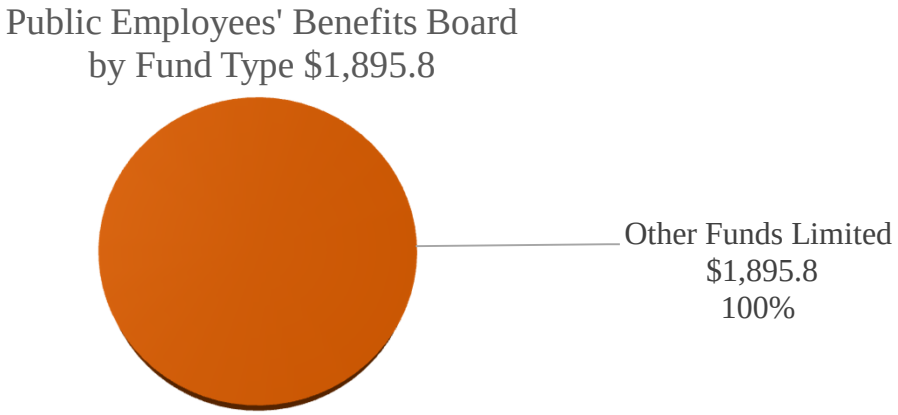
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	135	129.49	139,219,767	22,141,946	-	2,826,075	114,251,746	-	-
2015-17 Leg Approved Budget	**135**	**129.49**	**139,219,767**	**22,141,946**	**-**	**2,826,075**	114,251,746	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(8)	(4.84)	956,234	670,851	-	(30,811)	316,194	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**127**	**124.65**	**140,176,001**	**22,812,797**	**-**	**2,795,264**	114,567,940	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	422,074	229,691	-	18,630	173,753	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	514,382	216,272	-	19,808	278,302	-	-
Subtotal	**-**	**-**	**936,456**	**445,963**	**-**	**38,438**	452,055	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	15	11.50	7,233,388	4,067,616	-	-	3,165,772	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(20,595,641)	(300,000)	-	-	(20,295,641)	-	-
Subtotal	**15**	**11.50**	**(13,362,253)**	**3,767,616**	**-**	**-**	(17,129,869)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	3,361,591	318,525	-	51,345	2,991,721	-	-
Subtotal	**-**	**-**	**3,361,591**	**318,525**	**-**	**51,345**	2,991,721	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	2	2.00	770,090	-	-	770,090	-	-	-
Subtotal: 2017-19 Current Service Level	**144**	**138.15**	**131,881,885**	**27,344,901**	**-**	**3,655,137**	100,881,847	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**144**	**138.15**	**131,881,885**	**27,344,901**	**-**	**3,655,137**	100,881,847	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**144**	**138.15**	**131,881,885**	**27,344,901**	**-**	**3,655,137**	100,881,847	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	3,141,277	3,345,403	-	25,713	(229,839)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(60,839)	(17,870)	-	(2,517)	(40,452)	-	-
092 - Statewide AG Adjustment	-	-	(4,633)	(256)	-	(4,094)	(283)	-	-
095 - December 2016 Rebalance	2	2.00	3,719,796	523,271	-	2,700,873	495,652	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	12,983,343	-	-	12,983,343	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**2**	**2.00**	**19,778,944**	**3,850,548**	**-**	**15,703,318**	225,078	**-**	**-**
Total 2017-19 Governor's Budget	**146**	**140.15**	**151,660,829**	**31,195,449**	**-**	**19,358,455**	101,106,925	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	8.15%	8.23%	8.94%	40.89%	-	584.99%	-11.51%	-	-
Percentage Change From 2017-19 Current Service Level	1.39%	1.45%	15.00%	14.08%	-	429.62%	0.22%	-	-


Oregon Health Authority
2017-19 Governor's Budget
Public Employees' Benefits Board
Funds by Program $1,895.8
PEBB Operations
$10.0
0%
PEBB Fully Insured Plans
$275.8
15%
PEBB Optional Benefits
$67.0
4%
PEBB Stabilization
$27.6
1%
PEBB Flex Benefit Admin
$0.9
0%
PEBB Self Insurance
$1,514.5
80%


Public Employees' Benefits Board
by Fund Type $1,895.8
Other Funds Limited
$1,895.8
100%

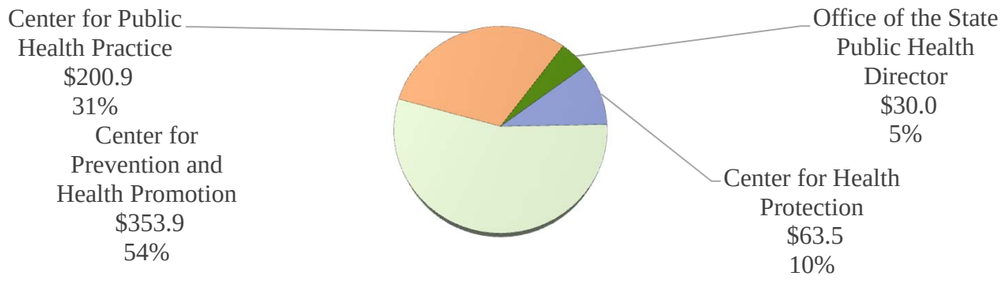
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	20	19.50	1,783,525,223	-	-	1,783,525,223	-	-	-
2015-17 Leg Approved Budget	**20**	**19.50**	**1,783,525,223**	**-**	**-**	**1,783,525,223**	-	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	132,220	-	-	132,220	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**20**	**19.50**	**1,783,657,443**	**-**	**-**	**1,783,657,443**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	27,570	-	-	27,570	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	32,055	-	-	32,055	-	-	-
Subtotal	**-**	**-**	**59,625**	**-**	**-**	**59,625**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	116,216,762	-	-	116,216,762	-	-	-
Subtotal	**-**	**-**	**116,216,762**	**-**	**-**	**116,216,762**	-	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**20**	**19.50**	**1,899,933,830**	**-**	**-**	**1,899,933,830**	-	**-**	**-**

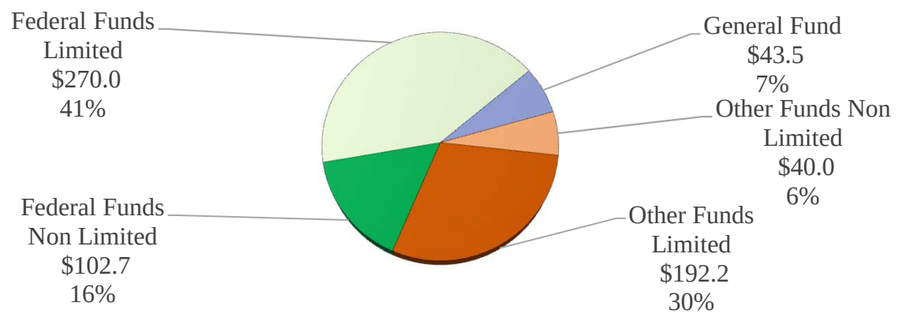
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**20**	**19.50**	**1,899,933,830**	**-**	**-**	**1,899,933,830**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**20**	**19.50**	**1,899,933,830**	**-**	**-**	**1,899,933,830**	-	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(55,688)	-	-	(55,688)	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(3,837,776)	-	-	(3,837,776)	-	-	-
092 - Statewide AG Adjustment	-	-	(16,782)	-	-	(16,782)	-	-	-
095 - December 2016 Rebalance	(1)	(1.00)	(212,600)	-	-	(212,600)	-	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**(1)**	**(1.00)**	**(4,122,846)**	**-**	**-**	**(4,122,846)**	-	**-**	**-**
Total 2017-19 Governor's Budget	**19**	**18.50**	**1,895,810,984**	**-**	**-**	**1,895,810,984**	-	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	-5.00%	-5.13%	6.30%	-	-	6.30%	-	-	-
Percentage Change From 2017-19 Current Service Level	-5.00%	-5.13%	-0.22%	-	-	-0.22%	-	-	-

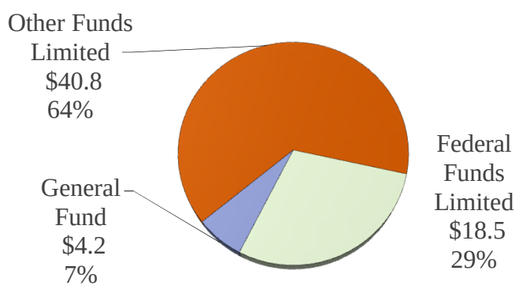
Oregon Health Authority
2017-19 Governor's Budget
Public Health
by Program $648.4



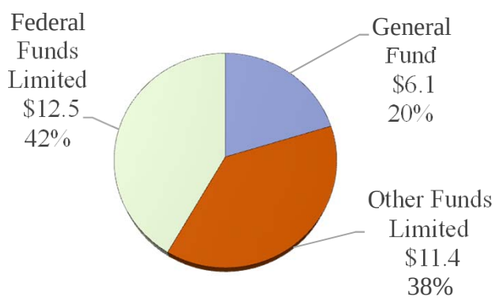
Public Health
by Fund Type $648.4



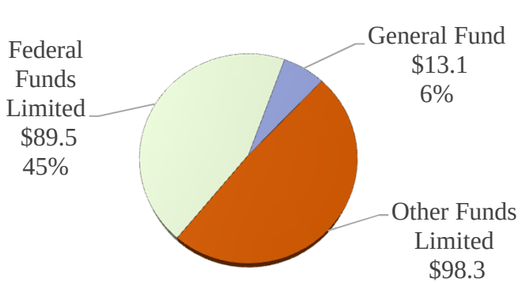
Center for Health Protection
by Fund Type $63.5



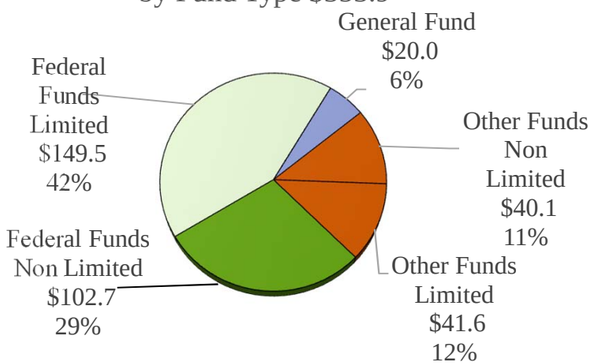
Office of the State Public Health Director
by Fund Type $30.0



Center for Public Health Practice
by Fund Type $200.9



Center for Prevention and Health Promotion
by Fund Type $353.9



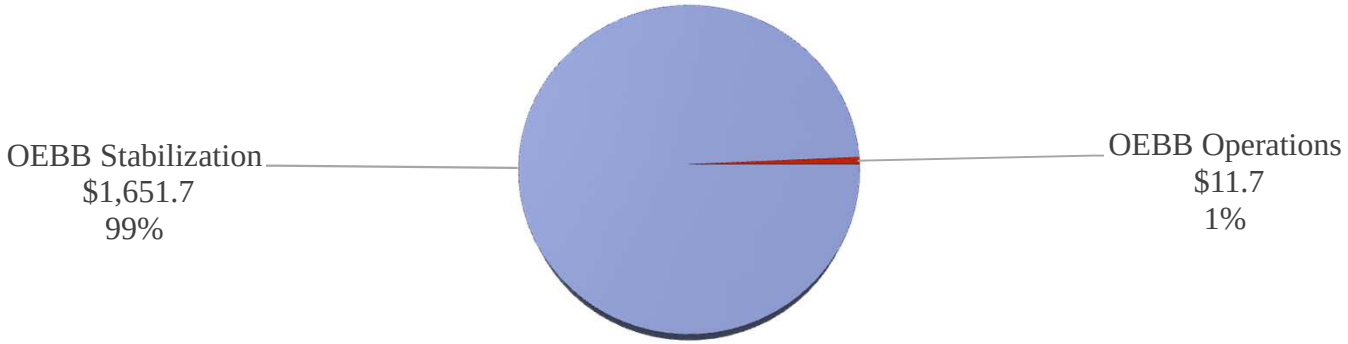
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	22	22.00	1,557,317,594	-	-	1,557,317,594	-	-	-
2015-17 Leg Approved Budget	**22**	**22.00**	**1,557,317,594**	**-**	**-**	**1,557,317,594**	-	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	123,869	-	-	123,869	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**22**	**22.00**	**1,557,441,463**	**-**	**-**	**1,557,441,463**	-	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	46,558	-	-	46,558	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	25,819	-	-	25,819	-	-	-
Subtotal	**-**	**-**	**72,377**	**-**	**-**	**72,377**	-	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(450,000)	-	-	(450,000)	-	-	-
Subtotal	**-**	**-**	**(450,000)**	**-**	**-**	**(450,000)**	-	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	107,258,841	-	-	107,258,841	-	-	-
Subtotal	**-**	**-**	**107,258,841**	**-**	**-**	**107,258,841**	-	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	(2)	(2.00)	(770,090)	-	-	(770,090)	-	-	-
Subtotal: 2017-19 Current Service Level	**20**	**20.00**	**1,663,552,591**	**-**	**-**	**1,663,552,591**	-	**-**	**-**

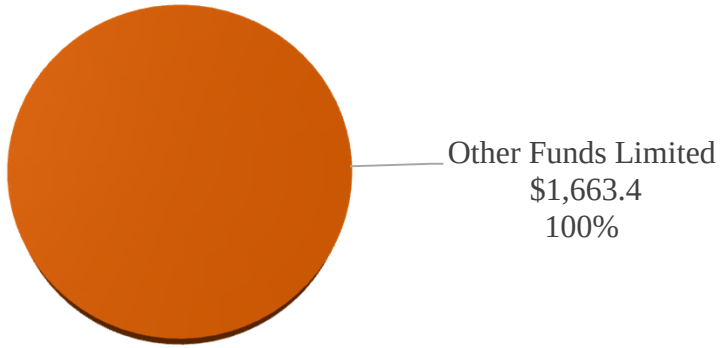
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**20**	**20.00**	**1,663,552,591**	**-**	**-**	**1,663,552,591**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**20**	**20.00**	**1,663,552,591**	**-**	**-**	**1,663,552,591**	-	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(83,436)	-	-	(83,436)	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(14,650)	-	-	(14,650)	-	-	-
092 - Statewide AG Adjustment	-	-	(57,028)	-	-	(57,028)	-	-	-
095 - December 2016 Rebalance	-	-	-	-	-	-	-	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**(155,114)**	**-**	**-**	**(155,114)**	-	**-**	**-**
Total 2017-19 Governor's Budget	**20**	**20.00**	**1,663,397,477**	**-**	**-**	**1,663,397,477**	-	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	-9.09%	-9.09%	6.81%	-	-	6.81%	-	-	-
Percentage Change From 2017-19 Current Service Level	-	-	-0.01%	-	-	-0.01%	-	-	-

Oregon Health Authority
2017-19 Governor's Budget
Oregon Educators Benefits Board
by Program $1,663.4



Oregon Educators Benefits Board
by Fund Type $1,663.4

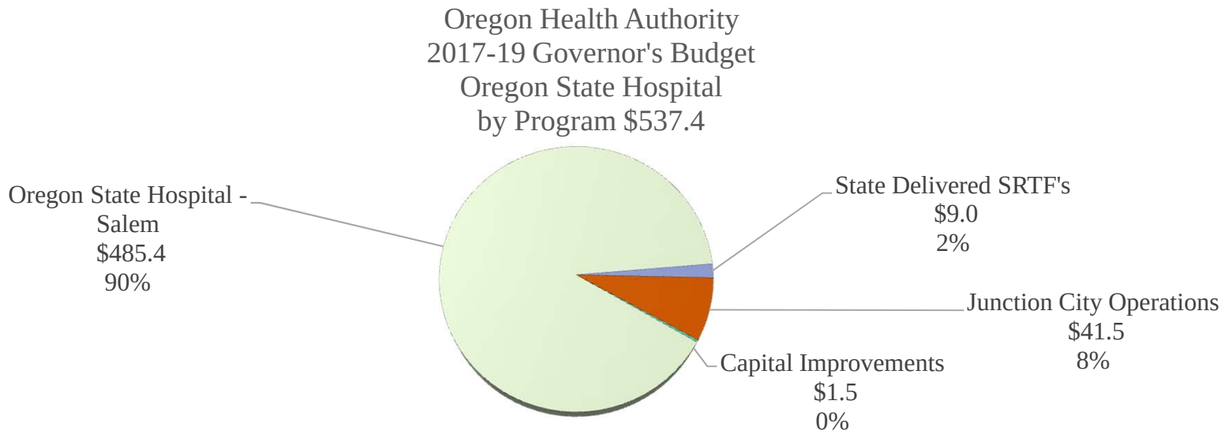


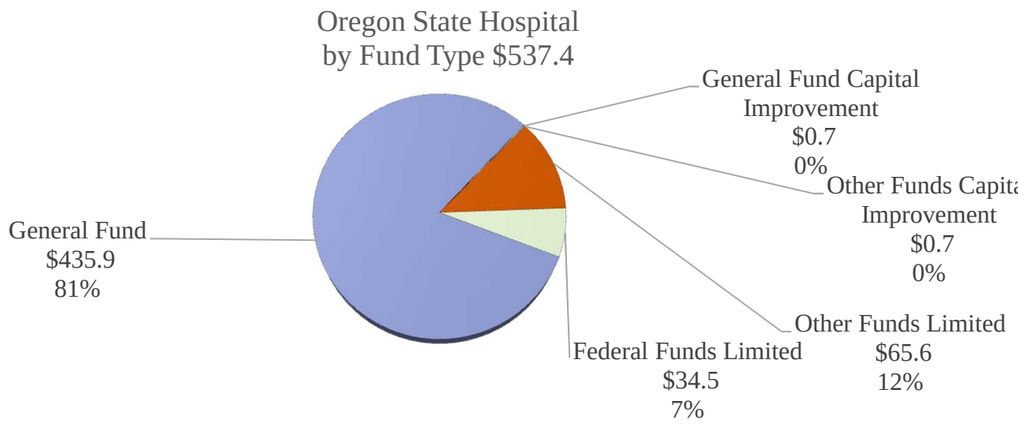
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	785	763.67	635,245,868	43,249,707	-	183,362,631	265,904,479	40,000,000	102,729,051
2015-17 Leg Approved Budget	**785**	**763.67**	**635,245,868**	**43,249,707**	**-**	**183,362,631**	265,904,479	**40,000,000**	**102,729,051**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	(32)	(16.60)	3,595,778	698,865	-	3,411,045	(514,132)	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**753**	**747.07**	**638,841,646**	**43,948,572**	**-**	**186,773,676**	265,390,347	**40,000,000**	**102,729,051**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	1,209,180	88,287	-	428,430	692,463	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	733,761	(352)	-	582,127	151,986	-	-
Subtotal	**-**	**-**	**1,942,941**	**87,935**	**-**	**1,010,557**	844,449	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	7	4.34	6,190,748	156,245	-	496,867	5,537,636	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(1,436,075)	(300,000)	-	(1,136,075)	-	-	-
Subtotal	**7**	**4.34**	**4,754,673**	**(143,755)**	**-**	**(639,208)**	5,537,636	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	2,151,448	1,225,323	-	926,125	-	-	-
Subtotal	**-**	**-**	**2,151,448**	**1,225,323**	**-**	**926,125**	-	**-**	**-**

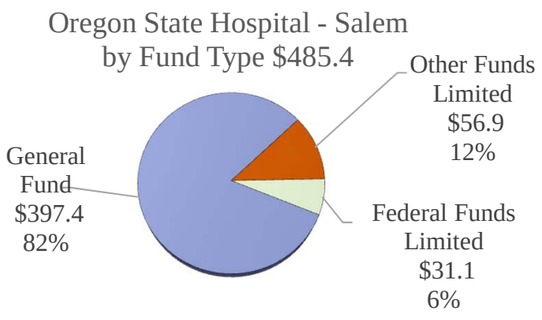
Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	(40,992)	-	-	(40,992)	-	-	-
Subtotal: 2017-19 Current Service Level	**760**	**751.41**	**647,649,716**	**45,118,075**	**-**	**188,030,158**	271,772,432	**40,000,000**	**102,729,051**

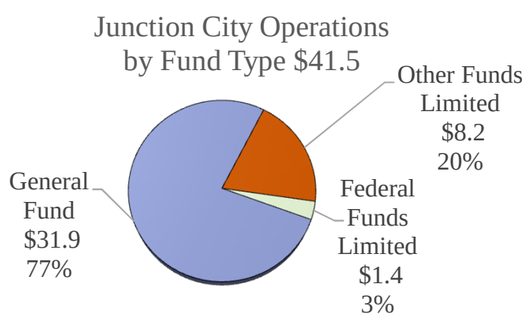
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**760**	**751.41**	**647,649,716**	**45,118,075**	**-**	**188,030,158**	271,772,432	**40,000,000**	**102,729,051**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	(5)	(5.00)	(2,184,864)	-	-	(2,184,864)	-	-	-
Modified 2017-19 Current Service Level	**755**	**746.41**	**645,464,852**	**45,118,075**	**-**	**185,845,294**	271,772,432	**40,000,000**	**102,729,051**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	(3,522,382)	(2,343,637)	-	(316,911)	(861,834)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(372,132)	(18,370)	-	(222,434)	(129,684)	-	(1,644)
092 - Statewide AG Adjustment	-	-	(136,783)	(5,813)	-	(121,172)	(9,798)	-	-
095 - December 2016 Rebalance	4	4.25	434,132	-	-	(388,900)	823,032	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	4,515,635	-	-	4,515,635	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	275,741	720,290	-	32,124	(476,673)	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

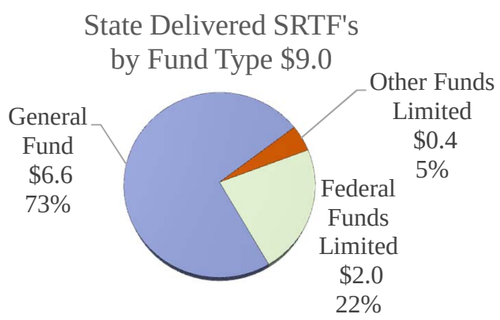
Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	5	5.00	1,678,862	-	-	2,842,264	(1,163,402)	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**9**	**9.25**	**2,873,073**	**(1,647,530)**	**-**	**6,340,606**	(1,818,359)	**-**	**(1,644)**
Total 2017-19 Governor's Budget	**764**	**755.66**	**648,337,925**	**43,470,545**	**-**	**192,185,900**	269,954,073	**40,000,000**	**102,727,407**
Percentage Change From 2015-17 Leg Approved Budget	-2.68%	-1.05%	2.06%	0.51%	-	4.81%	1.52%	-	-
Percentage Change From 2017-19 Current Service Level	0.53%	0.57%	0.11%	-3.65%	-	2.21%	-0.67%	-	-

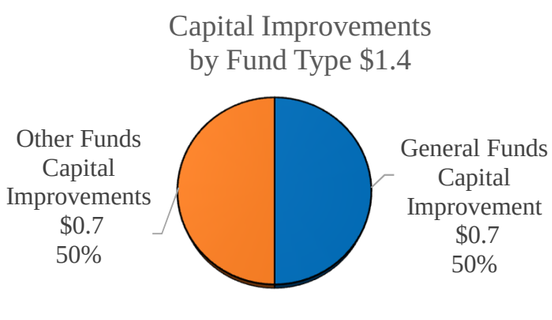

Oregon Health Authority
2017-19 Governor's Budget
Oregon State Hospital
by Program $537.4
Oregon State Hospital - Salem
$485.4
90%
State Delivered SRTF's
$9.0
2%
Junction City Operations
$41.5
8%
Capital Improvements
$1.5
0%


Oregon State Hospital
by Fund Type $537.4
General Fund Capital Improvement
$0.7
0%
Other Funds Capital Improvement
$0.7
0%
General Fund
$435.9
81%
Other Funds Limited
$65.6
12%
Federal Funds Limited
$34.5
7%


Oregon State Hospital - Salem
by Fund Type $485.4
Other Funds Limited
$56.9
12%
General Fund
$397.4
82%
Federal Funds Limited
$31.1
6%


Junction City Operations
by Fund Type $41.5
Other Funds Limited
$8.2
20%
General Fund
$31.9
77%
Federal Funds Limited
$1.4
3%


State Delivered SRTF's
by Fund Type $9.0
Other Funds Limited
$0.4
5%
General Fund
$6.6
73%
Federal Funds Limited
$2.0
22%


Capital Improvements
by Fund Type $1.4
Other Funds Capital Improvements
$0.7
50%
General Funds Capital Improvement
$0.7
50%

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	-	-	-	-	-	-	-
2015-17 Emergency Boards	2,268	2,261.90	522,103,960	448,221,830	-	24,081,344	49,800,786	-	-
2015-17 Leg Approved Budget	**2,268**	**2,261.90**	**522,103,960**	**448,221,830**	**-**	**24,081,344**	49,800,786	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	5.92	27,581,845	25,169,191	-	890,035	1,522,619	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**2,268**	**2,267.82**	**549,685,805**	**473,391,021**	**-**	**24,971,379**	51,323,405	**-**	**-**
Essential Packages									
010 - Non-PICS Pers Svc/Vacancy Factor									
Vacancy Factor (Increase)/Decrease	-	-	6,438,895	6,438,895	-	-	-	-	-
Non-PICS Personal Service Increase/(Decrease)	-	-	4,678,075	4,585,929	-	337,568	(245,422)	-	-
Subtotal	**-**	**-**	**11,116,970**	**11,024,824**	**-**	**337,568**	(245,422)	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	170	165.50	46,902,682	46,902,682	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	(18,187,838)	(2,689,503)	-	-	(15,498,335)	-	-
Subtotal	**170**	**165.50**	**28,714,844**	**44,213,179**	**-**	**-**	(15,498,335)	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	3,009,774	2,439,880	-	302,376	267,518	-	-
Subtotal	**-**	**-**	**3,009,774**	**2,439,880**	**-**	**302,376**	267,518	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**2,438**	**2,433.32**	**592,527,393**	**531,068,904**	**-**	**25,611,323**	35,847,166	**-**	**-**

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
Subtotal: 2017-19 Current Service Level	**2,438**	**2,433.32**	**592,527,393**	**531,068,904**	**-**	**25,611,323**	35,847,166	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**2,438**	**2,433.32**	**592,527,393**	**531,068,904**	**-**	**25,611,323**	35,847,166	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	(153)	(328.75)	(75,543,589)	(74,188,763)	-	-	(1,354,826)	-	-
091 - Statewide Adjustment DAS Chgs	-	-	(178,351)	(149,814)	-	(14,122)	(14,415)	-	-
092 - Statewide AG Adjustment	-	-	(102,278)	(101,227)	-	(876)	(175)	-	-
095 - December 2016 Rebalance	1	1.00	212,600	-	-	212,600	-	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	83	83.00	20,433,264	(20,055,765)	-	40,489,029	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**(69)**	**(244.75)**	**(55,178,354)**	**(94,495,569)**	**-**	**40,686,631**	(1,369,416)	**-**	**-**
Total 2017-19 Governor's Budget	**2,369**	**2,188.57**	**537,349,039**	**436,573,335**	**-**	**66,297,954**	34,477,750	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	4.45%	-3.24%	2.92%	-2.60%	-	175.31%	-30.77%	-	-
Percentage Change From 2017-19 Current Service Level	-2.83%	-10.06%	-9.31%	-17.79%	-	158.86%	-3.82%	-	-

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
2015-17 Leg Adopted Budget	-	-	1,399,230	699,615	-	699,615	-	-	-
2015-17 Emergency Boards	-	-	(1,399,230)	(699,615)	-	(699,615)	-	-	-
2015-17 Leg Approved Budget	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
2017-19 Base Budget Adjustments									
Net Cost of Position Actions									
Administrative Biennialized E-Board, Phase-Out	-	-	-	-	-	-	-	-	-
Estimated Cost of Merit Increase			-	-	-	-	-	-	-
Base Debt Service Adjustment			-	-	-	-	-	-	-
Base Nonlimited Adjustment			-	-	-	-	-	-	-
Capital Construction			-	-	-	-	-	-	-
Subtotal 2017-19 Base Budget	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
020 - Phase In / Out Pgm & One-time Cost									
021 - Phase - In	-	-	-	-	-	-	-	-	-
022 - Phase-out Pgm & One-time Costs	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
030 - Inflation & Price List Adjustments									
Cost of Goods & Services Increase/(Decrease)	-	-	-	-	-	-	-	-	-
Subtotal	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
040 - Mandated Caseload									
040 - Mandated Caseload	-	-	-	-	-	-	-	-	-
050 - Fundshifts and Revenue Reductions									
050 - Fundshifts	-	-	-	-	-	-	-	-	-
060 - Technical Adjustments									

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
060 - Technical Adjustments	-	-	-	-	-	-	-	-	-
Subtotal: 2017-19 Current Service Level	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**

Description	Positions	Full-Time Equivalent (FTE)	ALL FUNDS	General Fund	Lottery Funds	Other Funds	Federal Funds	Nonlimited Other Funds	Nonlimited Federal Funds
Subtotal: 2017-19 Current Service Level	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
070 - Revenue Reductions/Shortfall									
070 - Revenue Shortfalls	-	-	-	-	-	-	-	-	-
Modified 2017-19 Current Service Level	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
080 - E-Boards									
080 - May 2016 E-Board	-	-	-	-	-	-	-	-	-
Subtotal Emergency Board Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Policy Packages									
081 - September 2016 Emergency Board	-	-	-	-	-	-	-	-	-
090 - Analyst Adjustments	-	-	-	-	-	-	-	-	-
091 - Statewide Adjustment DAS Chgs	-	-	-	-	-	-	-	-	-
092 - Statewide AG Adjustment	-	-	-	-	-	-	-	-	-
095 - December 2016 Rebalance	-	-	-	-	-	-	-	-	-
501 - Cig Tax & Other Tobacco Product Increase	-	-	-	-	-	-	-	-	-
201 - Integrated Eligibility	-	-	-	-	-	-	-	-	-
202 - ISPO Investments	-	-	-	-	-	-	-	-	-
203 - SOS Performance Audits	-	-	-	-	-	-	-	-	-
204 - OPAR Position Reconciliation and True-up	-	-	-	-	-	-	-	-	-
205 - Background Check Unit Workload	-	-	-	-	-	-	-	-	-
206 - FMLA / OFLA	-	-	-	-	-	-	-	-	-
401 - Cleaner Air Oregon Initiative	-	-	-	-	-	-	-	-	-
402 - Enhance OHA Office of Program Integrity	-	-	-	-	-	-	-	-	-
403 - Hepatitis C Treatment Expansion	-	-	-	-	-	-	-	-	-

Description	*Positions*	*Full-Time Equivalent (FTE)*	*ALL FUNDS*	*General Fund*	*Lottery Funds*	*Other Funds*	*Federal Funds*	*Nonlimited Other Funds*	*Nonlimited Federal Funds*
404 - Juvenile Fitness to Proceed	-	-	-	-	-	-	-	-	-
405 - MMIS Modularization	-	-	-	-	-	-	-	-	-
406 - ONE System Enhancements	-	-	-	-	-	-	-	-	-
407 - OHP Coverage for All Kids	-	-	-	-	-	-	-	-	-
408 - OHP Demonstration Waiver Extension	-	-	-	-	-	-	-	-	-
409 - OHA Fee Changes	-	-	-	-	-	-	-	-	-
410 - Oregon State Hospital Improvements	-	-	-	-	-	-	-	-	-
411 - Public Health Modernization	-	-	-	-	-	-	-	-	-
412 - SGSC & Telecomm Exceptions	-	-	-	-	-	-	-	-	-
Subtotal Policy Packages	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Total 2017-19 Governor's Budget	**-**	**-**	**-**	**-**	**-**	**-**	-	**-**	**-**
Percentage Change From 2015-17 Leg Approved Budget	-	-	-	-	-	-	-	-	-
Percentage Change From 2017-19 Current Service Level	-	-	-	-	-	-	-	-	-

FALL 2016 DHS|OHA CASELOAD FORECAST

Budget Planning and Analysis
Office of Forecasting, Research and Analysis

OCTOBER 2016

DHS
Oregon Department of Human Services

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Oregon Health Authority

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EXECUTIVE SUMMARY

The 2015-17 **Supplemental Nutrition Assistance Program (SNAP)** biennial average forecast is 405,142 households, which is 0.2 percent lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 371,503 households, which is 8.3 percent lower than the 2015-17 forecast average.

The 2015-17 **Temporary Assistance to Needy Families (TANF)** biennial average forecast is 23,299 families, which is 0.9 percent lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 21,241 families, which is 8.8 percent lower than the 2015-17 forecast average.

The 2015-17 **Child Welfare (CW)** biennial average forecast is 21,293 children, which is 0.4 percent higher than the Spring 2016 forecast. The 2017-19 biennial average forecast is 21,584 children, which is 1.4 percent higher than the 2015–17 forecast average.

The 2015-17 **Vocational Rehabilitation (VR)** biennial average forecast is 9,570 clients, which is 2.8 percent higher than the Spring 2016 forecast. The 2017-19 biennial average forecast is 10,275 clients, which is 7.4 percent higher than the 2015-17 forecast average.

The 2015-17 **Aging and People with Disabilities Long–Term Care (LTC)** biennial average forecast is 34,086 clients, which is slightly lower than the Spring 2016 forecast. The 2017-19 biennial average forecast is 36,561 clients, which is 7.3 percent higher than the 2015-17 forecast average.

The 2015-17 **Intellectual and Developmental Disabilities Case Management (I/DD)** biennial average forecast is 25,309 clients, which is slightly higher from the Spring 2016 forecast. The 2017-19 biennial average forecast is 28,218 clients, which is 11.5 percent higher than the 2015-17 forecast average.

The 2015-17 **Health Systems Medicaid (HSM)** biennial average forecast is 1,116,810 clients, which is 0.4 percent lower than the Spring 2016 Forecast. The 2017-19 biennial average forecast is 1,057,045 clients, which is 5.4 percent lower than the 2015-17 forecast average.

The 2015-17 **Mental Health (MH)** biennial average forecast is 45,646 adults, which is 0.5 percent higher than the Spring 2016 Forecast. The 2017-19 biennial forecast average is 47,523 adults, which is 4.1 percent higher than the 2015-17 forecast average.

INTRODUCTION

This document summarizes the Fall 2016 forecasts of client caseloads for the Oregon Department of Human Services (DHS) and Oregon Health Authority (OHA). The Office of Forecasting, Research and Analysis (OFRA) issues these forecasts in the spring and fall each year. DHS caseload forecasts cover the major program areas administered by the department: Self Sufficiency Programs, Child Welfare, Vocational Rehabilitation, Aging and People with Disabilities, and Intellectual and Developmental Disabilities. OHA caseload forecasts cover the major program areas of Health Systems: Medicaid and Mental Health. Forecasts are used for budgeting and planning and usually extend through the end of the next biennium. Forecasts are developed using a combination of time-series techniques, input-output deterministic models and expert consensus. Forecast accuracy is tracked via monthly reports that compare actual caseload counts to the forecasted caseload, and through the annual forecast quality report which compares forecast accuracy across programs and over time.[1]

1.For more information, please visit *http://www.oregon.gov/DHS/BUSINESS-SERVICES/OFRA/Pages/About-Us.aspx*

Forecast Environment and Risks

Oregon's economy continues to recover from the 2008-2009 Great Recession. Since the recovery began, Oregon has steadily gained jobs and recently entered "full-throttle growth" mode. In 2015, job growth reached its highest level in 20 years. Oregon job gains are outpacing the average state, and wages are growing in all parts of the state. Participation in the labor force has improved from its recession-era low, but remains below historic averages. Much of this is driven by demographics – baby boomers retiring and voluntarily exiting the workforce and younger adults staying in school longer; however, some is also due to a lack of job opportunities and the business cycle.

According to the U.S. Bureau of Labor Statistics, in 2015, 11.7 percent of potential workers in Oregon said they were unemployed, marginally attached to the workforce, or were working part-time involuntarily (due to economic reasons). That is higher than the national average and affects DHS clients. An examination of employment among adults on SNAP in 2013 and 2014 shows that although almost half of them are employed, 70 percent of those who are employed are working less than full-time (defined as 30 hours per week) and forty percent work less than half-time. The most common employment for SNAP recipients fall into three primary industries – Food Services, Social Assistance, and Retail Trade – that tend to offer few full-time jobs. This helps explain why Oregon's SNAP caseload has remained stubbornly high in spite of overall job gains.

Forecasts are based on specific assumptions about the future, and an important part of forecasting is identifying the major risks to those assumptions. Caseload dynamics are influenced by demographics, the economy, and policy choices. Demographic changes have a long-term and predictable influence on caseloads, whereas economic factors can have a dramatic effect on some caseloads, both during recessions and during recoveries. The most immediate and dramatic effects on caseloads result from policy changes that alter the pool of eligible clients or the duration of their program eligibility. Sometimes economic factors influence policy changes. For example, a poor economy will cause tax receipts to decline, which can in turn force spending cuts that limit eligibility for some programs.

The Office of Economic Analysis (OEA) identifies major risks to Oregon's economy in its quarterly forecasts. Some of the major risks listed in the third quarter 2016 edition are volatility of the U.S. economy in general, the strength of the housing market, the affordability of housing, the drought impacting the western states, and restructuring of federal timber payments. The full OEA economic forecast can be found at *http://www.oregon.gov/DAS/OEA/pages/index.aspx.*

Forecasts are based on current practices and policies applied to the expected state of external factors such as demographics and the economy. We do not attempt to anticipate future policy changes. In addition, some new policies lack the necessary case history to be used accurately in forecasts. Future policy changes or uncertainty about recent policy changes represent a major risk to the caseload forecasts.

Oregon Miniumm Wage

Enacted in the 2016 legislative session, Senate Bill 1532 establishes a series of increases to the Oregon minimum wage beginning July 2016 and continuing in phases through July 2022. These phased increases are specified at three separate rates for different parts of the state. The Portland Metro area will have a rate higher than the standard, and certain specified “Non-urban” counties will have a rate slightly lower than the standard. More on the rates can be found at the Oregon Bureau of Labor and Industries website: *http://www.oregon.gov/boli/Pages/index.aspx*.

A good deal has been written about the economic effects of an increase in minimum wage. Summarizing the various arguments and evidence is beyond the scope of this document; however, there is no clear consensus on the impact of a minimum wage increase on public assistance caseloads. Given this lack of consensus, the minimum wage increase must be considered a risk to the forecast. The Office of Forecasting Research and Analysis will monitor caseloads and wages paid to those on our caseloads for evidence of a minimum wage effect.

Department of Human Services

Total Department of Human Services Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Self-Sufficiency								
Supplemental Nutrition Assistance Program (Households)	405,818	405,142	-676	-0.2%	405,142	371,503	-33,640	-8.3%
Temporary Assistance for Needy Families - Basic & UN (Families: Cash Assistance)	23,508	23,299	-209	-0.9%	23,299	21,241	-2,057	-8.8%
Child Welfare (children served)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care[1]	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Vocational Rehabilitation	9,310	9,570	260	2.8%	9,570	10,275	705	7.4%
Aging & Physical Disabilities								
Long-Term Care: In Home	18,155	17,959	-196	-1.1%	17,959	19,982	2,023	11.3%
Long-Term Care: Community Based	11,834	11,886	52	0.4%	11,886	12,456	570	4.8%
Long-Term Care: Nursing Facilities	4,184	4,241	57	1.4%	4,241	4,123	-118	-2.8%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment[2]	25,281	25,309	28	0.1%	25,309	28,218	2,909	11.5%
Total I/DD Services	19,141	19,254	113	0.6%	19,254	21,009	1,755	9.1%

1. Includes residential and foster care.

2. Some clients enrolled in Case Management do not receive any additional I/DD services.

Self Sufficiency Programs (SSP)

In July 2016 there were 398,352 households (706,792 persons) receiving SNAP benefits, which constitutes approximately 17.4 percent of all Oregonians. The SSP portion of SNAP (made up mostly of parents and children) rose rapidly in 2009 and continued to grow until leveling off in mid-2012 when it began it decline. The caseload has declined by 67,106 households since June 2012. The smaller APD SNAP caseload (designed for people aged 60 and older) also rose rapidly due to the Great Recession, but now is returning to its traditional, less-steep growth pattern. The combined 2015-17 SNAP biennial average forecast is 405,142 households, which is 0.2 percent lower than the Spring 2016 forecast. The projected biennial average for 2017–19 is 371,503 households, which is 8.3 percent lower than the 2015-17 biennial average forecast.

APD SNAP is in the pilot phase of increasing from 12-month to 24-month redeterminations (the formal scheduled re-evaluation of eligibility). When this policy is implemented statewide it may decrease the "churn" in the APD SNAP caseload. Churn occurs when clients do not complete the redetermination process in a timely manner and temporarily drop off the caseload. All other things being equal, implementation of this change could increase the total caseload, and should be considered a risk.

The federal government reinstated the "Able Bodied Adults without Dependents" or ABAWD rule in January 2016 for Washington and Multnomah Counties. The ABAWD rule is a three-month limit to SNAP benefits that applies to non-disabled adults without dependents age 50 and under. Oregon was granted an exemption from this time limit for all counties during the Great Recession. As a result of the reinstatement of ABAWD in Washington and Multnomah counties, caseloads dropped by between 5 and 6 percent. Despite the fact that these counties are the most populous in the state, the reduction had only a modest effect on the overall statewide caseload. The rule is due to be applied to Clackamas County in the fall of 2016, and may be applied to other counties through the coming years.

Although reintroduction of this rule is likely to have only a minor impact on the caseload, it must be considered a risk to the forecast.

In addition, the SNAP caseload could be affected by the issues stated in the "Forecast Environment and Risks" section, above.

Temporary Assistance for Needy Families (TANF) – In April 2016, there were 23,007 families receiving TANF benefits, representing 63,088 persons. Starting in January 2008, the TANF caseload underwent nearly uninterrupted growth until leveling off in mid-2012. After a seasonal increase in the winter of 2012-2013, the caseload declined rapidly, and is currently 13,604 cases below its February 2013 peak, a drop of approximately 37 percent. The 2015-17 TANF biennial average forecast is 23,299 families, which is 0.9 percent lower than the Spring 2016 forecast. The 2017-19 biennial average is 21,241 families, which is 8.8 percent lower than the biennial average forecast for 2015-17.

TANF Reinvestment and Data Accuracy

The 2015 Legislature passed House Bill 3535 and House Bill 5026. Taken together, these two acts provide the statutory authority and funding to modify TANF in order to provide better opportunities for families to successfully transition out of the program. This set of policy changes are commonly called "TANF Reinvestment." These reforms began in May 2016.

The elements of TANF Reinvestment that were expected to impact caseloads – and have therefore been built into the forecast – included an increase in the income limit for existing TANF households, expanding the definition of a caretaker relative, the elimination of deprivation as an eligibility requirement, and the creation of a post-TANF Employment Payment (TANF-EP) which provides a cash payment for three months to TANF households exiting TANF due to employment.

Additional elements of TANF Reinvestment which are not forecast, but are considered risks included increasing the use of support and stabilization services to prevent families from entering TANF; and increased client engagement.

Implementation of TANF Reinvestment has led to unintended consequences in the area of data accuracy. For caseloads to be accurately forecast, a case must be in one program – and only one program – within a given month. In the early months of TANF Reinvestment (starting in May 2016) it appeared that cases were being counted in both the TANF category as well as the post-TANF Employment Payments category. In order to reconcile this duplicate count, cases that appeared in both categories were counted only in the TANF-EP caseload, and dropped from the active TANF caseload. This reduced the number of TANF cases, putting them more in line with prior forecast assumptions. The Fall 2016 forecast is based on this revised caseload count.

Given that budget and program timing dictated that the forecast be completed before these data accuracy issues could be fully investigated and understood, the Fall 2016 TANF forecast and the caseload actuals it is built upon must be considered subject to revision. This possibility must be considered a risk to the forecast.

In addition to the risks associated with TANF Reinvestment, the caseload could also be affected by the more general demographic and economic issues stated in the "Forecast Environment and Risks" section of this document.

Because of the increases due to TANF reinvestment, the overall caseload is expected to essentially flatten over this biennia and the next, but with small seasonal increases during the winter months and decreases in the summer.

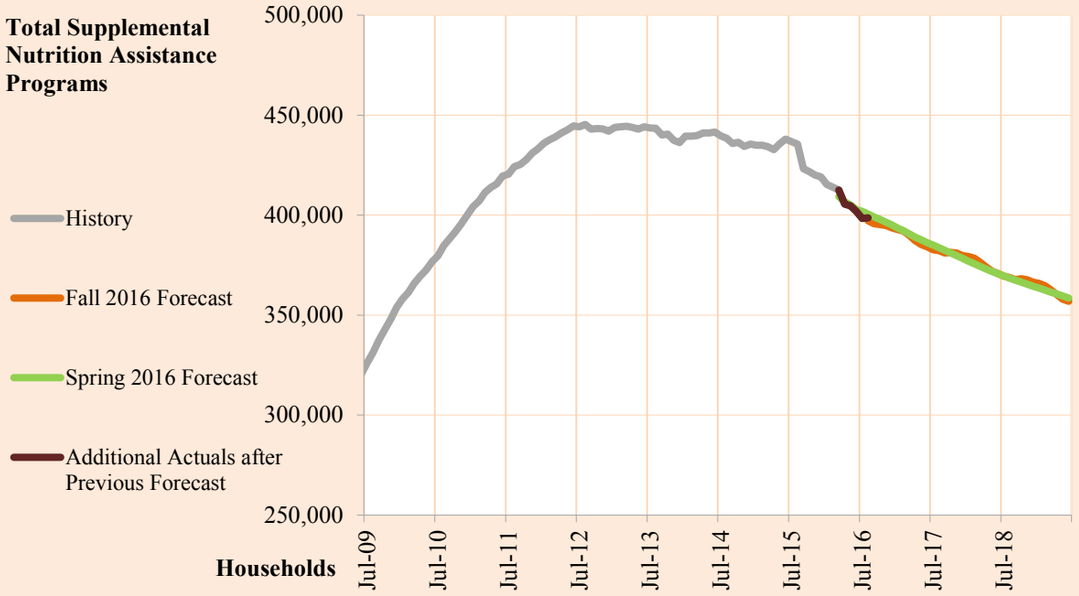
Pre SSI – The 2015–17 biennial average forecast is 517 families, which is 4.2 percent lower than the Spring 2016 forecast. This decrease is due to a reduction in the number of backlogged cases being addressed by staff. With the backlog addressed, the caseload is forecast to return to its recent historical level. The 2017-19 biennial average caseload is expected to be 512 families, which is 0.8 percent lower than the forecast for the current biennium.

Temporary Assistance for Domestic Violence Survivors (TA-DVS) – In the past, the portion of the TA-DVS program that was forecast in this document was limited to those domestic violence survivors who accepted TA-DVS payments (which are used to help defray the costs of housing). Over the course of the past few years, the proportion of TA-DVS clients being seen in DHS field offices but NOT accepting TA-DVS payments has grown. This is likely due to the inadequacy of housing payments at a time of high rents and limited housing availability. This dichotomy has led us to expand the forecast to include both TA-DVS with payments and TA-DVS without payments.

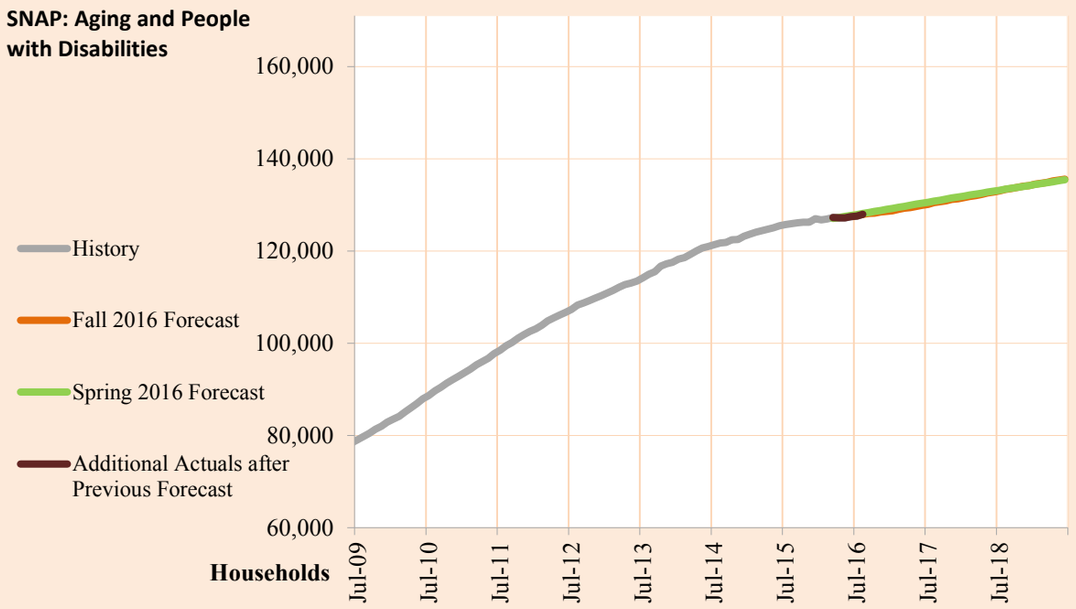
The TA-DVS with-payment caseload is a relatively small caseload that has been falling steadily amid strong seasonal fluctuations. After reaching an historic low in January 2016 of 311 cases, it began its usual seasonal increase before that usual increase also faltered. The TA-DVS with-payment caseload is expected to continue falling, with a 2015–17 biennium average projected at 377 families, which is 6.8 percent lower than the Spring 2016 forecast. The caseload is expected to continue to fall to 282 families per month during the 2017–19 biennium.

The TA-DVS without-payment caseload has been holding relatively steady despite the decreases in the with-payment category. TA-DVS without-payment is expected to average 1,184 cases per-month through the remainder of the 2015-17 biennium, and average 1,188 cases per month in the 2017-19 biennium, a change of only 0.3 percent.

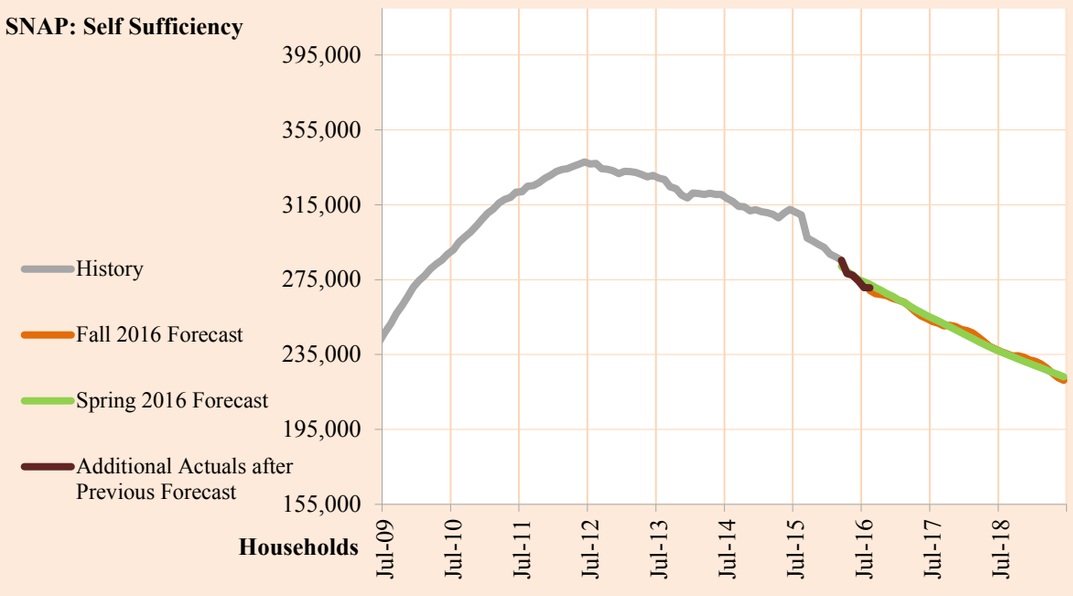
Total Supplemental Nutrition Assistance Programs



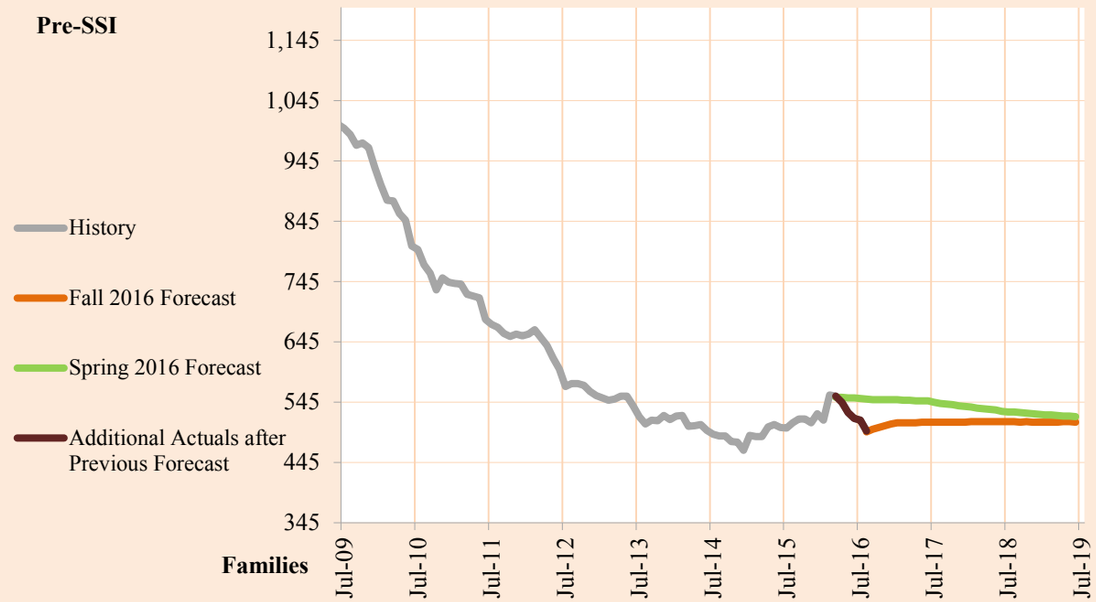
SNAP: Aging and People with Disabilities



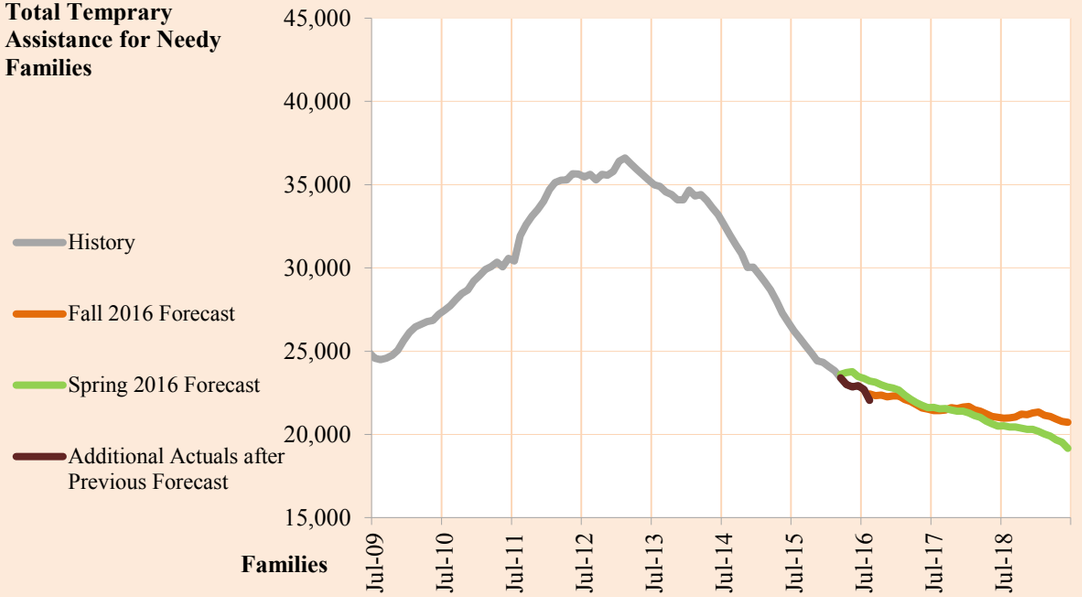
SNAP: Self Sufficiency



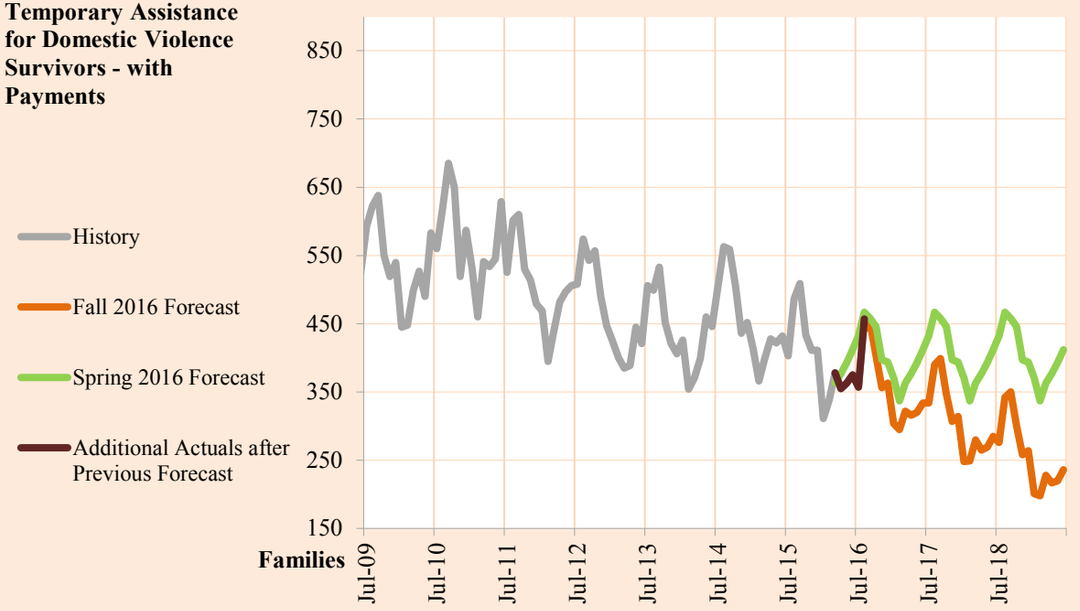
Pre-SSI



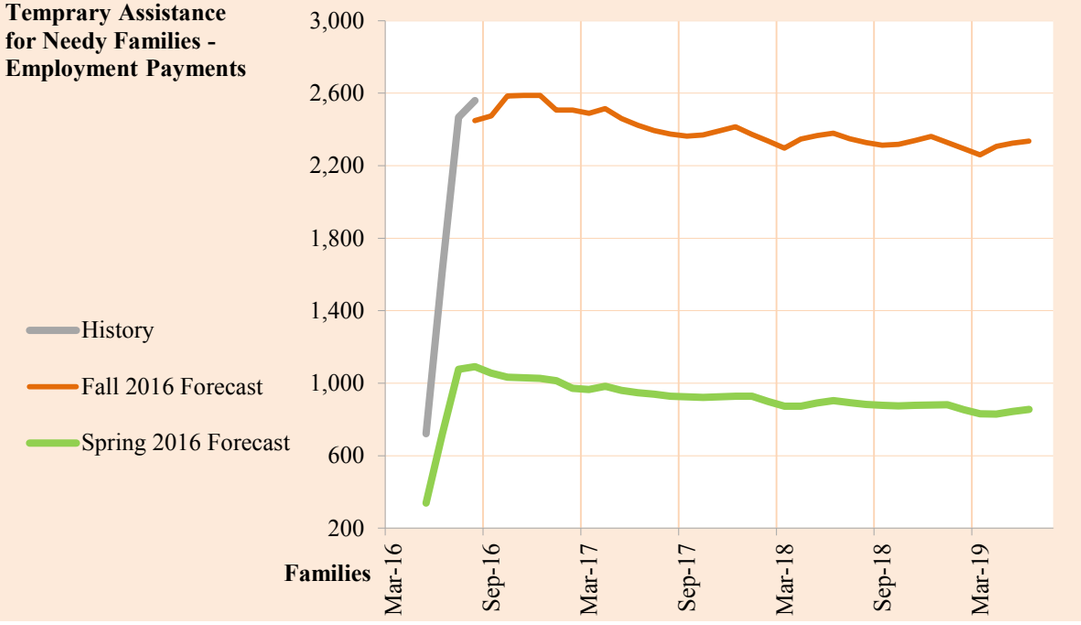
Total Temprary Assistance for Needy Families



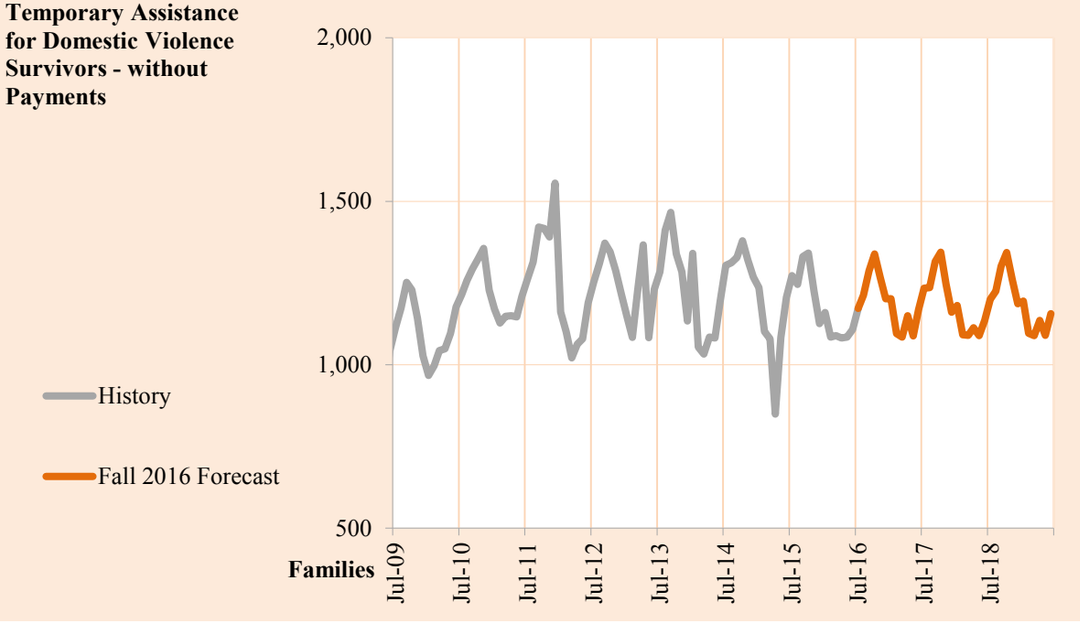
Temporary Assistance for Domestic Violence Survivors - with Payments



Temprary Assistance for Needy Families - Employment Payments



Temporary Assistance for Domestic Violence Survivors - without Payments



Self Sufficiency Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
SELF SUFFICIENCY PROGRAMS								
Supplemental Nutrition Assistance Program (Households)								
Children, Adults and Families	277,902	277,427	-475	-0.2%	277,427	238,594	-38,832	-14.0%
Aging and People with Disabilities	127,916	127,716	-200	-0.2%	127,716	132,908	5,193	4.1%
Total SNAP	**405,818**	**405,142**	-676	-0.2%	**405,142**	**371,503**	-33,640	-8.3%
Temporary Assistance for Needy Families (Families: Cash/Grants)								
Basic	20,303	20,113	-190	-0.9%	20,113	19,046	-1,067	-5.3%
UN	3,205	3,186	-19	-0.6%	3,186	2,195	-991	-31.1%
Total TANF	**23,508**	**23,299**	**-209**	**-0.9%**	**23,299**	**21,241**	**-2,057**	**-8.8%**
TANF Employment Payments	1,165	2,269	1,104	94.8%	2,269	2,348	79	3.5%
Pre-SSI	540	517	-23	-4.3%	517	512	-4	-0.8%
Temp. Assist. For Dom. Violence Survivors (Families)								
TADVS: With Payment	404	377	-28	-6.8%	377	282	-94	-25.0%
TADVS: Without Payment*	-	1,184	-	-	1,184	1,188	4	0.3%
Total TADVS	**-**	**1,561**	**-**	**-**	**1,561**	**1,471**	**-90**	**-5.8%**

*TADVS: Without Payment is a new forecast category.

Child Welfare (CW)

Four main groups are forecast for Child Welfare: Adoption Assistance, Guardianship Assistance, Out of Home Care, and Child In-Home. Children may move between these groups, and typically enter the Child Welfare system via an Assessment. The number of children on open assessments has climbed over the past several years, however a plateau is expected, as there is an executive directive for branches to complete assessments in less than sixty days.

Adoption Assistance – This caseload exhibited moderate growth beginning in early 2012, but during the second half of 2015 the caseload leveled off. Since January 2016, there has been a slow decline to the caseload due to an increase in children aging out. Almost all new clients are from paid foster care so changes to the foster care caseload can directly increase or decrease the adoption assistance caseload. The caseload is expected to average 11,141 for the 2015-17 biennium, which is 0.9 percent lower than the Spring 2016 forecast. The caseload is expected to average 11,135 over the 2017-19 biennium, which is 0.1 percent lower than the 2015-17 biennial average forecast.

Guardianship Assistance – This caseload has exhibited steady growth for its entire history. The caseload grew 5 percent from March 2015 to March 2016. Policies are in place to shorten the length of time to permanent placement, so this caseload will continue to increase as children move out of foster care. In recent months, however, workers have been re-prioritizing work around safety issues and this may be affecting caseload numbers. Recent caseload numbers following the Spring 2016 forecast were about 1.5 percent lower than forecasted. The new forecast for 2015-17 caseload is expected to average 1,555 for the 2015-17 biennium, which is 1.9 percent lower than the Spring 2016 forecast. The caseload is expected to average 1,690 over the 2017-19 biennium, which is 8.7 percent higher than the 2015-17 biennial average forecast.

Out of Home Care – This caseload is comprised of paid foster care, non-paid foster care (including trial home visits), and residential care. Paid foster care is the largest portion of the group. The total foster care caseload experienced a 16.5 percent drop between 2010 and 2015, declining from 8,408 children in December 2010 to 7,024 children in December 2015. During this period, the number of children supervised in-home also declined overall, as well as the percentage of in-home children who transferred into foster care. Many initiatives now in place are designed to decrease the foster care caseload even though the child population in Oregon continues to grow. However, in recent months the caseload has leveled off and exhibited some growth. Between November 2015 and March 2016 the caseload grew 1.3 percent. The caseload is expected to average 7,092 for the 2015-17 biennium, which is 1.3 percent higher than the Spring 2016 forecast. The caseload is expected to average 7,173 over the 2017-19 biennium, which is 1.1 percent higher than the 2015-17 biennial average forecast.

Child In-Home – Following implementation of the OR-KIDS data system in 2011, this caseload exhibited an almost continuous decline until 2015. Since January 2015 the caseload has been climbing. In March 2016 the caseload rose to 1,572, and between April 2015 and March 2016 the caseload increased 22 percent. Recent increases are likely due to a change in reporting. There has been an increase in data entry, which may reflect a more accurate number of children served in-home. The caseload is expected to average 1,505 for the 2015-17 biennium, which is 9.5 percent higher than the Spring 2016 forecast. The caseload is expected to average 1,586 over the 2017-19 biennium, which is 5.4 percent higher than the 2015-17 biennial average forecast.

Risks and Assumptions

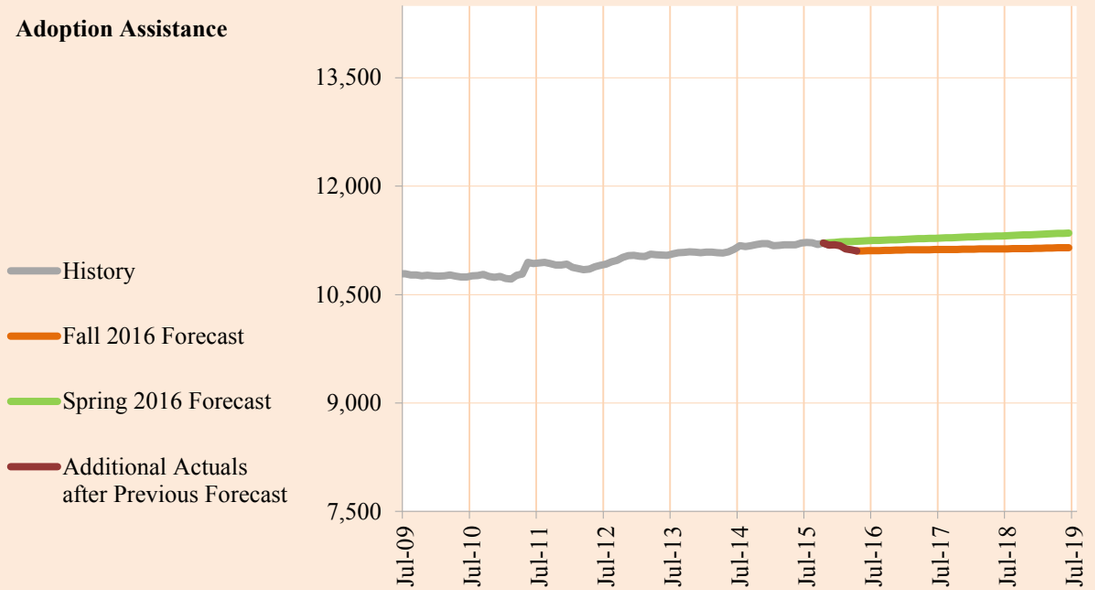
In the past year the Child Welfare Program has experienced changes in leadership, and there is a new review process for licensed residential facilities. Since January 2016, there has been a shift in prioritization to child protective services work, and this may affect Adoption Assistance and Guardianship Assistance caseloads.

Risks to the Out of Home Care caseload mainly involve the treatment foster care program. Providers may close suddenly or not accept referrals. They also

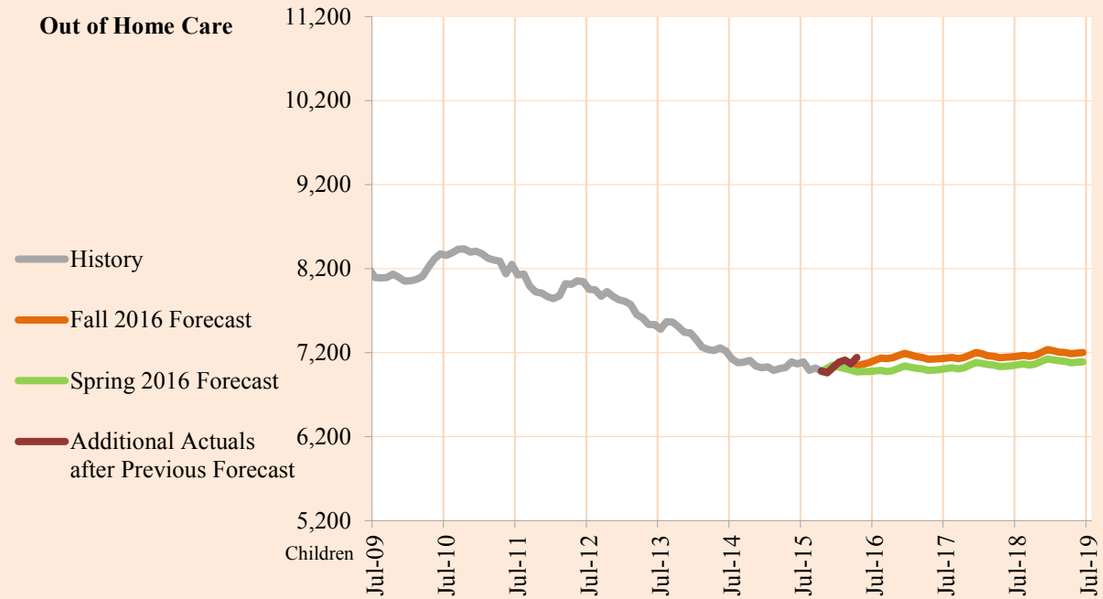
face challenges recruiting foster parents. There may be a need for services but a lack of people to provide those services. As new programs start, it is unknown how quickly the beds will fill.

The Child In-Home data are still being worked on and checked. The percentage of case plans entered into the system increased for the first half of 2016. This led to more children being counted in the Child In-Home caseload. Another risk to the forecast of the Child In-Home caseload is the number of overdue or unclosed assessments that have not been entered into the data system. In May 2016 a clean-up effort around overdue assessments began, and overdue assessments have started to decline. The Child In-Home caseload may increase as a result.

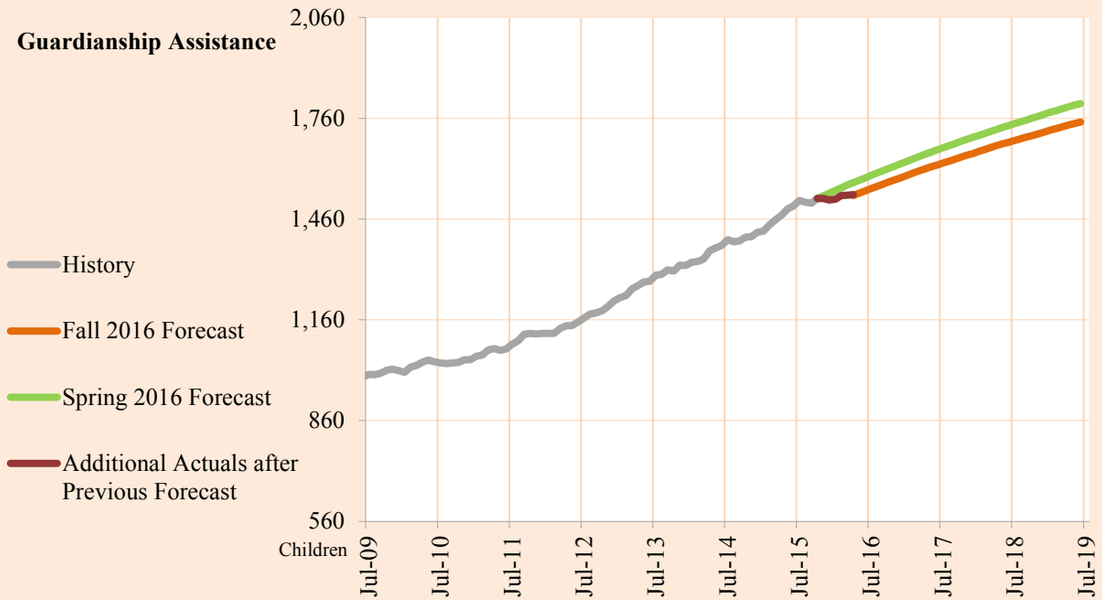
Adoption Assistance



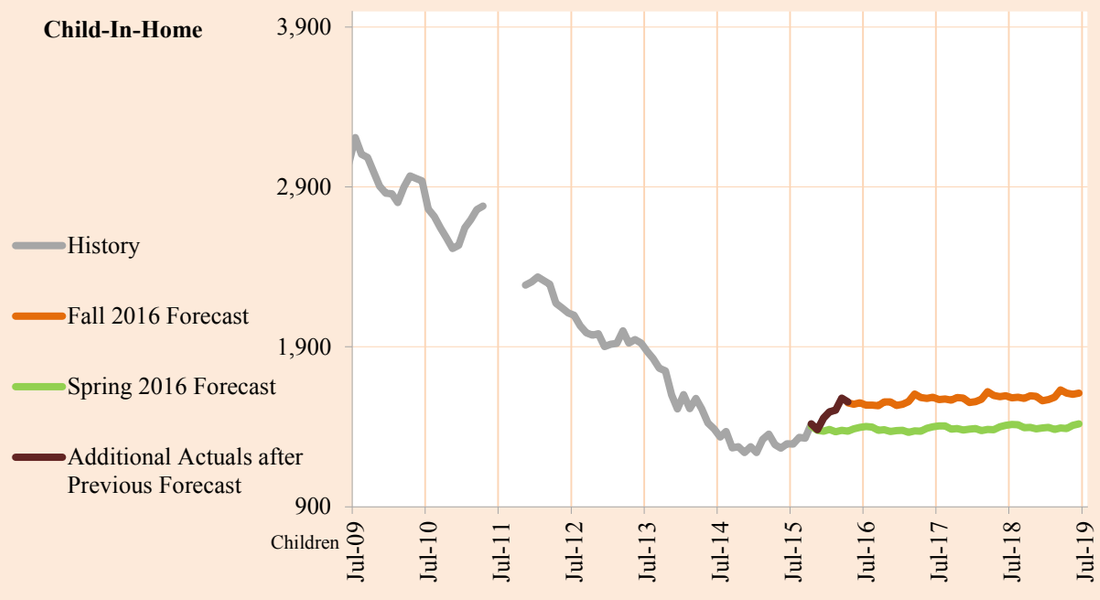
Out of Home Care

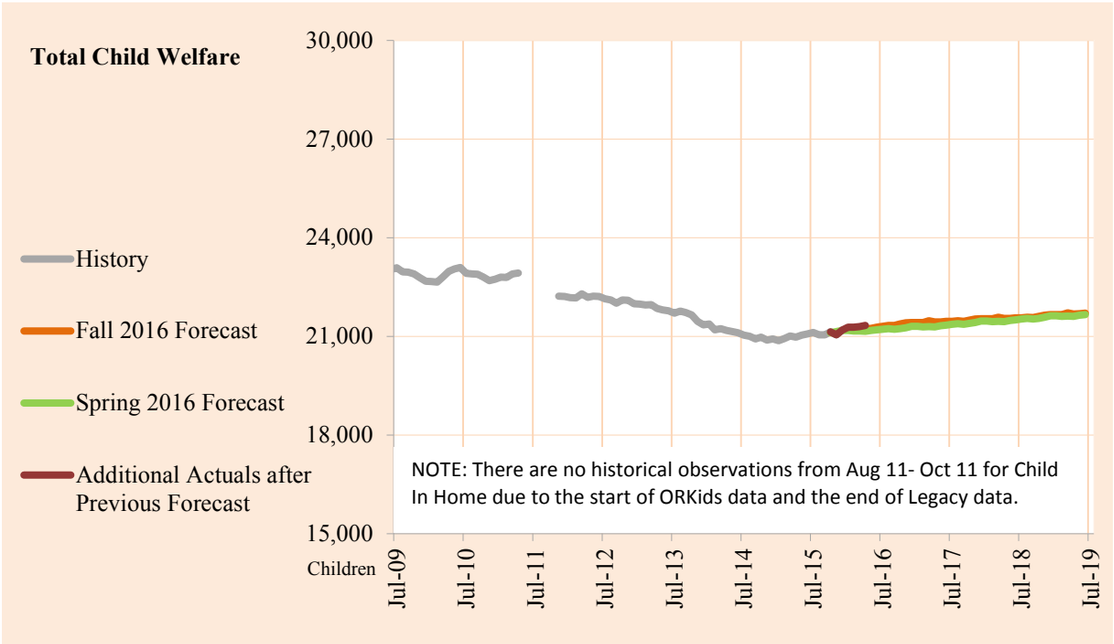


Guardianship Assistance



Child-In-Home




Total Child Welfare
30,000
27,000
24,000
21,000
18,000
15,000
Children
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
NOTE: There are no historical observations from Aug 11- Oct 11 for Child In Home due to the start of ORKids data and the end of Legacy data.
Jul-09
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

Child Welfare Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
CHILD WELFARE (Children)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care[1]	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Total Child Welfare	**21,209**	**21,293**	**84**	**0.4%**	**21,293**	**21,584**	**291**	**1.4%**

1. Includes residential and foster care.

Vocational Rehabilitation (VR)

Vocational Rehabilitation (VR) assists individuals with disabilities to get and keep a job that matches their skills, interests and abilities. VR staff work in partnership with the community and businesses to develop employment opportunities for people with disabilities. VR services are individualized to help each eligible person to receive services that are essential to their employment success.

In the last few years, there have been several important program changes. The Workforce Innovation and Opportunity Act (WIOA) was passed by Congress in 2014 and regulations were completed July 2016. Among other things, it mandates provision of services to school-age youth, with joint responsibility between Local Education Agencies and VR. State Executive Order 15-01 instituted an Employment First policy to increase competitive integrated employment of people living with Intellectual and Developmental Disabilities (I/DD). The Lane v. Brown settlement set specific numeric targets for moving clients out of sheltered workshops and into competitive integrated employment, and also for providing services to transition age clients.

These changes are all fairly complex and interwoven, and have combined to have substantial impacts on the VR caseload. This recent period of rapid change started approximately in January of 2015 and changes are expected to continue through at least the next biennium.

Prior to the Spring 2016 forecast, only the total program caseload was officially forecast. Although counts for the Application, Eligibility, In Plan and Post Employment Services stages of VR were forecasted and shared internally, they were not published in the official forecast. Due to changes in the last year that have impacted how clients move through the program stages, the official forecast now includes the caseload for each stage of VR rather than just the total.

The most significant ongoing change is a large increase in the number of clients who are currently In Plan, receiving services. Policy and process changes have also resulted in larger numbers of clients applying for service each month, particularly from individuals with I/DD.

Since individuals with I/DD typically have more completed paperwork when they apply, they move through the Application and Eligibility stages faster. This has resulted in a substantial decrease in the average number of clients who have been determined eligible, but who are not yet In Plan each month. So while the number of clients In Plan has increased substantially, there are also fewer clients waiting at the Eligibility stage. Consequently, the total number of clients in VR has risen only modestly. This is a significant increase in clients receiving services that would be largely invisible to anyone looking only at the total number of people served by the VR program.

Risks and Assumptions

There is a risk that the program may have to enter order of selection in the 2017-19 beinnium. This could happen if the program has insufficient funds to provide services to all eligible clients. The program did receive some federal re-allotment dollars recently, but insufficient state funds in the 2017-19 budget could also trigger order of selection, changing caseloads dramatically.

There is also a risk that additional clients from the ‘woodwork effect’ of the settlement may drive application numbers above those forecast.

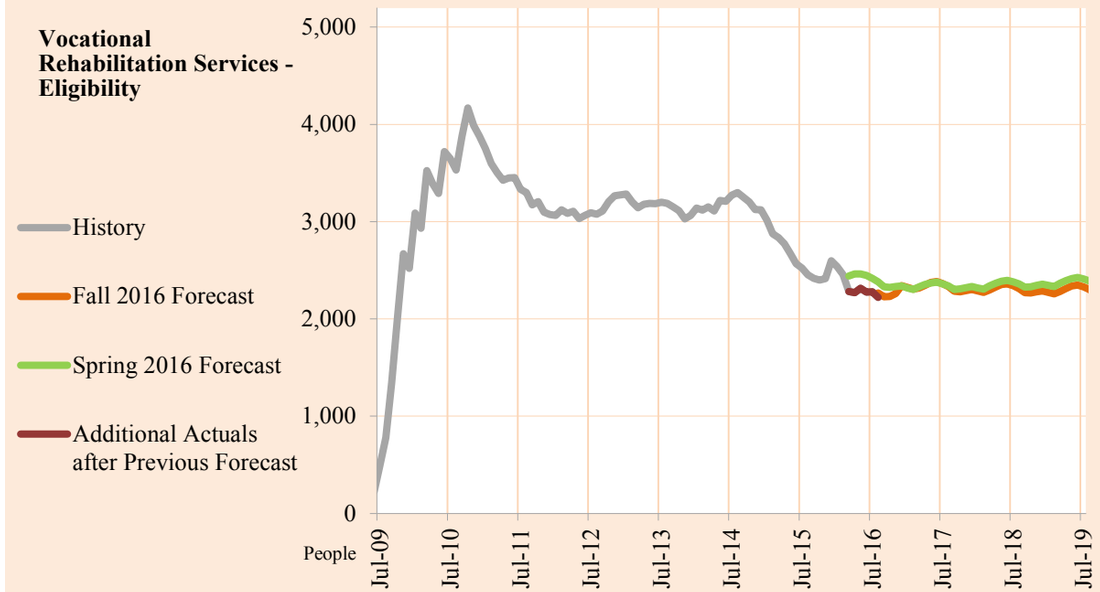
Pre-employment Transition Services started in October 2014. This is a new mandate of the Workforce Investment and Opportunity Act (W.I.O.A.) designed to help high school students with disabilities make the transition to employment or higher education. This mandate includes a 15 percent set aside of the Federal dollars each year, to be spent on specific core services. The five core services being;

- Job exploration counseling
- Work-based learning experiences
- Counseling on opportunities for enrollment in comprehensive transition or postsecondary educational programs at institutions of higher education
- Workplace readiness training to develop social skills and independent living
- Instruction in self-advocacy

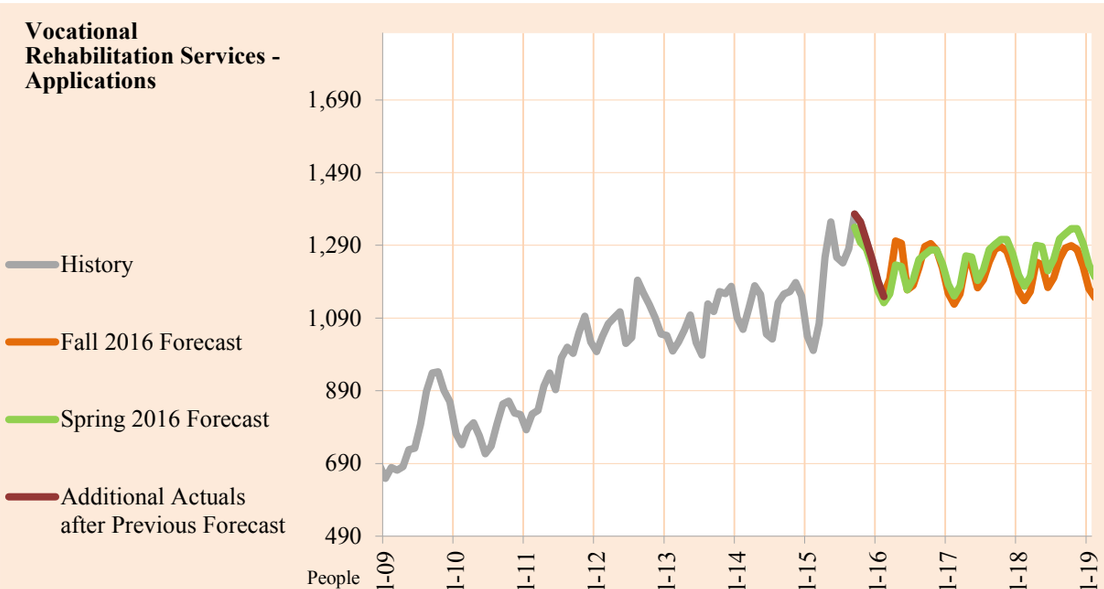
It is expected to have an impact on VR caseload, but as a new mandate, its full impacts are not yet known.

Vocational Rehabilitation Services

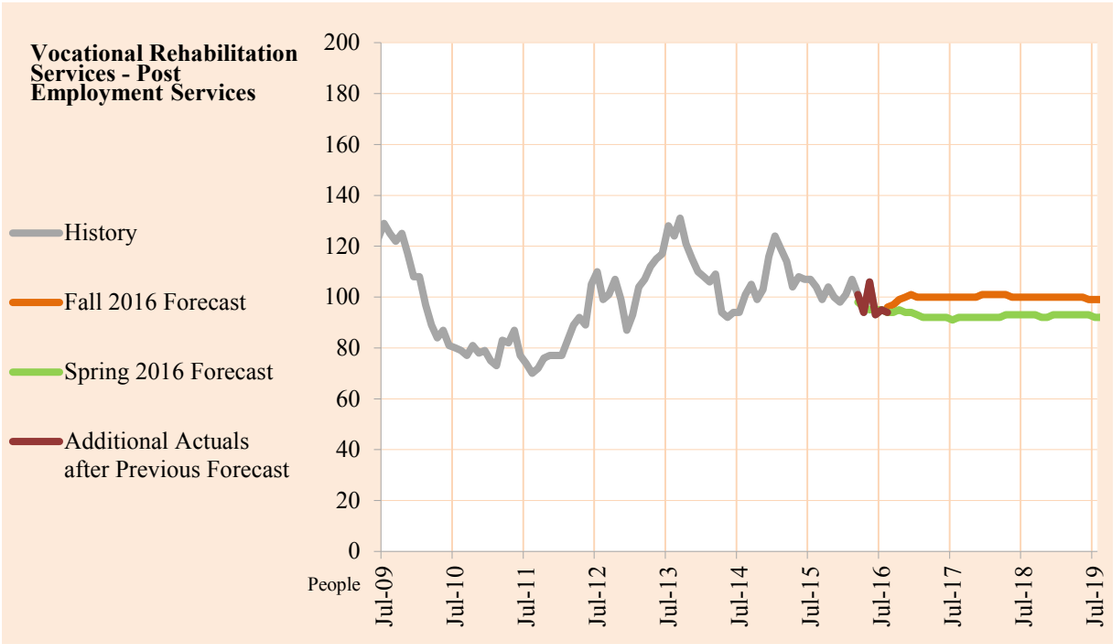
Vocational Rehabilitation Services - Eligibility



Vocational Rehabilitation Services - Applications



Vocational Rehabilitation Services - In Plan


Vocational Rehabilitation Services - Post Employment Services
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
People
200
180
160
140
120
100
80
60
40
20
0
Jul-09
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

Vocational Rehabilitation Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
VOCATIONAL REHABILITATION								
Application	1,224	1,238	14	1.1%	1,238	1,219	-19	-1.5%
Eligibility	2,407	2,359	-48	-2.0%	2,359	2,305	-54	-2.3%
In Plan	5,582	5,872	290	5.2%	5,872	6,650	778	13.2%
Post Employment Services	97	100	3	3.1%	100	100	0	0.0%
Total Vocational Rehabilitiation	**9,310**	**9,570**	**260**	**2.8%**	**9,570**	**10,275**	**705**	**7.4%**

Aging and People with Disabilities (APD)

Historically, Oregon's Long Term Care (LTC) services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. Starting in July 2013, Oregon began offering services through the Community First Choice Option under 1915 (k) of the Social Security Act (referred to as "K Plan"); and now most services are provided through the K Plan rather than the HCBS Waiver.

During the last 13 years, the total Long-Term Care (LTC) caseload has varied from a high of 31,500 clients in November 2002 to a low of 25,900 clients in May 2008; with slightly more than half of that decline occurring between November 2002 and June 2003 when the LTC eligibility rules were modified to cover only clients in Service Priority Levels 1 to 13. From 2008 to 2013 the caseload grew by an average of 2.5 percent a year, despite a serious recession, driven in part by a significant growth in the number of Oregon seniors. Between 2014 and 2015 the average annual caseload grew by 6.7 percent due to factors such as implementation of the K Plan, expansion of Medicaid, and policy changes to make in-home care more attractive. We will not know for some time how long this new trend will continue.

Total Long-Term Care (LTC) – A total of 33,815 clients received long-term care services in April 2016. The 2015-17 biennial average is projected to be 34,086 clients, which is slightly lower than the Spring 2016 Forecast. The 2017-19 forecast is 7.3 percent higher than the forecast for 2015-17.

The LTC forecast is divided into three major categories: In-Home, Community-Based Care (CBC), and Nursing Facilities. Most of the projected increase from 2015-17 to 2017-19 is in In-Home Care. In-Home Care continues to be a popular placement choice, particularly since 2013 when APD implemented several changes designed to make In-Home services comparatively more attractive to clients. CBC is still forecasted to grow, although at a reduced rate to reflect the anticipated shift toward In-Home Care. Community-Based Care will continue to be a stable placement choice for many LTC clients because this type of care is easier to set up and coordinate than In-Home Care and because hospitals prefer discharging patients to higher service settings in order to reduce the risk of repeat emergency visits or readmission. On the other hand, Medicaid reimbursement rates continue to lag behind private market rates, thus making Medicaid clients relatively less attractive to CBC providers.

In-Home Care – In April 2016, 17,779 clients received In-Home Care, which accounted for 52.6 percent of total LTC services. The 2015-17 biennial average forecast of 17,656 clients is slightly lower than the Spring 2016 forecast. The 2017-19 forecast is expected to be 11.3 percent higher than 2015-17, and by June 2019 In-Home Care is projected to be 55.4 percent of total LTC services.

Recent growth in the In-Home Care caseload is due to several factors including implementation of the K Plan, expansion of Medicaid, and implementation of policy and program changes intended to promote the use of In-Home Care rather than more expensive forms of service. For example, under the new rules, clients who want long-term care services are required to contribute to their own support by relinquishing to the State all income over $1,210 per month. Previously, the limit for how much a client could keep was $710 per month – an amount that was difficult to live on. Clients who may have been reluctant to relinquish some of their limited income, even in exchange for needed supports, might now find the program more attractive. In addition, the fact that options exist which allow family members, friends, or neighbors (natural supports) to be paid (under certain circumstances) for providing services may lead more individuals to request In-Home Care.

Community-Based Care (CBC) – In April 2016, 11,815 clients received Community-Based Care, which accounted for 34.9 percent of total LTC. The 2015-17 projected biennial average is 11,886 clients, which is slightly higher than the Spring 2016 forecast. The 2017-19 projection is 4.8 percent higher than 2015-17, and by June 2019 Community-Based Care is forecasted to be 33.7 percent of total LTC.

Community-Based Care includes several different types of services. Each caseload type is revised to more accurately reflect clients' recent, actual utilization of services. Consequently, Assisted Living and Residential Care have become a larger portion of the forecast, while Adult Foster Care (AFC) became smaller.

Several factors are contributing to the recent decline in AFC caseload: policy changes that make In-Home Care more attractive; providers' perception of inadequate reimbursement rates; increasing adversarial relationship between workers and providers; and declining capacity as individual providers retire.

Nursing Facility Care – In April 2016, 4,221 clients received Nursing Facility Care, which accounted for 12.5 percent of total LTC. The 2015-17 biennial average forecast is 4,241 clients, slightly higher than the Spring 2016 forecast. The 2017-19 projection is 2.8 percent lower than 2015-17, and by June 2019 Nursing Facility Care is forecasted to be 10.9 percent of Total LTC.

Affordable Care Act (ACA) Long-Term Care

Starting in January 2014, a new population of individuals became eligible for medical and long-term care services under the Affordable Care Act of 2010 (ACA). When discussed in the forecast, these clients will be referred to as "ACA LTC" clients. ACA LTC clients are, by definition, citizens aged 18-64 with income under 138 percent of FPL and who require the institutional Level of Care (LOC) of a hospital or skilled nursing facility. Under Oregon's CMS waiver, these clients may be served through any of the approved long-term care channels – nursing facilities, community-based care, or in-home.

These clients constitute a small sub set of the total LTC population, but their funding sources are significantly different. Consequently, OFRA is beginning to track these clients separately within the LTC population. Data allowing OFRA to know which individuals are ACA LTC has only recently become available. OFRA anticipates that when sufficient data is available, these clients will be forecast separately within the LTC caseload.

Risks and Assumptions

Patient Protection and Affordable Care Act of 2010 – Implementation of ACA changed the playing field for long-term care in Oregon and introduced significant new risks to the forecast. By shifting from operating under the HCBS Waiver to the K Plan in late 2013, the eligibility rules for long-term care were changed.

At roughly the same time, Oregon chose to extend Medicaid coverage (including long-term care) to a significantly larger pool of low income adults. To qualify for LTC under the prior HCBS Waiver, clients had to meet four separate criteria: 1) be assessed as needing the requisite Level of Care; 2) be over 65 years old or have an official determination of disability; 3) have income below 300 percent of SSI (roughly 225 percent of FPL); and 4) have very limited assets. However, under the ACA's K Plan option, clients only need to meet two criteria: 1) be assessed as needing requisite Level of Care, and 2) have income below 138 percent of FPL. Note that the HCBS Waiver allows clients with higher incomes than the K Plan; but the K Plan has no asset limits and no requirement that clients to be over 65 or officially determined disabled. Recent changes in the pattern of new clients entering long-term care indicates that the ACA (the combined effects of the K Plan and Medicaid expansion) is contributing to long-term care caseload growth. However, the new service use patterns have not yet emerged and normalized.

Policy and Program Changes – Another significant risk was created by policy and program changes implemented in 2013 which were designed to increase the attractiveness of In-Home Care relative to more expensive forms of care, and to delay or prevent individuals from even needing LTC assistance. While successful prevention measures should save money in the future, changes that make In-Home Care more attractive now could either reduce costs by leading clients to choose lower cost services, or increase costs by making accepting assistance more attractive.

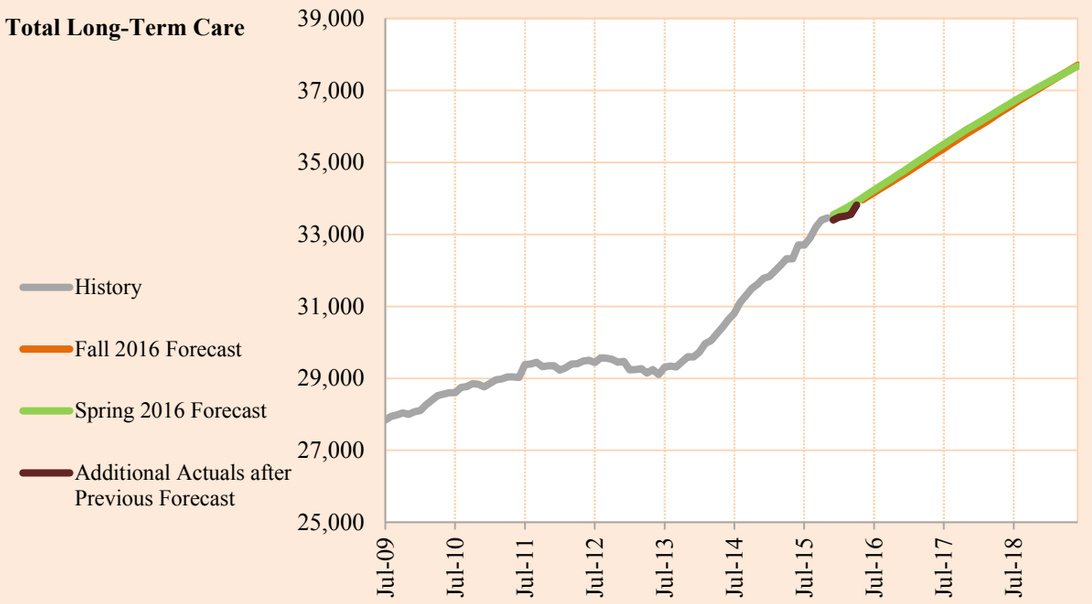
Oregon Demographic Shift – In addition to internal policy and program related changes, external changes such as demographic shifts in Oregon's population also

pose a risk to the forecast's accuracy over the longer term (for example, more seniors living longer, or the financial or physical health of those seniors). Oregon's population is aging, and elderly Oregonians are among the fastest growing segments of the state population. Oregonians with multiple chronic conditions in the 85 and older age group also risk depleting their resources, which will increase the likelihood they will become eligible for Long-Term Care programs.

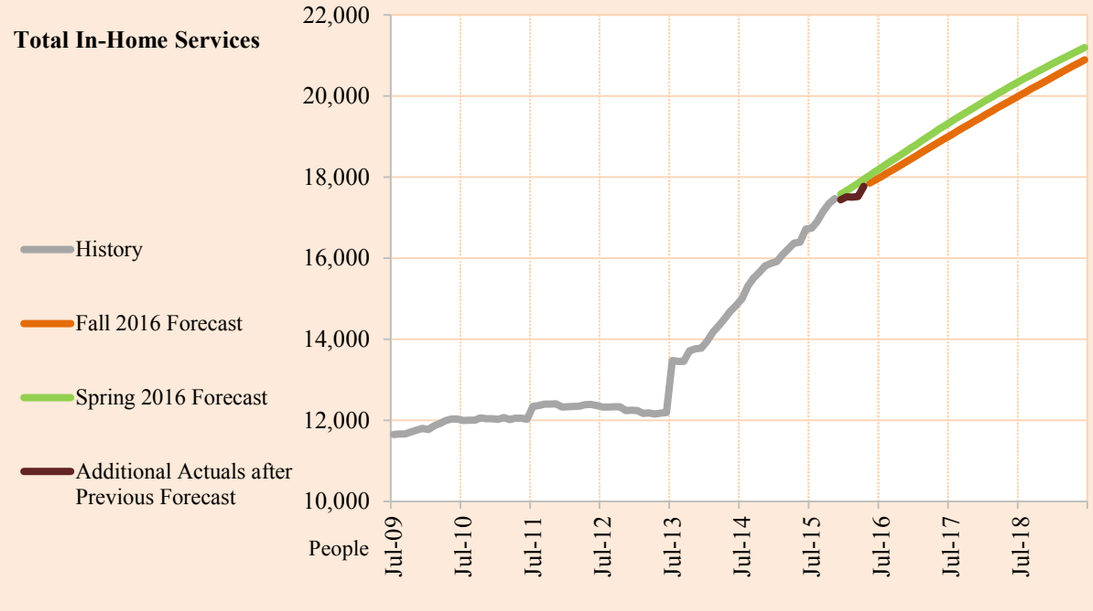
The long-term care caseload forecast has a shorter time horizon of two to three years, while the Demographic forecast has a longer time horizon of five to ten years. This presents a challenge to properly account for the impact of demographic shifts on the long-term care caseload. The OFRA (caseload forecast) is much more responsive to internal policy and program changes than the indirect and external effect of demographic shifts in a shorter time horizon. OFRA recognizes, however, the importance of indirect impacts of Oregon demographic changes, especially in elderly population, and regularly monitors it.

Oregon House Bill 2216 - Another factor that may impact LTC caseloads is Oregon HB 2216, passed in 2013, which calls for a statewide reduction in the Long-Term Care Nursing Facilities bed capacity.

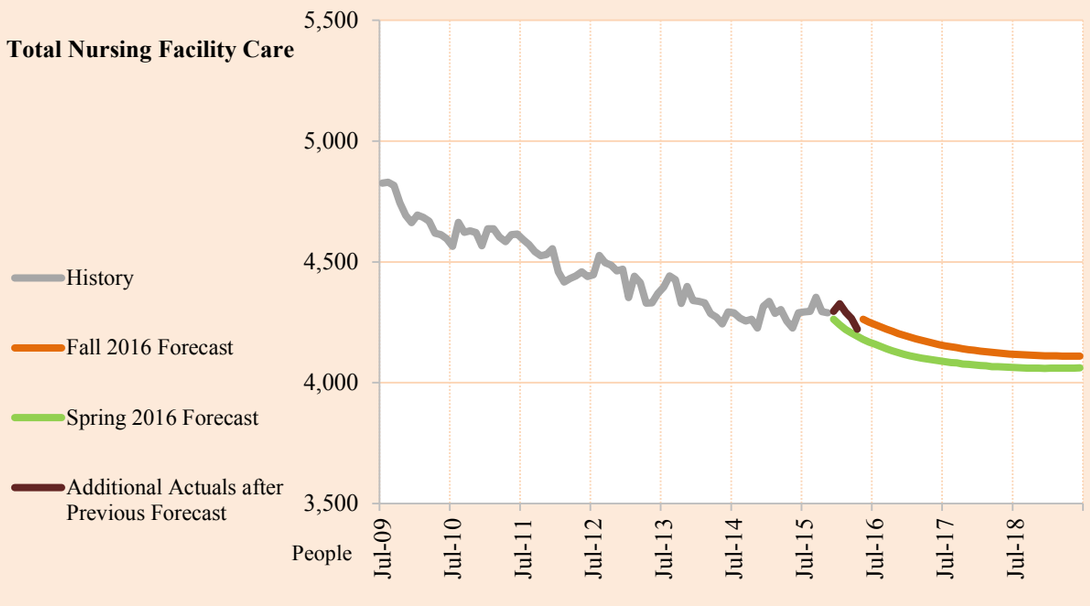
Total Long-Term Care



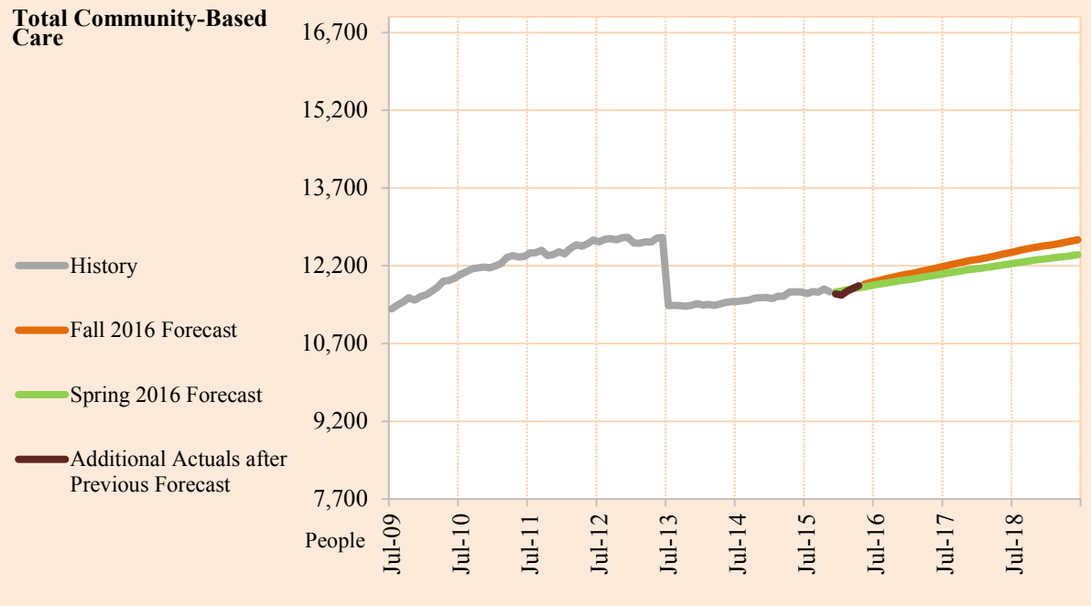
Total In-Home Services



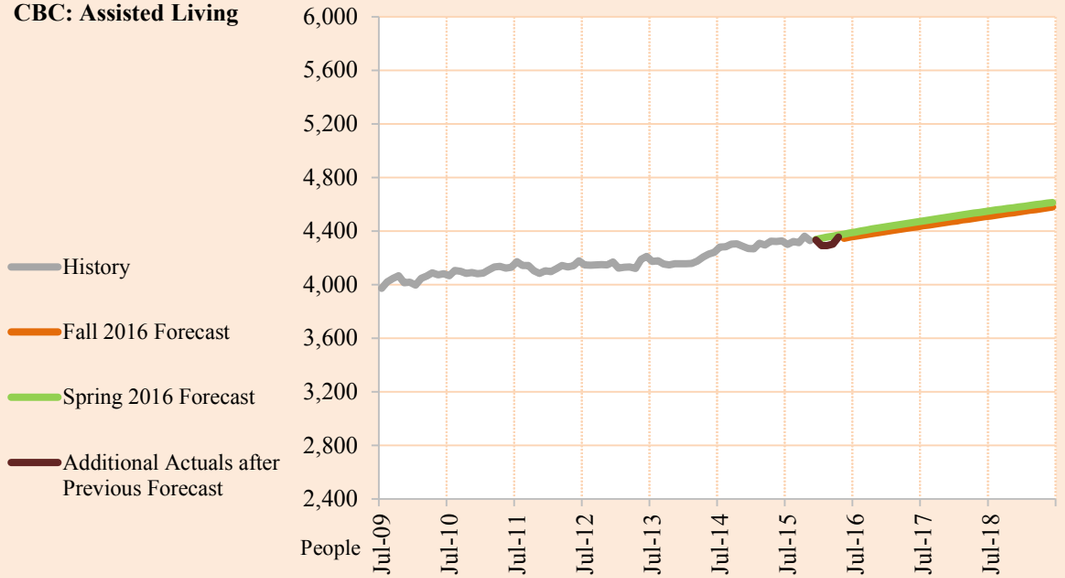
Total Nursing Facility Care



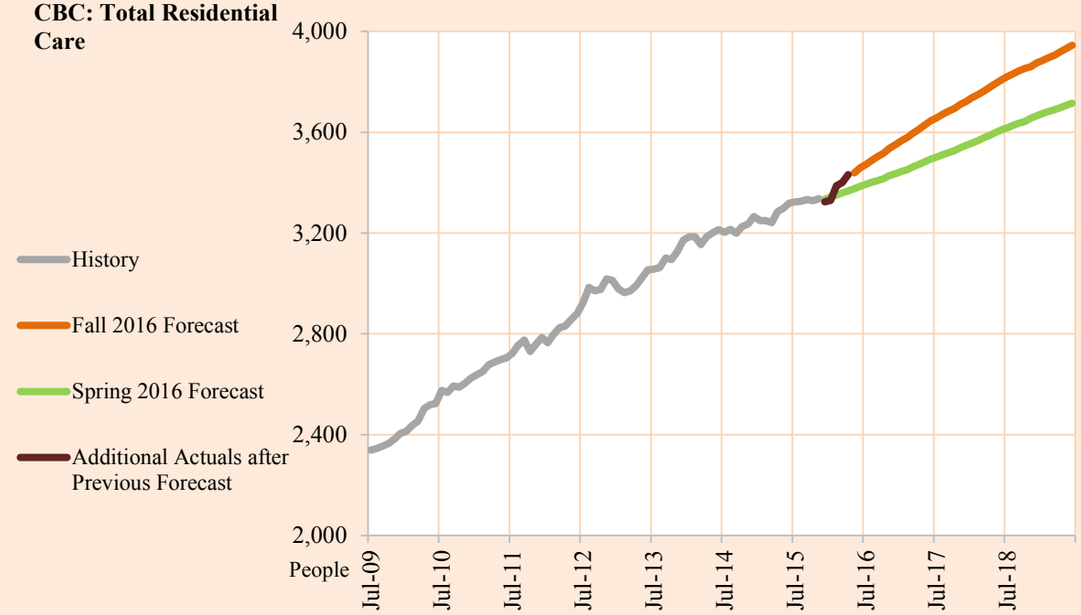
Total Community-Based Care



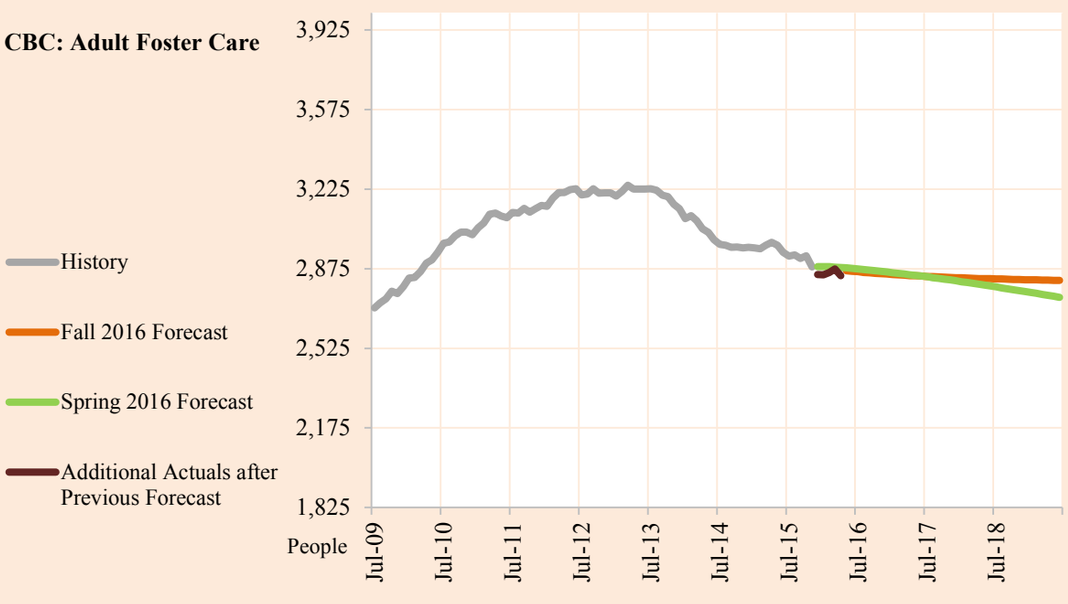
CBC: Assisted Living



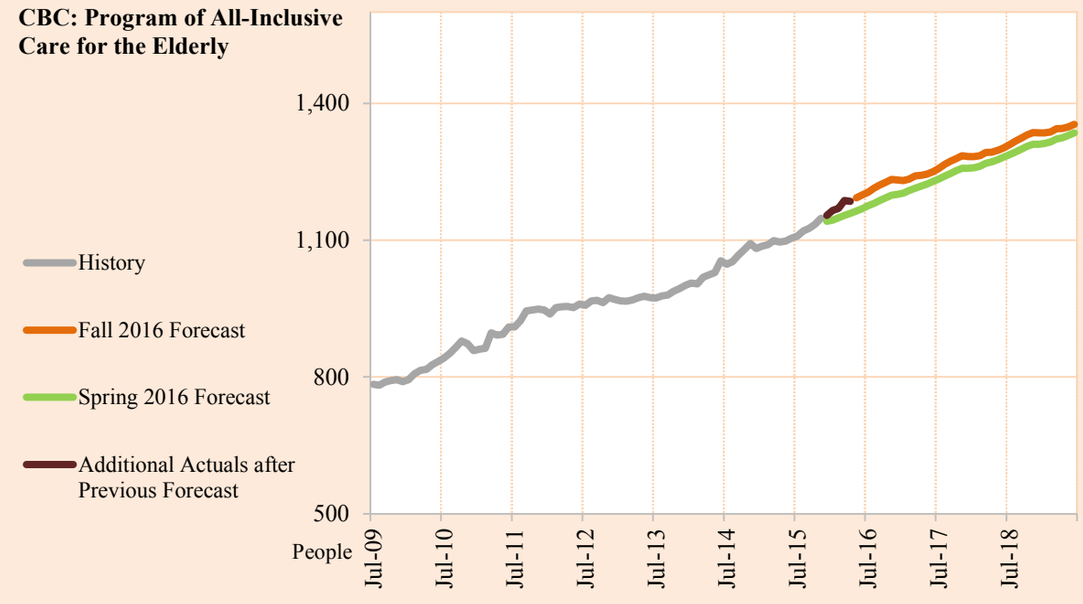
CBC: Total Residential Care



CBC: Adult Foster Care



CBC: Program of All-Inclusive Care for the Elderly



Aging and People with Disabilities Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
AGING AND PEOPLE WITH DISABILITIES								
In-Home Hourly without SPPC	12,360	12,775	415	3.4%	12,775	14,672	1,897	14.8%
In-Home Agency without SPPC	1,826	1,879	53	2.9%	1,879	2,131	252	13.4%
In-Home Live-In	1,474	922	-552	-37.4%	922	500	-422	-45.8%
In-Home Spousal Pay	103	67	-36	-35.0%	67	66	-1	-1.5%
Independent Choices	459	458	-1	-0.2%	458	587	129	28.2%
Specialized Living	199	198	-1	-0.5%	198	200	2	1.0%
In-Home K Plan Subtotal	**16,421**	**16,299**	**-122**	**-0.7%**	**16,299**	**18,156**	**1,857**	**11.4%**
In-Home Hourly with State Plan Personal Care	1,400	1,323	-77	-5.5%	1,323	1,451	128	9.7%
In-Home Agency with State Plan Personal Care	334	337	3	0.9%	337	375	38	11.3%
In-Home non-K Plan Subtotal	**1,734**	**1,660**	**-74**	**-4.3%**	**1,660**	**1,826**	**166**	**10.0%**
Total In-Home	**18,155**	**17,959**	**-196**	**-1.1%**	**17,959**	**19,982**	**2,023**	**11.3%**
Adult Foster Care	2,878	2,868	-10	-0.3%	2,868	2,831	-37	-1.3%
Assisted Living	4,389	4,361	-28	-0.6%	4,361	4,510	149	3.4%
Contract Residential Care	2,308	2,406	98	4.2%	2,406	2,727	321	13.3%
Regular Residential Care	1,086	1,057	-29	-2.7%	1,057	1,079	22	2.1%
Program of All-Inclusive Care for the Elderly (PACE)	1,173	1,194	21	1.8%	1,194	1,309	115	9.6%
Community-Based Care Subtotal	**11,834**	**11,886**	**52**	**0.4%**	**11,886**	**12,456**	**570**	**4.8%**
Basic Nursing Facility Care	3,556	3,571	15	0.4%	3,571	3,459	-112	-3.1%
Complex Medical Add-On	528	575	47	8.9%	575	569	-6	-1.0%
Enhanced Care	55	54	0	0.0%	54	55	1	1.9%
Pediatric Care	45	41	0	0.0%	41	40	-1	-2.4%
Nursing Facilities Subtotal	**4,184**	**4,241**	**57**	**1.4%**	**4,241**	**4,123**	**-118**	**-2.8%**
Total Long-Term Care	**34,173**	**34,086**	**-87**	**-0.3%**	**34,086**	**36,561**	**2,475**	**7.3%**

Intellectual and Developmental Disabilities (I/DD)

Historically, Oregon provided I/DD services under a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver. However, starting in July 2013 Oregon began offering services through the Community First Choice Option in 1915 (k) of the Social Security Act (referred to as the K Plan), and now most I/DD services are delivered under the K Plan. Implementation of K Plan required adjustments to program policies related to both eligibility and program delivery. As a result, more individuals with I/DD have chosen to enroll in Case Management and to request services.

Case Management Enrollment

This is an entry-level eligibility, evaluation, and coordination service available to all individuals determined to have intellectual and developmental disabilities, regardless of income level. In 2013-15 Case Management Enrollment averaged 22,459 and is projected to increase to 25,309 or by 12.7 percent in 2015-17. In 2017-19 Case Management biennial average caseload is projected to increase to 28,218 or by 11.5 percent. Enrollment is projected to grow rapidly until most I/DD individuals have enrolled. Research is underway to determine what might be the "natural limit," where caseload would plateau. Oregon's Office of Developmental Disabilities Services (ODDS) has contracted with Human Services Research Institute (HSRI) to estimate the youth and adult populations likely to seek I/DD services in Oregon through 2019. HSRI estimated demand for I/DD services by applying national prevalence estimates to Oregon's youth and adult populations.

The remaining caseload categories are divided into adult services, children services, and other services.

Adult Services

Brokerage Enrollment (BE) – Under K Plan, services must be provided to all eligible I/DD clients who wish to be served. In Oregon, adults with I/DD can obtain services through either of two channels: Brokerages or the Community Developmental Disability Programs (CDDPs). Brokerage demand was expected to grow at the historical rate until reaching the contractual limit of 7,805 brokerage slots – with subsequent growth diverted to the county CDDPs (where most clients would be served in Comprehensive In-Home Services (CIHS)). In reality, Brokerage Enrollment has remained under capacity, while CDDPs have been struggling to keep up with demand. The 2015-17 biennial average forecast for Brokerage Enrollment is 7,659, slightly lower from the Spring 2016 forecast. The forecast for 2017-19 is 7,769, or 1.4 percent higher than 2015-17.

Comprehensive In-Home Services (CIHS) – Due to the K Plan requirement that all eligible clients be served, and the fact that Brokerage capacity is limited, CIHS caseload has grown dramatically since July 2014. While a significant rise was anticipated, the exact timing and magnitude has been difficult to project. CIHS caseload was 312 in mid-2013, 371 in mid-2014, and 1,084 in mid-2015. CIHS is forecast to grow dramatically in both 2015-17 and 2017-19, reaching 1,931 by mid-2017 and 2,482 by mid-2019. The 2015-17 biennial average forecast is 1,569 clients, and the 2017-19 biennial average forecast is 2,229 clients.

24-Hour Residential Care – The 2015-17 biennial average forecast is 2,804, slightly higher than the Spring 2016 forecast. The 2017-19 forecast for is 2,883, which represents a 2.8 percent increase over 2015-17.

Supported Living – The 2015-17 biennial average forecast is 700, which is 2.1 percent lower than the Fall 2015 forecast. The 2017-19 forecast is the same as 2015-17.

I/DD Foster Care – I/DD Foster Care serves both adults and children, with children representing approximately 15 percent of the caseload. The 2015-17 biennial average forecast is 3,169 clients, slightly higher from the Spring 2016 forecast. The 2017-19 forecast is 3,267, which represents a 3.1 percent increase over 2015-17.

Stabilization and Crisis Unit – The Stabilization and Crisis Unit serves both adults and children, with children representing approximately 10.1 percent of the caseload. This caseload is limited by bed capacity and is expected to remain at the current level of 99 for both 2015-17 and 2017-19.

Children Services

In-Home Support for Children (IHSC) – This caseload started growing rapidly in late 2013 as K Plan was implemented. While a rapid and significant rise was anticipated, the exact timing and magnitude has been difficult to project. The caseload was 187 clients in mid-2013; 872 clients in mid-2014; and 2,008 in mid-2015. In-Home Support for Children is forecasted to grow dramatically in both 2015-17 and 2017-19, reaching 3,193 by mid-2017 and 3,681 by mid-2019. The 2015-17 biennial average forecast is 2,696 clients, and the 2017-19 biennial average forecast is 3,484 clients.

Growth in this caseload is primarily due to implementation of the Community First Choice Option (K Plan), which allows individuals eligible for the Oregon Health Plan to receive In-Home services if they have an extended need for assistance with Activities of Daily Living. In addition, the income criteria used for children no longer considers family resources. The forecasted growth for this caseload incorporates assumptions about the historical pattern for children entering Case Management and the percentage of children enrolled in Case Management who will apply for services. However, the K Plan is a significant change and our assumptions may not be correct. For this and other reasons, this caseload was especially complex to forecast and the risk of error is high. For additional information, see the "Risks and Assumptions" section below.

Children Intensive In-Home Services (CIIHS) – This caseload includes Medically Fragile Children Services, Intensive Behavior Programs, and Medically Involved Program. This caseload is limited by capacity and is expected to remain at the level of 412 for both 2015-17 and in 2017-19.

Other Services

Employment and Day Support Services – In order to better reflect recent I/DD program changes, the definition of employment services has been revised. The new definition is broader, including all of the services previously counted as well as new services offered under Employment First and Plan of Care.

Based on the old definition (called Employment and Attendant Care Services), caseload averaged 4,166 in 2013-15. The new, more inclusive definition (renamed Employment and Day Support Services) is different enough that comparison to prior forecasts would be misleading.

This forecast projects moderate growth from 2015-17 to 2017-19, reflecting stabilization of the changes being implemented, including an increased focus on early job preparation for qualifying high school students. It is anticipated that these students will graduate from high school with their employment training and/or employment already in place. Using the new caseload definition, the 2015-17 biennial average is 6,304 and the 2017-19 biennial average is 6,425, which represents a 1.9 percent increase over 2015-17.

Transportation – Historically, this caseload included only services paid with state funds, not those using local match funding. In order to provide a more complete picture, the definition of services counted in the Transportation caseload has been expanded to include all of the services previously counted, plus transportation services provided under Plan of Care (e.g. transit passes and non-medical community transportation).

Using the old definition, the 2013-15 Transportation caseload averaged 1,818. The new, more inclusive definition is different enough that comparison to prior forecasts would be misleading.

This forecast projects moderate growth from 2015-17 to 2017-19, reflecting stabilization of the changes being implemented by I/DD employment services biennial average is 6,433, which represents a 3.3 percent increase over 2015-17.

Risks and Assumptions

There are a variety of additional factors that create risks for all I/DD caseload forecasts.

Although the K Plan started in July 2013, initial work began slowly at first and work accelerated in 2014 with most CDDPs experiencing higher caseloads and more requests for services than previous to July 2013. The increase in requests for services and higher caseloads caused some delays in access to service. Many of the CDDPs have recently hired new staff as a result of funding based on the workload model. With additional staff added, this may result in quicker entry of new individuals with I/DD. All of these practical operational changes mean that new service use patterns are not yet stable and may continue to fluctuate for some time. In addition, the estimate may be low if many families who have children with I/DD had never chosen to enroll their children in Case Management.

The increase in people requesting I/DD services has created capacity challenges for CDDPs and their provider networks. To receive funded services, enrollees' Medicaid eligibility must be established, a level of care and assessment completed as well as an Individual Support Plan developed.

The caseloads most directly impacted by K Plan implementation are those where the individual lives in their own home or with family members; specifically Comprehensive In-Home Services (for adults) and the In-Home Support for Children.

Comprehensive In-Home Services – Adults can be served through two channels – Brokerages or CDDPs. However, since the brokerages are near capacity, most caseload growth is occurring in the CDDP service known as Comprehensive In-Home Services. Growth in adult caseloads generally comes from children who age into adult services, or previously unserved adults who are newly interested. Since this caseload is growing rapidly and without precedent, the forecast is highly sensitive to the assumptions used to produce it, and the risk of error is higher than usual.

Furthermore, it should be noted that since Brokerage capacity is contractually constrained, contracting changes (e.g., increasing the number of contracted slots, or shifting unutilized seats to brokerages with waiting lists) could shift this growth from Comprehensive In-Home Services back to Brokerage Enrollment.

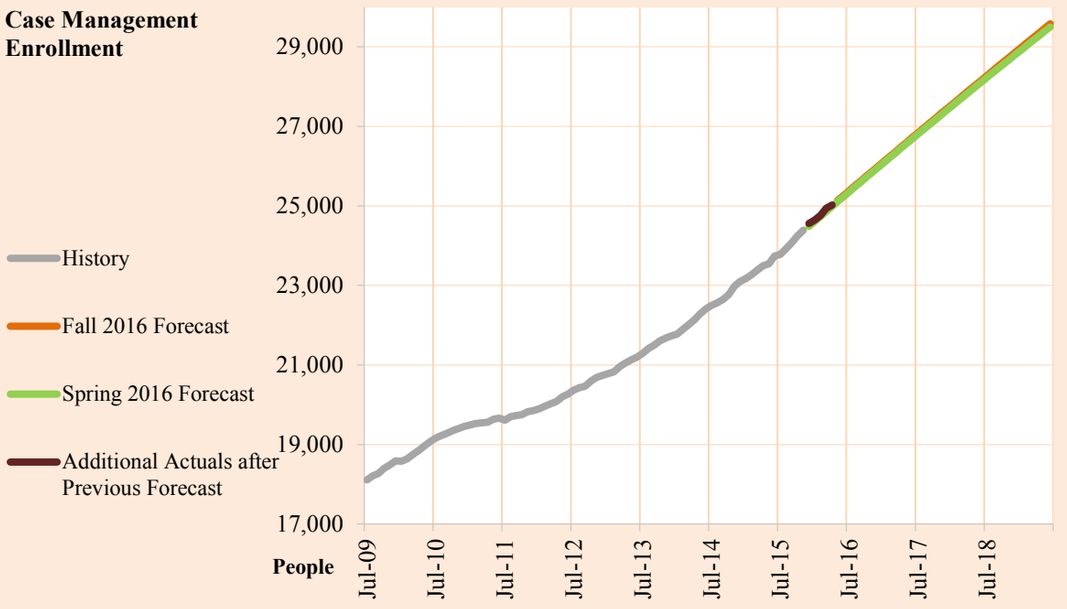
In-Home Support for Children – the K Plan implementation expanded the availability of services for many children. Prior to the implementation of the K Plan children were only able to receive limited in-home services and could only access additional services if they met crisis criteria. A child may now access significant in-home support without meeting crisis criteria if they are eligible for I/DD services and Medicaid. As a result, a significantly larger number of children may now access in-home services. Also, under Oregon's comprehensive waiver, additional children are now eligible for Medicaid services based solely on having a disability (meeting SSI standards), while not accounting for family financial resources. This may also increase the number of children who are able to access in-home services through the K Plan.

Summary of the key assumptions and steps used to project the In-Home Support for Children caseload

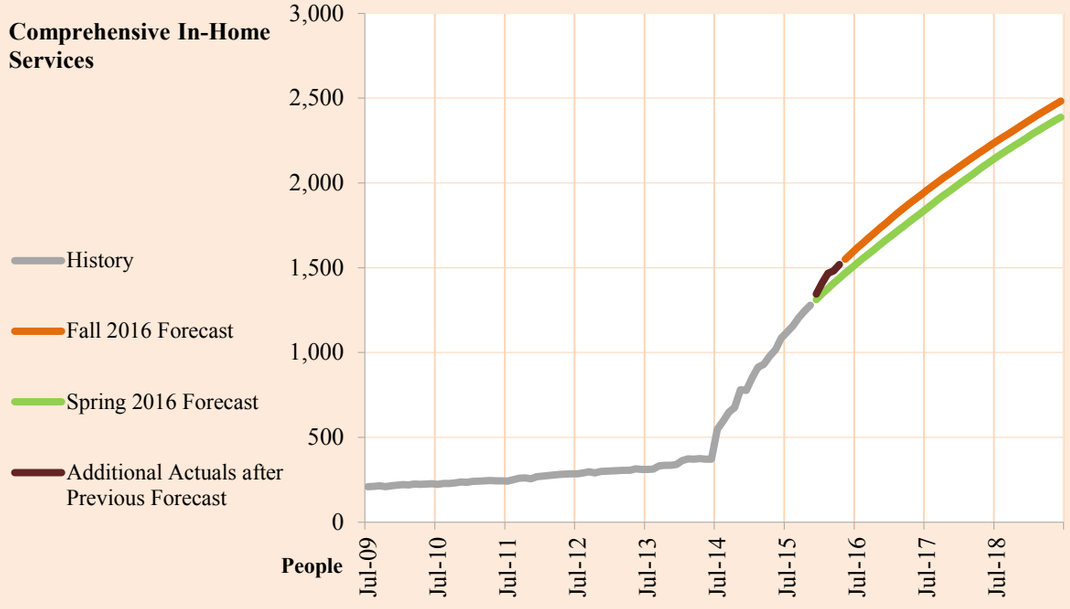
- Case Management enrollees under 18 years of age and not receiving additional I/DD services were used as the basis for estimating new entrants to this caseload.
- Next, the growth projected for Case Management was applied to this caseload as well.
- Then the percentage of children in Case Management and not receiving additional services was gradually reduced from 44 percent to 20 percent over four years.

These assumptions were discussed and debated by the I/DD Caseload Forecast Advisory Committee; then the forecaster made final changes based on personal judgment.

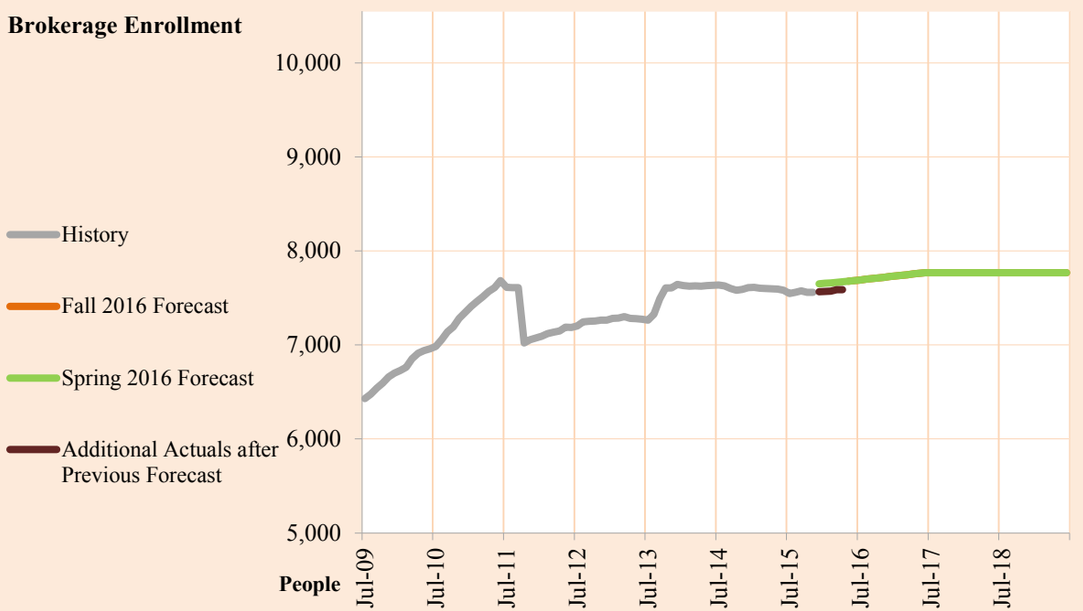
Case Management Enrollment



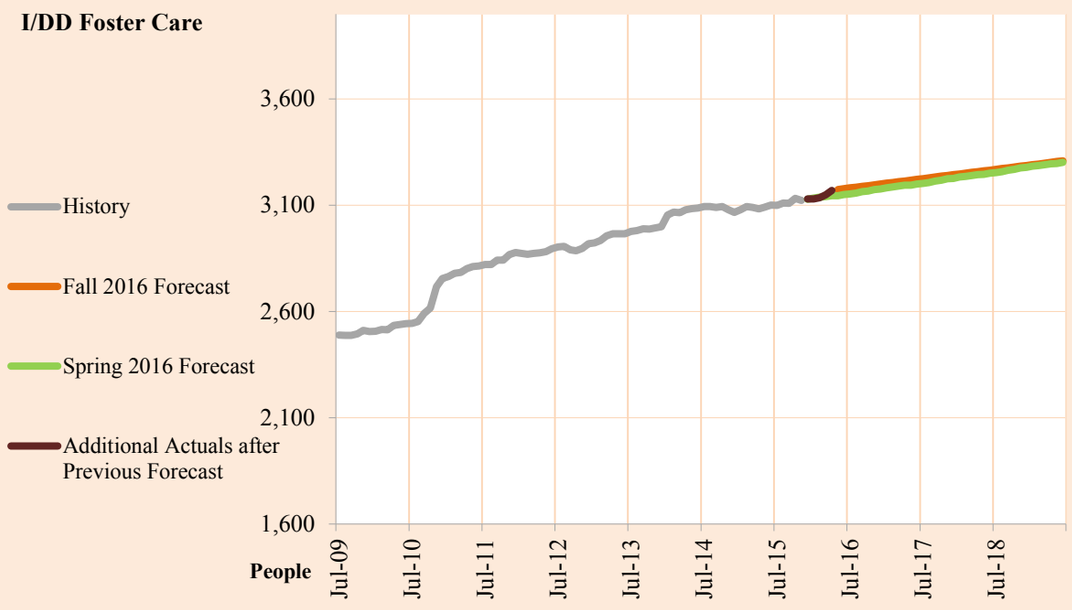
Comprehensive In-Home Services



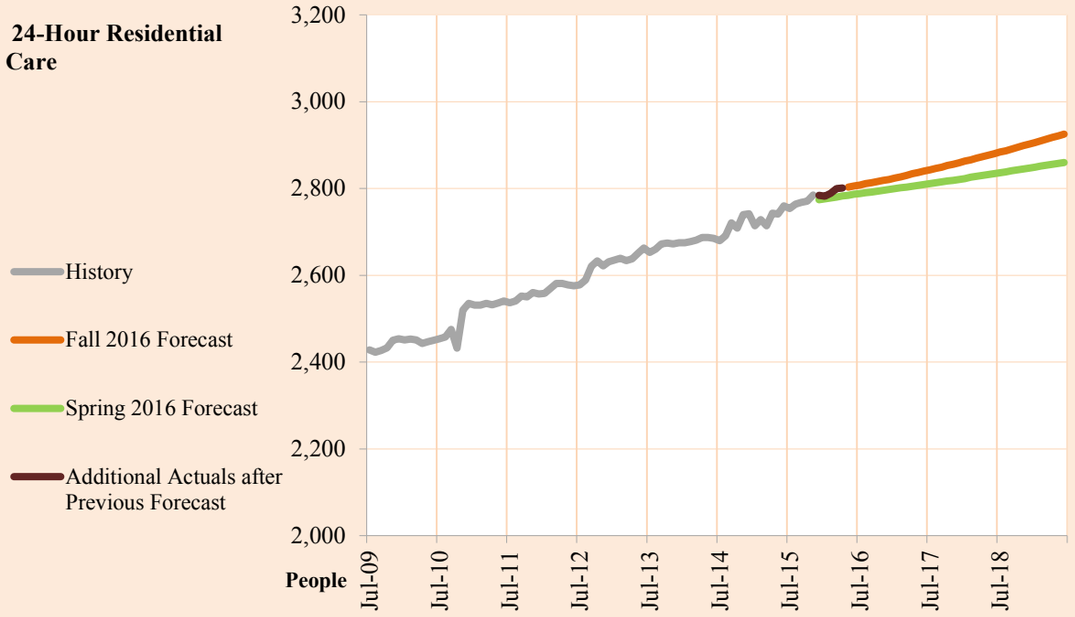
Brokerage Enrollment



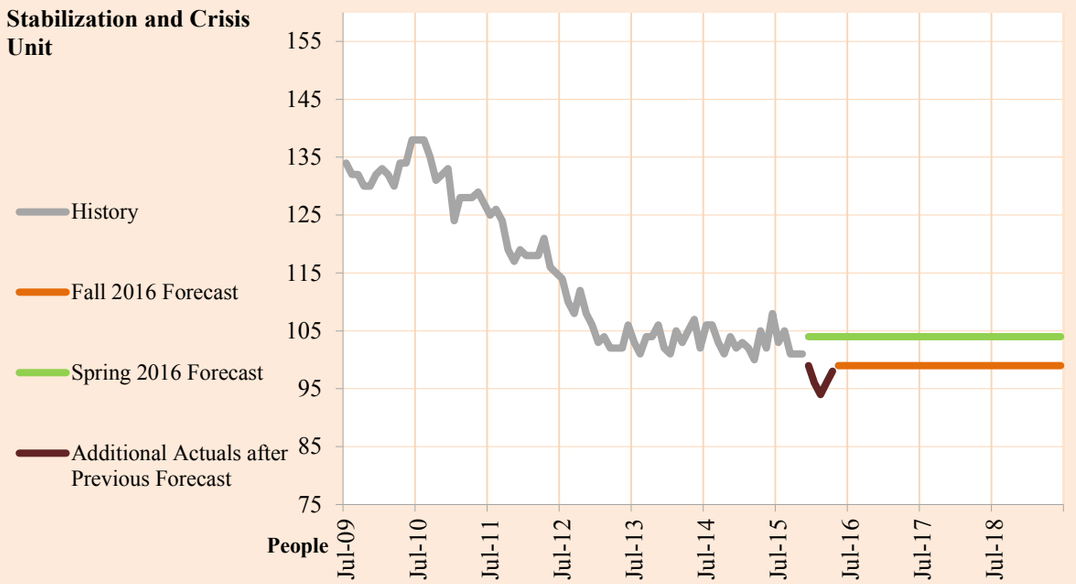
I/DD Foster Care



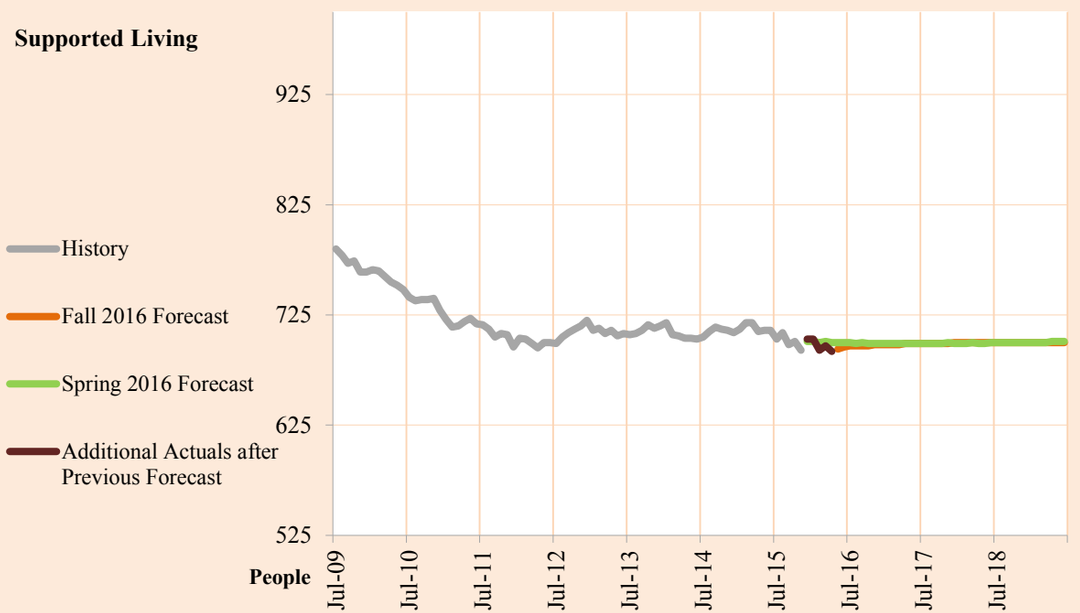
24-Hour Residential Care



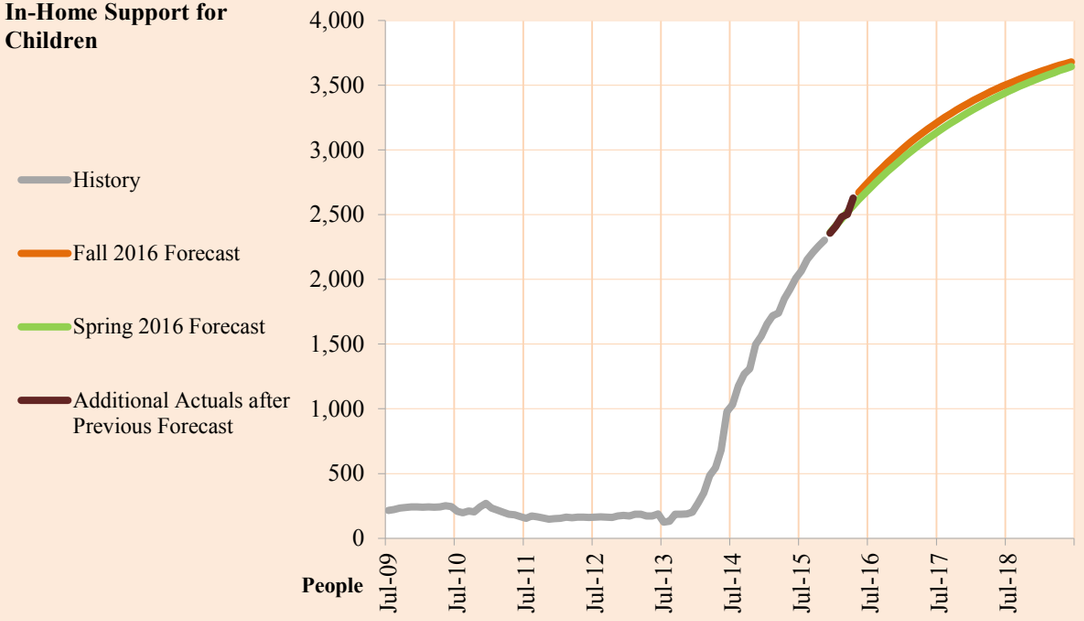
Stabilization and Crisis Unit



Supported Living

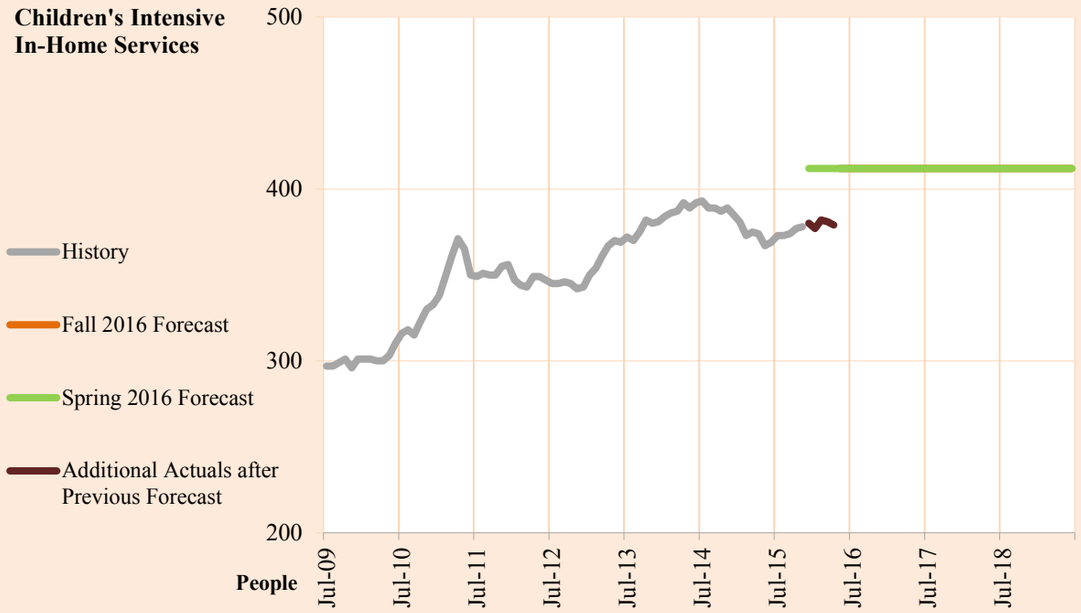


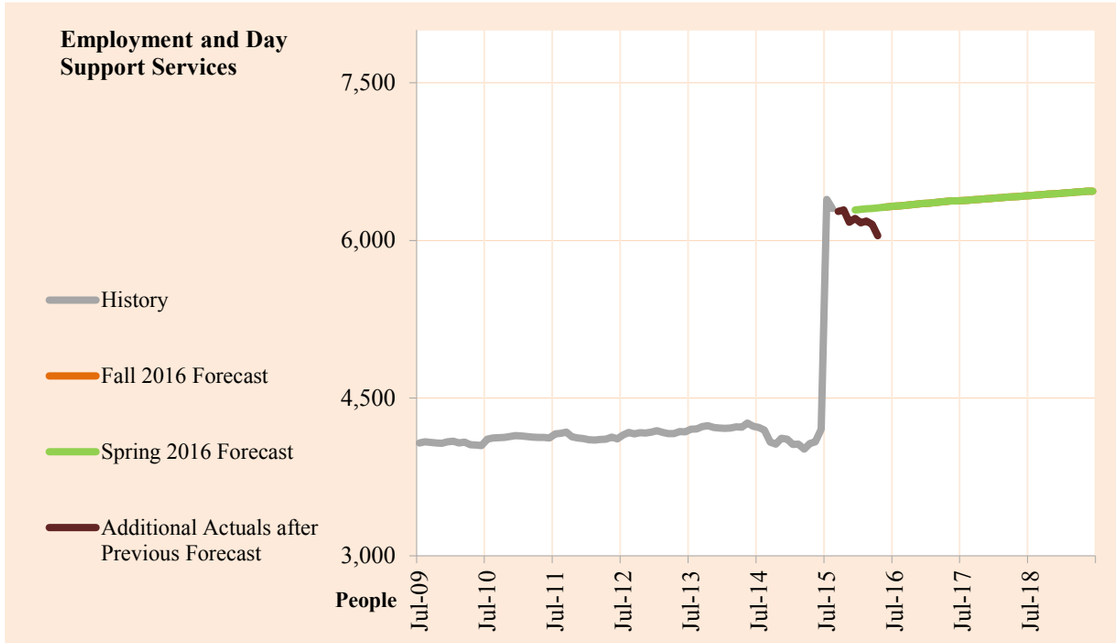
In-Home Support for Children



Children's Residential Care

Children's Intensive In-Home Services




Employment and Day Support Services
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6,000
4,500
3,000
People
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
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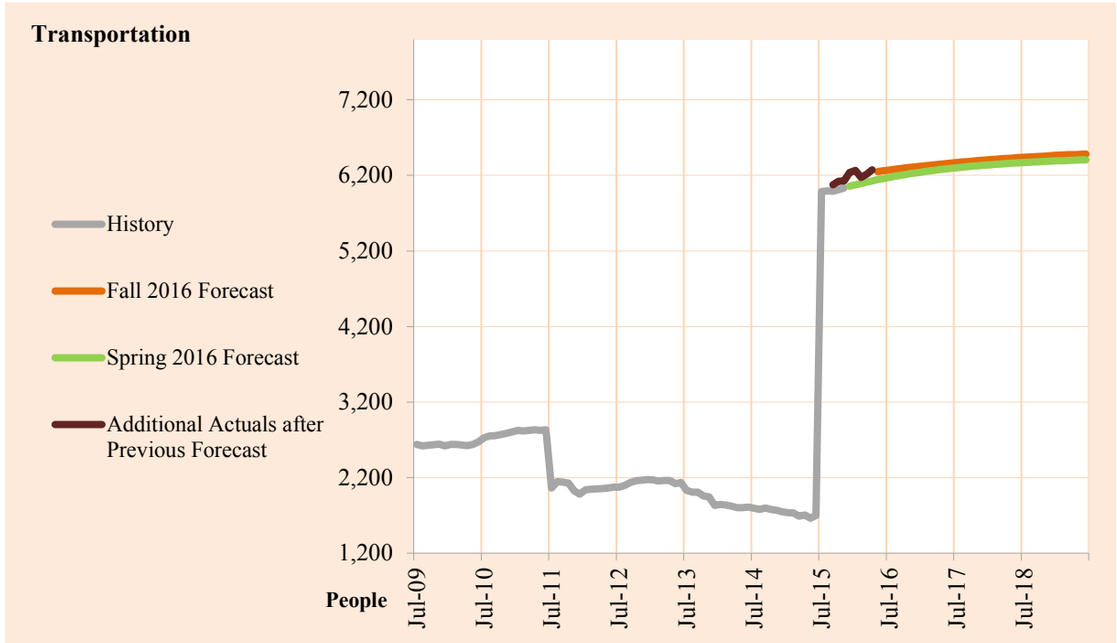
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18


Transportation
7,200
6,200
5,200
4,200
3,200
2,200
1,200
People
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
Jul-09
Jul-10
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18

Intellectual and Developmental Disabilities Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES								
Total Case Management Enrollment [1]	**25,281**	**25,309**	**28**	**0.1%**	**25,309**	**28,218**	**2,909**	**11.5%**
Adult								
Brokerage Enrollment	7,676	7,659	-17	-0.2%	7,659	7,769	110	1.4%
Comprehensive In-Home Services [2]	1,499	1,569	70	4.7%	1,569	2,229	660	42.1%
I/DD Foster Care [3]	3,154	3,169	15	0.5%	3,169	3,267	98	3.1%
24 hrs Residential Care	2,787	2,804	0	0.6%	2,804	2,883	79	2.8%
Supported Living	700	698	-2	-0.3%	698	700	2	0.3%
Stabilization and Crisis Unit [3]	104	99	0	-4.8%	99	99	0	0.0%
Children								
In-Home Support for Children [2]	2,654	2,696	42	1.6%	2,696	3,484	788	29.2%
Children Intensive In-Home Services	404	398	-6	-1.5%	398	412	14	3.5%
Children Residential Care	163	162	-1	-0.6%	162	166	4	2.5%
Total I/DD Services	**19,141**	**19,254**	**113**	**0.6%**	**19,254**	**21,009**	**1,755**	**9.1%**
Other I/DD Services								
Employment & Day Support Activities	6,302	6,304	2	0.0%	6,304	6,425	121	1.9%
Transportation	6,151	6,230	79	1.3%	6,230	6,433	203	3.3%

1. Some clients enrolled in Case Management do not receive any additional I/DD services.
2. Caseloads for both Comprehensive In-Home Services and In-Home Support for Children are rising significantly due to implementation of K Plan.
3. Foster Care and the Stabilization and Crisis Unit serve both adults and children: (I/DD FC - 83% / 17%; SACU - 89% / 11% respectively).

Oregon Health Authority

Total Oregon Health Authority Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 2016 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Medical Assistance								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	4.2%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	0.6%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	1.1%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	6.5%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance Total	73,016	73,765	749	1.0%	73,765	74,384	619	0.8%
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Mental Health [1]								
Under Commitment								
Total Forensic Care	828	859	31	3.7%	859	861	2	0.2%
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	45,425	45,645	220	0.5%	45,645	47,523	1,878	4.1%

1. Numbers reported represent adults only.

Health Systems Medicaid (HSM)

Since 2008, the primary drivers of the Medicaid caseload growth were:

- The most recent recession (December 2007 through an official ending date of June 2009).
- Implementation of the Oregon Healthy Kids Initiative in July 2009.
- Implementation of Patient Protection and Affordable Care Act (ACA) in January of 2014.

Taken together these three factors drove the total Medicaid caseload from approximately 408,000 clients prior to the recession to about 1,009,000 clients in January 2014, for a net increase of 601,000 clients or 147 percent. As of April 2016, the Medicaid caseload was 1,162,147 and the preliminary estimate for July 2016 is 1,117,367. For the past few years, the average caseloads were higher due to some delays in planned redeterminations, but since the redetermination work resumed in February 2016 the caseloads have been consistently declining. In general, the caseloads will continue to decline thru the forecast horizon as long as the economy remains in the current state and there are no further delays in the planned redeterminations.

ACA Adults – Since the redeterminations resumed in March 2016, the ACA Adult caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 410,731 clients on this caseload, down by roughly 38,000 compared to March 2016 count of 448,823. The caseload is expected to drop to 367,582 by the end of 2015-17 biennium and will account for about 36.9 percent of the total OHP caseload. The caseload is expected to continue declining at a slower pace through 2017-19 biennium as well.

Parent/Caretaker Relative – Although the improving economy puts downward pressure on this caseload, the inflow from ACA Adults, as a result of redeterminations, caused the caseload to grow. The most recent preliminary estimate for July 2016 shows 74,689 clients on this caseload, up by 6,604 compared to March 2016 count of 68,085. However, the current forecast does not project inflow to continue at that pace. The caseload is expected to drop to 70,608 by the end of 2015-17 biennium and will account for about 7.1 percent of the total OHP caseload. Similar to the previous caseload, this caseload is also expected to continue declining through 2017-19 biennium.

Pregnant Women – As of April 2016 there were 17,786 women on this caseload. The caseload has been declining steadily in the past few months as redeterminations were resumed. The caseload is expected to drop to 13,912 by the end of 2015-17 biennium and will account for 1.4 percent of the total OHP Plus caseload.

Children's Medicaid – Since redeterminations resumed in March 2016, this caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 337,543 clients on this caseload, down by 23,731 compared to March 2016 count of 361,274. The forecast predicts a small period of growth for this caseload this winter, when fewer redeterminations are planned and higher inflow of new clients is expected due to open enrollment. Overall, the caseload is expected to stay flat for the forecast horizon. By the end of 2015-17 biennium there will be 337,796 clients on this caseload and it will account for about 33.9 percent of the total OHP caseload.

Children's Health Insurance Program (CHIP) – As of April 2016 there were 63,280 children on this caseload. The caseload has been declining steadily in the past few months as redeterminations were resumed. The caseload is expected to drop to 58,892 by the end of 2015-17 biennium and will account for 5.9 percent of the total OHP Plus caseload.

Foster, Substitute Care & Adoption Assistance – As of April 2016 there were 19,576 children on this caseload. This caseload is growing and will continue to grow slowly through the forecast horizon. By the end of 2015-17 biennium there will be 20,004 clients on this caseload and it will account for 2.0 percent of the total OHP caseload.

Aid to the Blind and Disabled (ABAD) – As of April 2016 there were 81,387 clients on this caseload. Historically this caseload grew steadily. The ACA reform had a profound impact on this caseload. First, the availability of health insurance to low income adults (ACA Adults caseload) and, second, the availability of K-Plan (access to long term care without having to obtain a federal designation of disability) negatively impacted the demand for this caseload. Despite the declining trend immediately following the ACA implementation, there was always a consensus among the experts that the caseload will start growing again although at a more moderate growth rate. The most recent data proves that point. The caseload is expected to grow to 83,213 by the end of 2015-17 biennium and will account for 8.3 percent of the total OHP Plus caseload.

Old Age Assistance (OAA) – There were 41,768 clients on this caseload as of April 2016. The caseload is projected to grow steadily through the foreseeable future. This caseload is driven by population dynamics as well as economic conditions. Oregon's elderly population is projected to increase by roughly 4 percent per year. The caseload is expected to be 44,618 by the end of 2015-17 biennium and will account for 4.5 percent of the total OHP Plus caseload.

Other Medical Assistance Programs

Citizen-Alien Waived Emergent Medical - Regular (CAWEMR) – Since the redeterminations resumed in March 2016, this caseload has been steadily declining. The most recent preliminary estimate for July 2016 shows 43,861 clients on this caseload, down by 7,561 compared to the March 2016 count of 51,422. The caseload is expected to grow slightly to 44,849 by the end of 2015-17 biennium and will account for about 61.5 percent of Other Medicaid caseload.

Qualified Medicare Beneficiary (QMB) – There were 23,921 clients on this caseload as of April 2016. This caseload is expected to be 25,715 by the end of 2015-17 biennium and will account for about 35.3 percent of Other Medicaid caseload. This caseload has grown consistently since January of 2009 and is expected to continue growing through the forecast horizon.

Breast and Cervical Cancer Treatment Program (BCCTP) – There were 362 clients on this caseload as of April 2016. This caseload is expected to be 286 by the end of 2015-17 biennium and will account for about 0.4 percent of Other Medicaid caseload. This caseload is forecast to continue declining since ACA has reduced the number of uninsured adults who might qualify for the program.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance – There were 6,468 clients on this caseload as of April 2016. This caseload is expected to grow through the foreseeable future, and is expected to be 6,714 by the end of 2015-17 biennium.

Medicare Part-B Premium Assistance – There were 116,938 clients on this caseload as of April 2016. This caseload is projected to continue growing steadily, similar to the OAA and QMB caseloads. It is expected to be 124,297 by the end of 2015-17 biennium. Twenty-eight percent of those receiving Medicare Part-BA assistance are in OAA caseload; 27 percent are in ABAD; 20 percent are in QMB; and most of the remaining 25 percent are not in any of the forecasted Medicaid caseloads.

Risks and Assumptions

Implementation of the ACA continues to create uncertainty and forecast risk. The biggest known risks for the current forecast are:

- Deferred redeterminations.
- Next phase of Oregon Eligibility (ONE) system implementation.
- Volatility of historical data.

The first major risk arises from temporary changes made to eligibility redetermination practices. Since the implementation of ACA, the scheduled redeterminations have been delayed a few times:

- Oct-2013 thru Sep-2014, scheduled redeterminations were delayed in order to focus resources on ACA reform and the inflow of newly eligible adults and children.

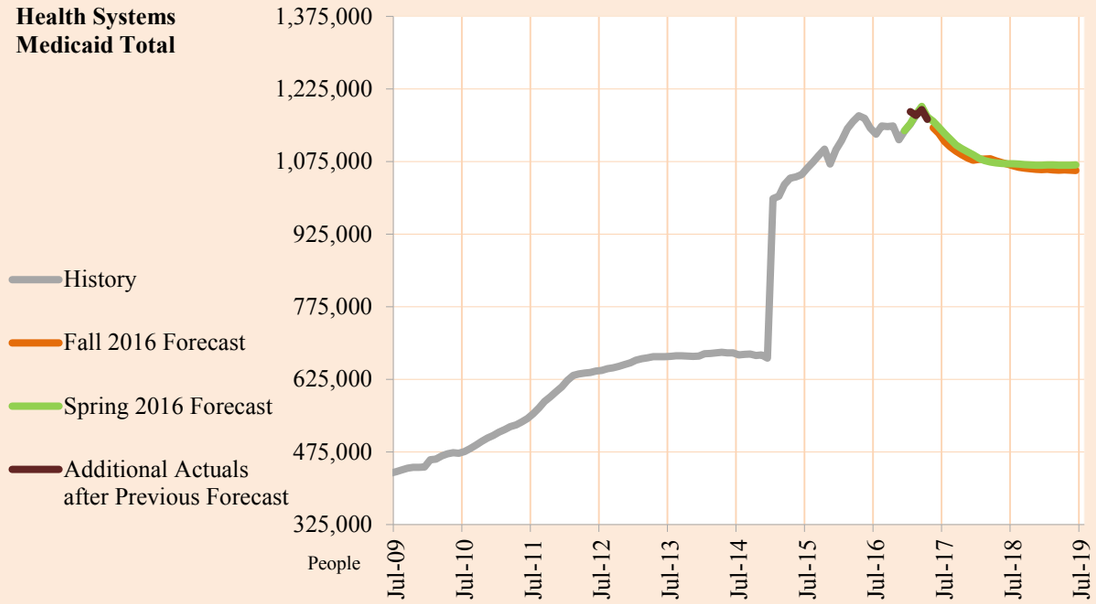
- Dec-2014 thru Mar-2015, scheduled redeterminations were delayed due to issues with Cover Oregon system and consequent challenges with the upcoming open enrollment period.
- Dec-2015 thru Feb-2016, scheduled redeterminations were delayed in order to focus resources on the transition to Oregon's new eligibility system – ONE.

As of March 2016, the scheduled redeterminations have been resumed and the transition to ONE is on schedule. There will be a brief slowing of redeterminations this Fall as OHA moves forward with the next phase of ONE implementation. To the extent possible, the Fall 2016 forecast incorporates the impact and consequences of anticipated changes to redeterminations. However, because operational details can change, this remains a major risk to our current forecast.

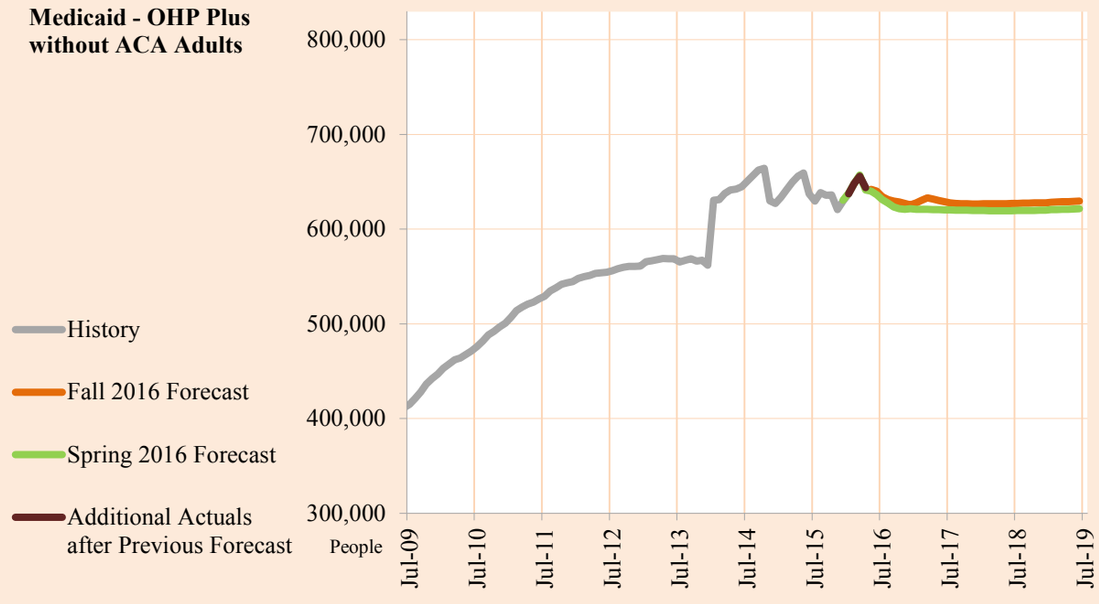
The second major risk is associated with the last phase of the ONE system implementation. In this phase OHA intends to fully launch ONE and make it directly available to Oregonians so they can access the application process themselves. So far, the implementation of ONE overall has been going smoothly, but nevertheless, system changes are tricky and there could be technical setbacks that could in turn cause delays in redeterminations and other issues.

The third major risk is associated with volatility of post-ACA data, which results in wide confidence intervals and could result in high forecast errors. The delays in redeterminations resulted in periods of caseload growth and consequent decline, which makes it very challenging to detect the true trends. Additionally, this had some profound consequences on all of the underlying model components – survival curves (used to predict leavers), new client flow, and transfer rates between caseloads. As the migration to ONE is complete (in early 2017) and there are more delays and disruptions to the ongoing renewal processes, the data will start to improve, however it might take an additional year until new patterns are established.

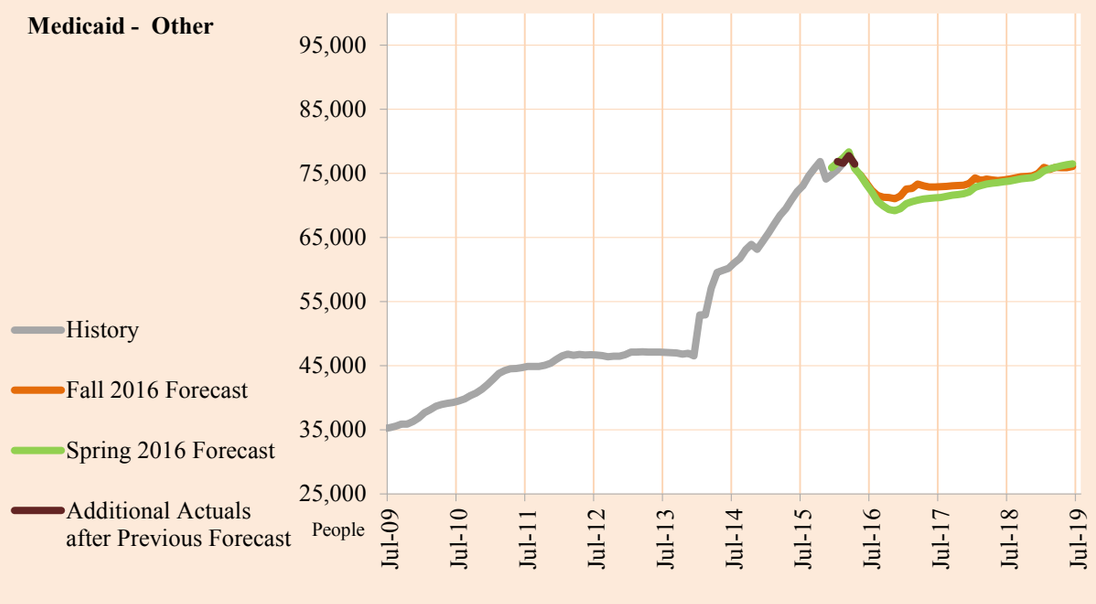
Health Systems Medicaid Total



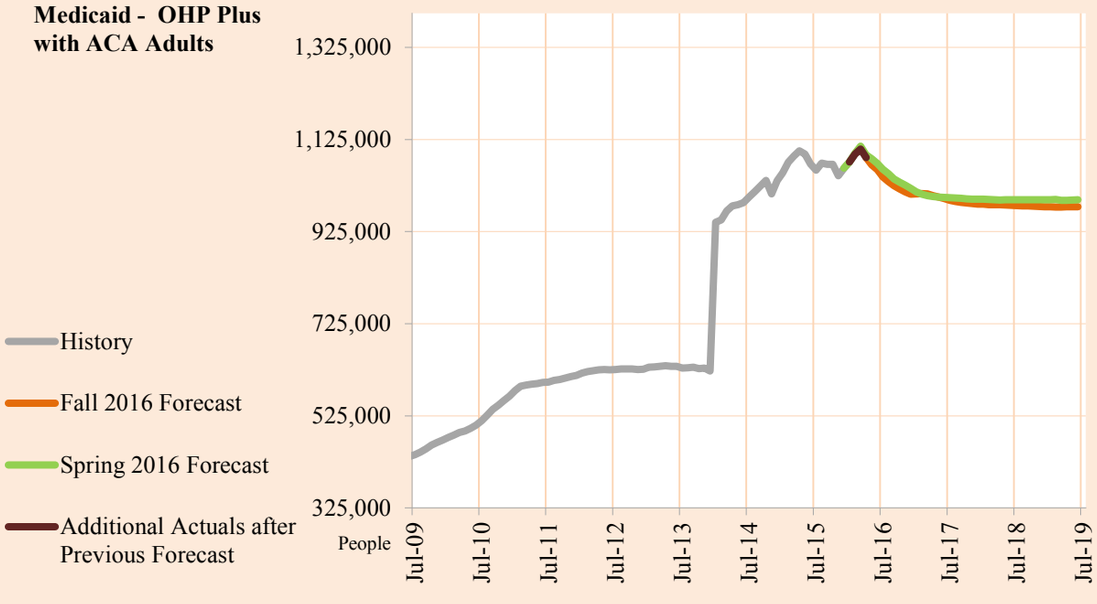
Medicaid - OHP Plus without ACA Adults



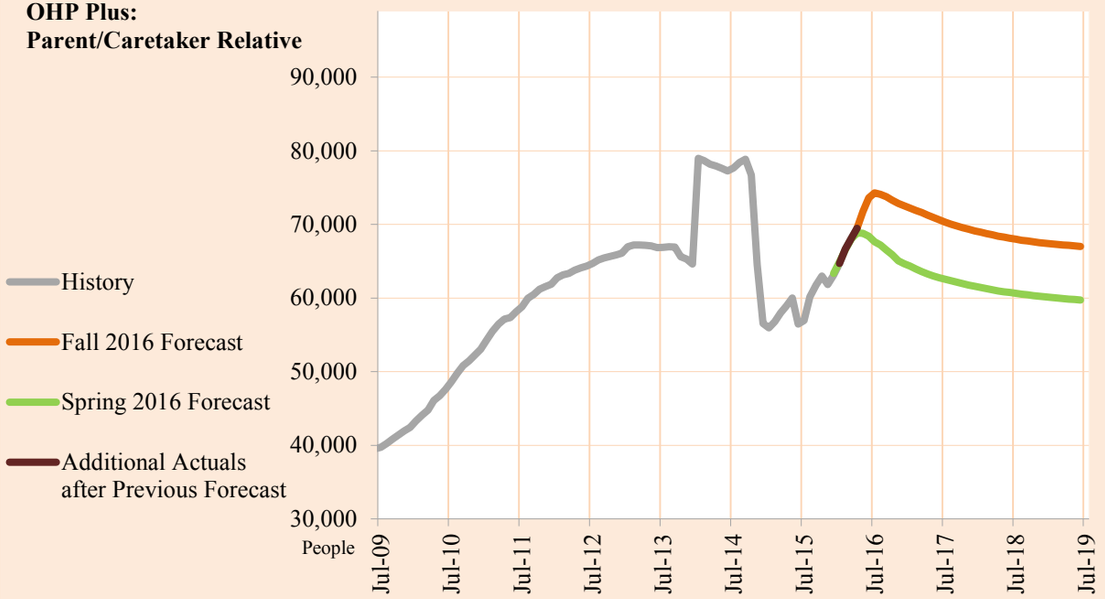
Medicaid - Other



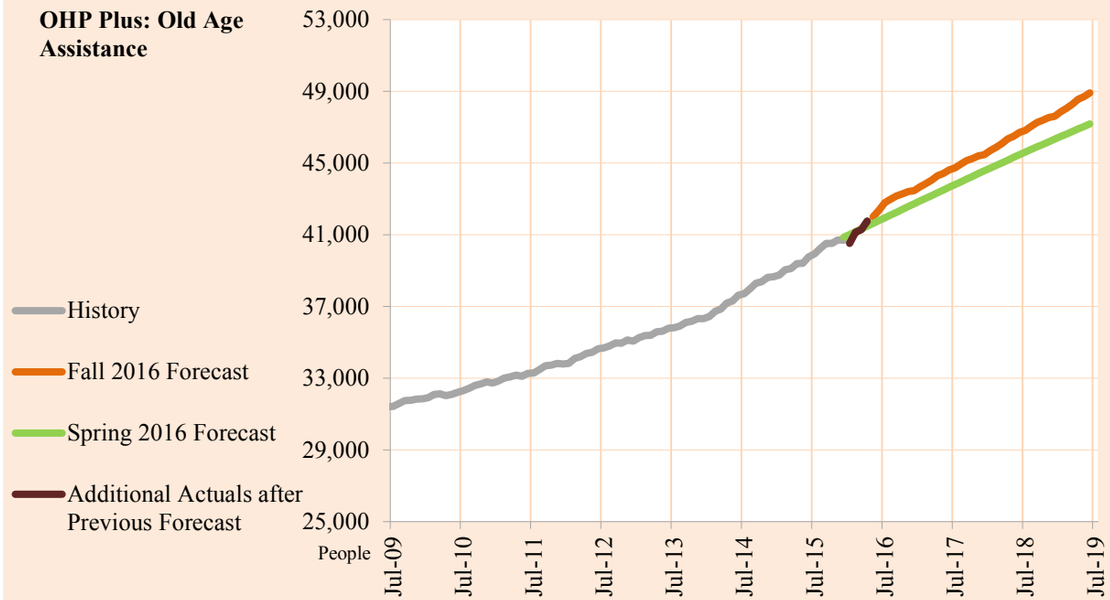
Medicaid - OHP Plus with ACA Adults



OHP Plus: Parent/Caretaker Relative

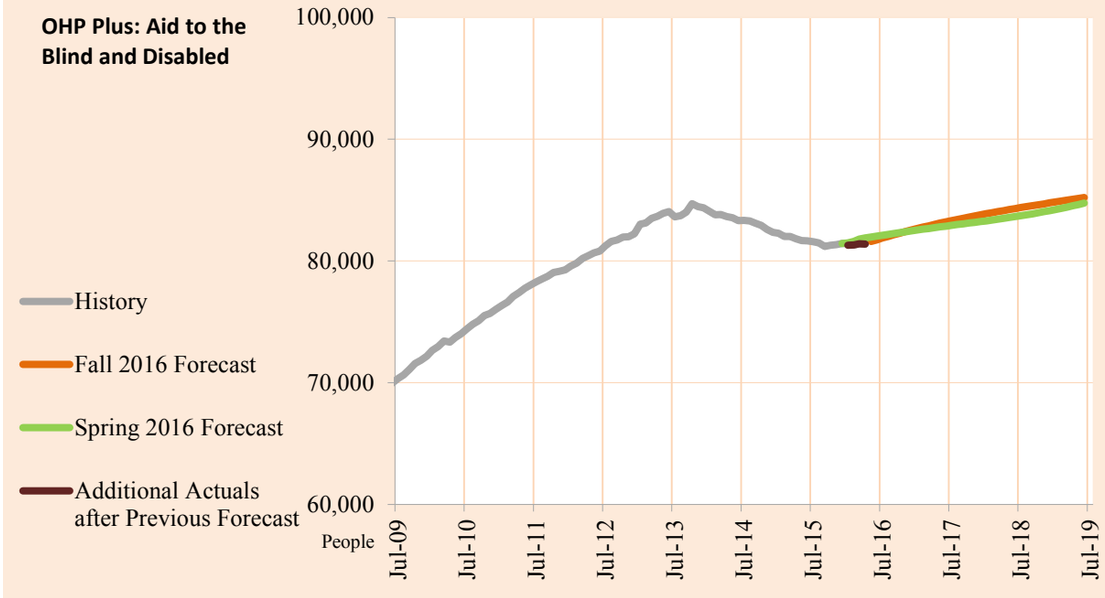


OHP Plus: Old Age Assistance

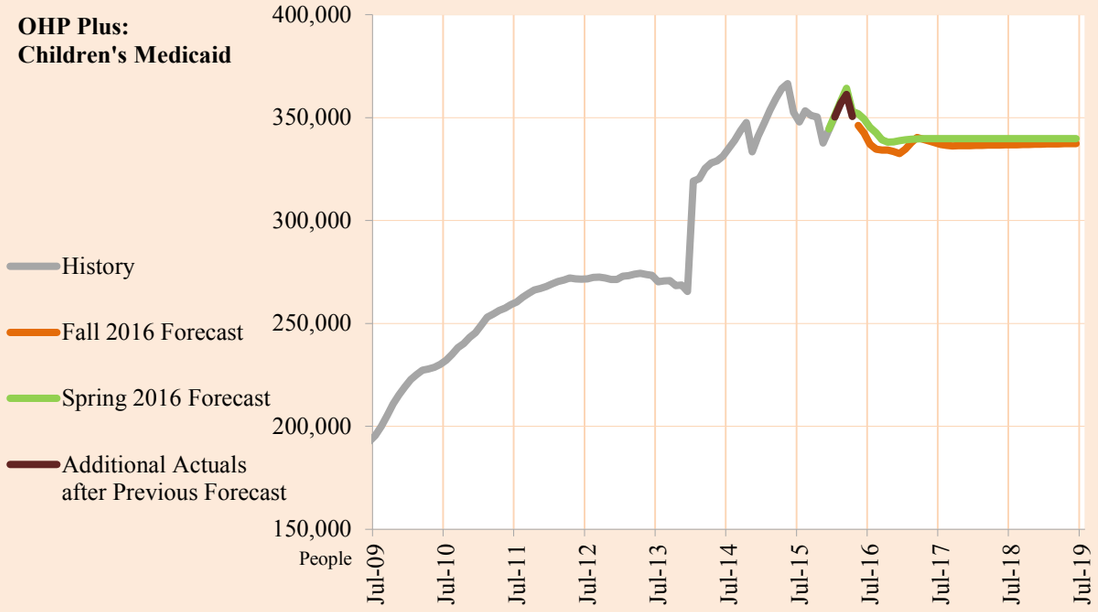


OHP Plus: Pregnant Woman Program

OHP Plus: Aid to the Blind and Disabled

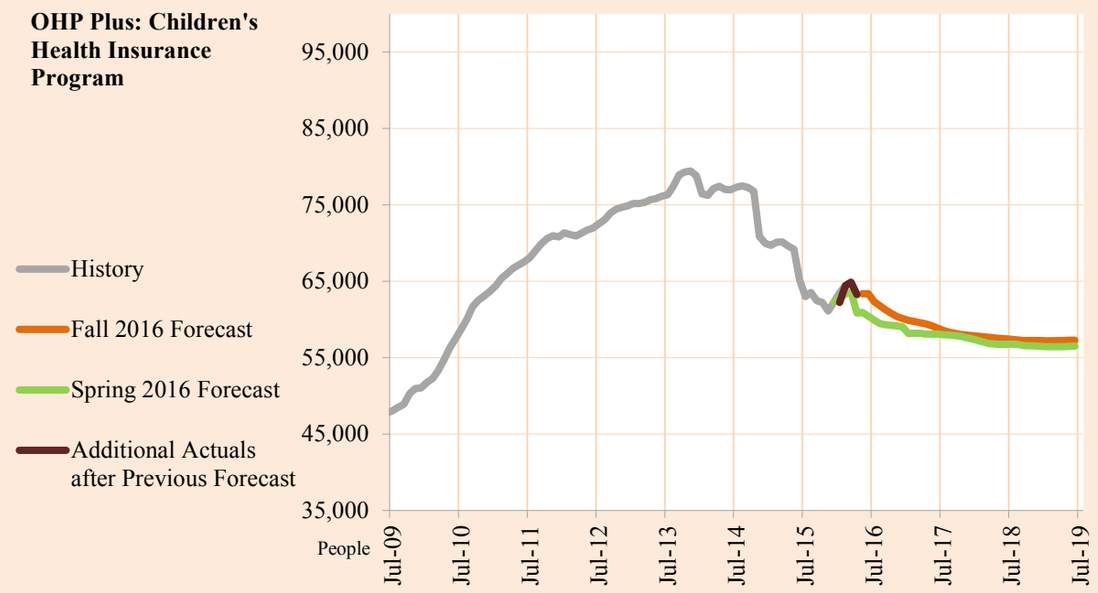


OHP Plus: Children's Medicaid

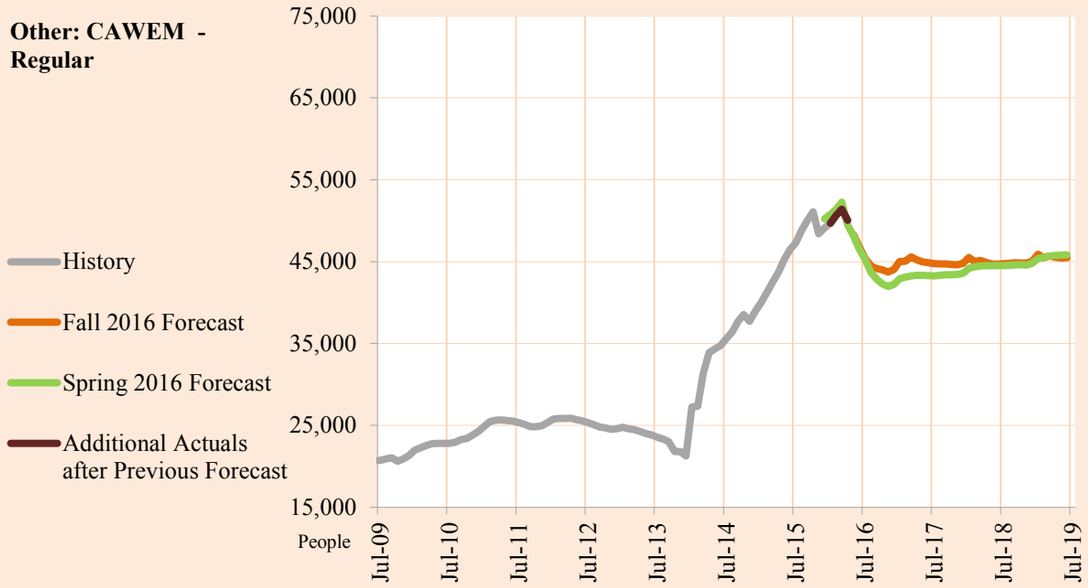


OHP Plus: Foster, Substitute Care and Adoption Assistance

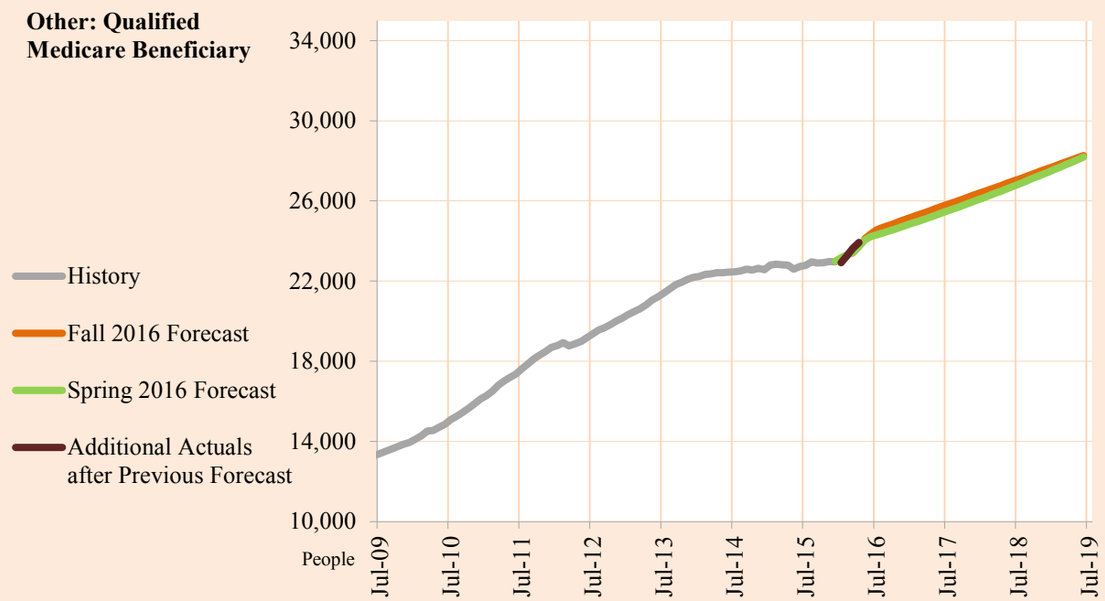
OHP Plus: Children's Health Insurance Program



Other: CAWEM - Regular

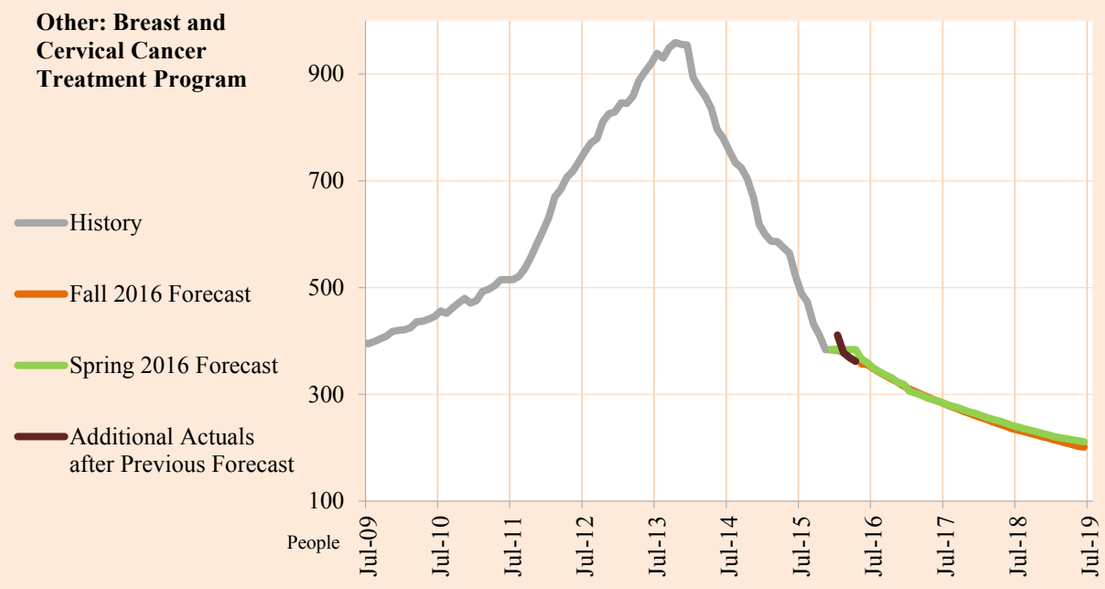


Other: Qualified Medicare Beneficiary

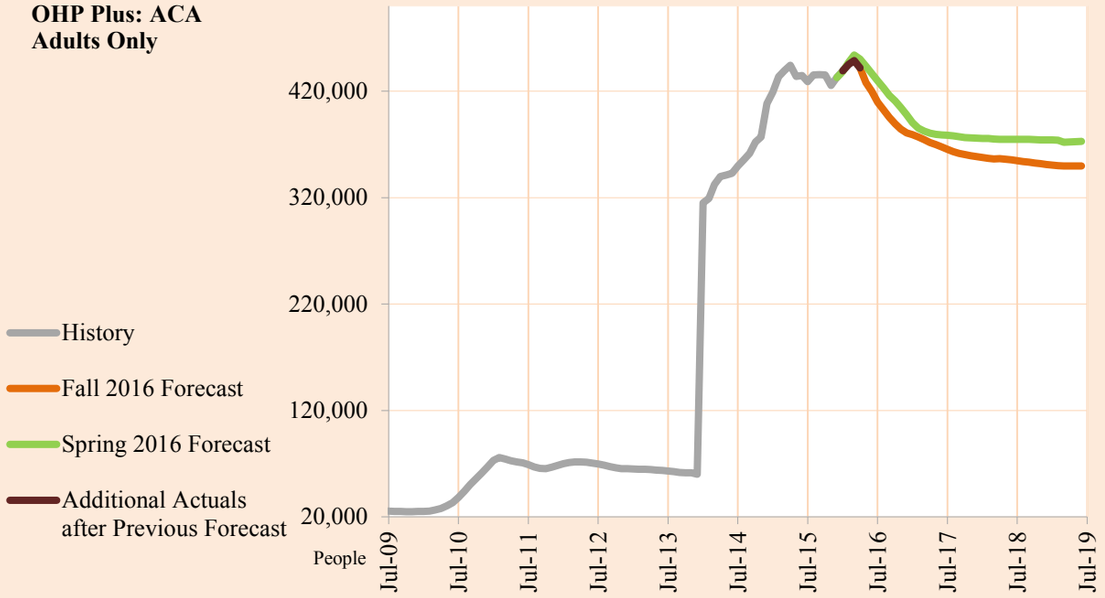


Other: CAWEM - Prenatal

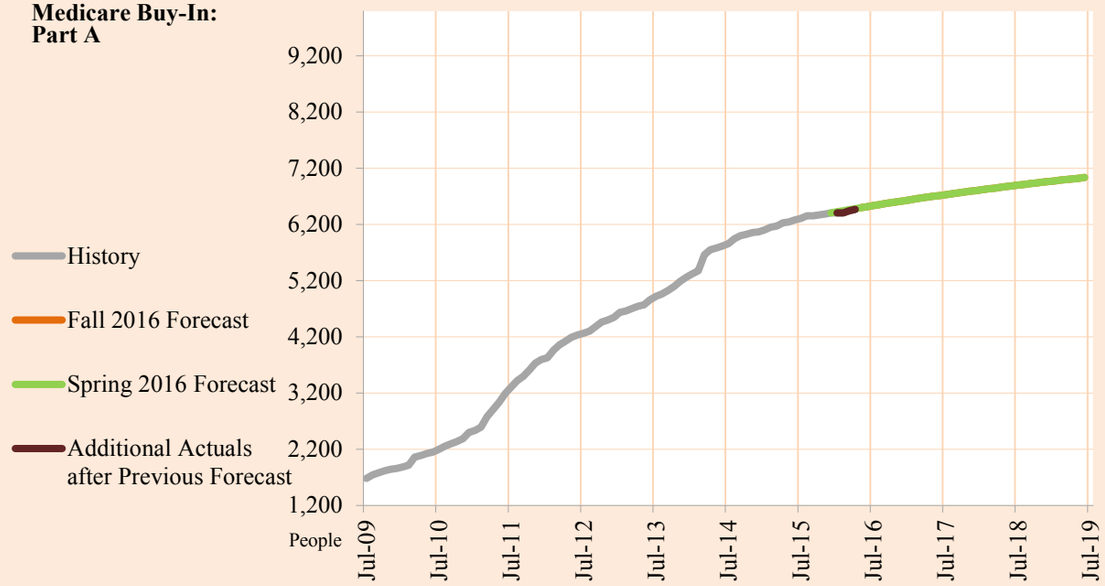
Other: Breast and Cervical Cancer Treatment Program



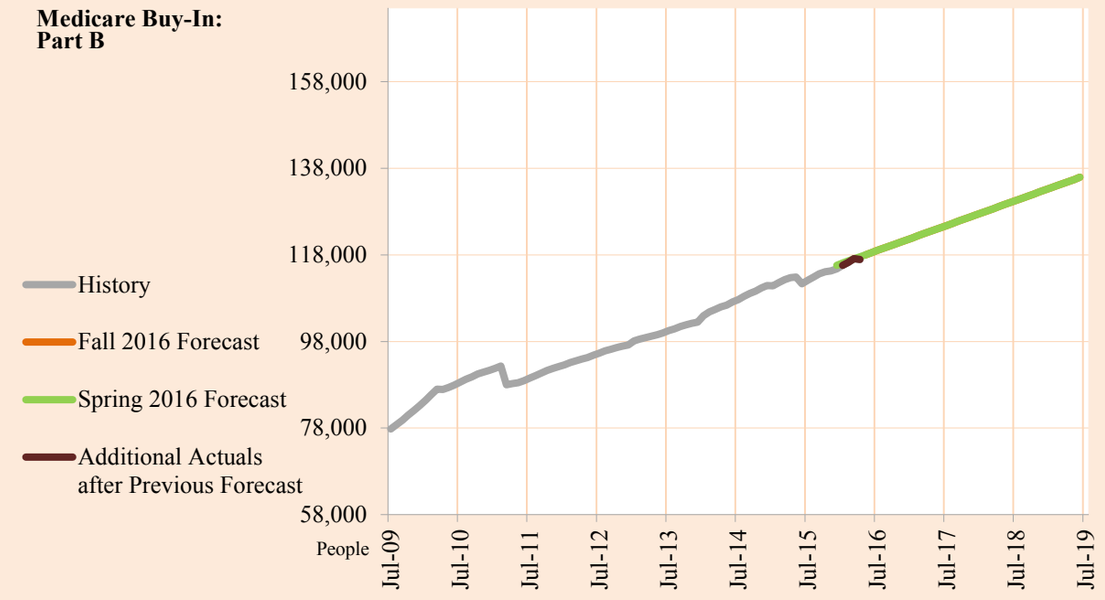
OHP Plus: ACA Adults Only



Medicare Buy-In: Part A



Medicare Buy-In: Part B



Health Systems Medicaid Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
MEDICAL ASSISTANCE								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	0.6%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	1.1%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	6.5%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	4.2%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance								
Breast & Cervical Cancer Treatment Program	359	356	-3	-0.8%	356	237	-119	-33.4%
Citizen-Alien Waived Emergent Medical - Prenatal	2,257	2,168	-89	-3.9%	2,168	2,075	-93	-4.3%
Citizen-Alien Waived Emergent Medical - Regular	46,339	47,007	668	1.4%	47,007	45,036	-1,971	-4.2%
Qualified Medicare Beneficiary	24,061	24,234	173	0.7%	24,234	27,036	2,802	11.6%
Other Subtotal	**73,016**	**73,765**	749	1.0%	**73,765**	**74,384**	**619**	**0.8%**
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Medicare Part A	6,522	6,518	-4	-0.1%	6,518	6,888	370	5.7%
Medicare Part B	118,626	118,532	-94	-0.1%	118,532	130,332	11,800	10.0%

Mental Health (MH)

This forecast includes adults who are receiving mental health services from the Oregon Health Authority. For budgeting purposes, the Mental Health caseload is divided between Mandated and Non-Mandated populations. Oregon law requires Mandated populations, including criminally and civilly committed patients, to receive mental health services. There are three Mandated populations: (1) Aid and Assist, served at the State Hospital; (2) Guilty Except for Insanity (GEI), served at the State Hospital and in the community; and (3) Civilly Committed, also served at both the State Hospital and in the community. The Non-Mandated populations include two groups: (1) Previously Committed individuals, served mostly in the community; and (2) Never Committed individuals, also served mostly in the community. Due to data system changes, the Civilly Committed, Previously Committed, and Never Committed populations were not forecast during the Fall 2015 forecast cycle. As service providers have become more consistent in their use of the Measures and Outcomes Tracking System (MOTS), data for these populations have continued to be refined.

Mandated mental health services are provided through community programs, including residential care, and the Oregon State Hospital system. Non-Mandated services are primarily provided in community outpatient settings. Community programs provide outpatient services including intervention, therapy, case management, crisis, and pre-commitment services. The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, including people who have been found guilty except for insanity.

Total Mandated Mental Health Services

The mandated caseload encompasses the committed caseload (Aid and Assist, GEI, and Civilly Committed clients). The 2015-17 biennial average forecast is 1,834 clients. The 2017-19 biennial average is 1,782 clients, which is 2.8 percent lower than the 2015-17 biennial average. As with all MH categories forecasted in this report, the Mandated population includes only adults.

Total Forensic Mental Health Services

The forensic caseload encompasses the Aid and Assist and GEI clients. The 2015-17 biennial average forecast is 859 clients. The 2017-19 biennial average is 861 clients, which is 0.2 percent higher than the 2015-17 biennial average.

Aid and Assist – This caseload exhibited steady growth throughout 2013, 2014, 2015 and into 2016. Aid and Assist currently counts only clients served at the State Hospital. As MH moves toward mobile forensic evaluation teams, Aid and Assist in the State Hospital will likely decrease, but the timing is unknown. The total number served may continue to increase, but we will be unable to forecast that number unless community Aid and Assist data are also tracked and available for analysis. The 2015-17 biennial average forecast is 260 clients. The 2017-19 biennial average is 271 clients, which is 4.2 percent higher than the 2015-17 biennial average forecast.

Guilty Except for Insanity (GEI) – These clients are under the jurisdiction of the Psychiatric Security Review Board and State Hospital Review Panel. Nationally, violent crimes are down despite population growth. For the past several years the Total GEI caseload in Oregon has steadily declined. The 2015-17 biennial average forecast is 599. The 2017-19 biennial average is 590, which is 1.5 percent lower than the 2015-17 biennial average forecast.

Civil Commitments – This caseload has been subject to several data system changes, rendering conclusions about caseload trends variable. For the past two years the caseload has been declining. This may be due in part to the expansion of Medicaid. It is also possible that new investments are helping to reduce this caseload. The 2015-17 biennial average forecast is 975 clients. The 2017-19 biennial average is 921 clients, which is 5.5 percent lower than the 2015-17 biennial average.

Previously Committed – This caseload captures clients receiving mental health services that had been civilly or criminally committed at some time since the year 2000.

About 80 percent of these clients are served in non-residential settings, and the rest are served in residential settings, the State Hospital, or Acute Care hospital settings. The 2015-17 biennial average forecast is 2,567 clients. The 2017-19 biennial average is 2,543 clients, which is 0.9 percent lower than the 2015-17 biennial average.

Never Committed – This caseload captures clients receiving mental health services that have not been civilly or criminally committed since the year 2000. More than 99 percent of these clients are served in non-residential settings. The 2015-17 biennial average forecast is 41,244 clients. The 2017-19 biennial average is 43,198 clients, which is 4.7 percent higher than the 2015-17 biennial average.

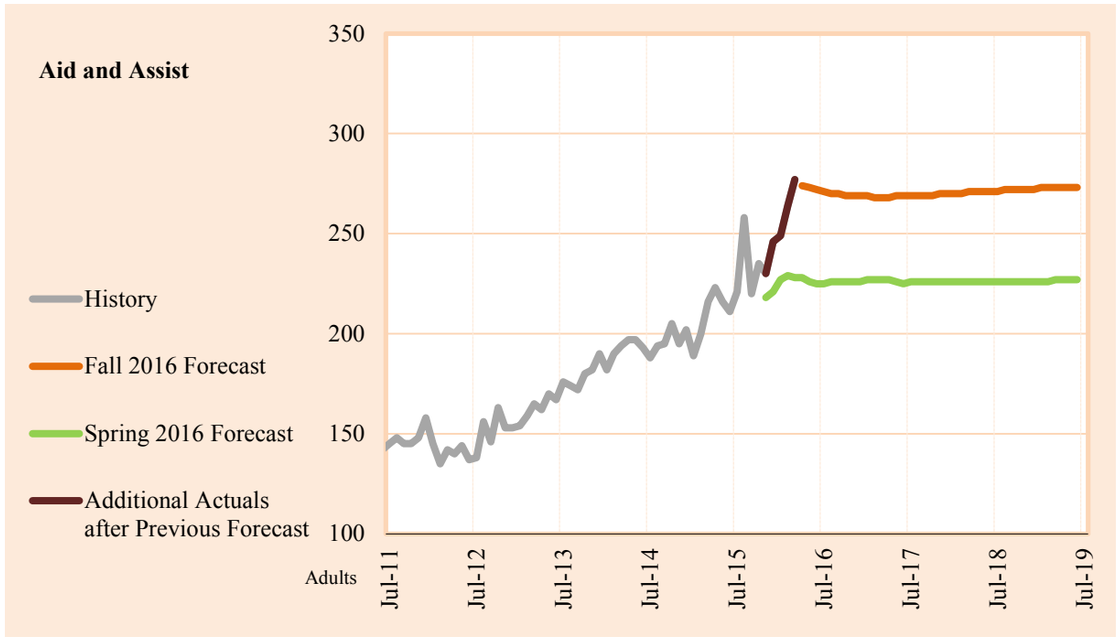
Risks and Assumptions

The Aid and Assist caseload may be impacted by community level efforts to keep people out of the State Hospital. In particular, misdemeanor admissions have decreased in Marion County, and this may spread to other counties. Additionally, program leadership is promoting the idea that Aid and Assist can be provided locally, not just at the Oregon State Hospital. Resource development is under way, and funding is going to high-utilizing areas. To the extent this idea gains traction, caseload would under count the actual number served since data are not currently available for Aid and Assist clients served outside the State Hospital.

The Aid and Assist caseload is subject to variation at the county level. For example, differences in police training as well as local judges can affect the Aid and Assist caseload at the Oregon State Hospital.

The Guilty Except for Insanity caseload is subject to review by the Psychiatric Security Review Board and/or the State Hospital Review Panel. When clients are released by the Board/Panel prior to their end of jurisdiction date, the caseload is driven down. Based on end of jurisdiction date alone, January and March of 2017 are expected to have above normal numbers ending jurisdiction.

A major risk to the Civilly Committed caseload is related to the timeliness of reporting. Provider input delays, especially concerning civil commitment data, can lead to artificially low caseload numbers.


Aid and Assist
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
350
300
250
200
150
100
Adults
Jul-11
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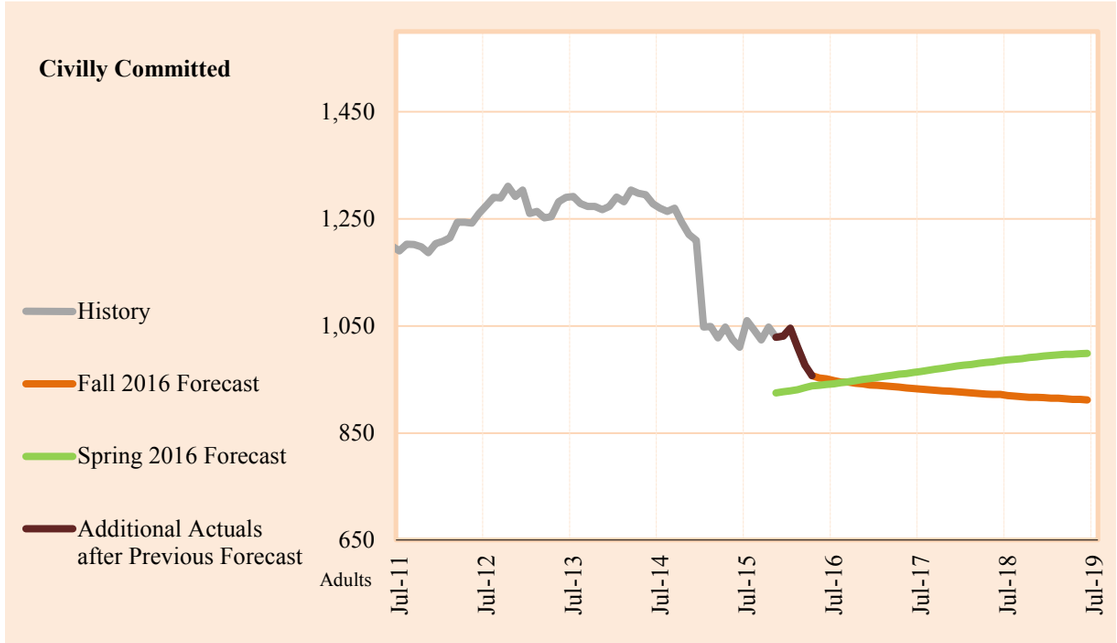
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19


Civilly Committed
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
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1,250
1,050
850
650
Adults
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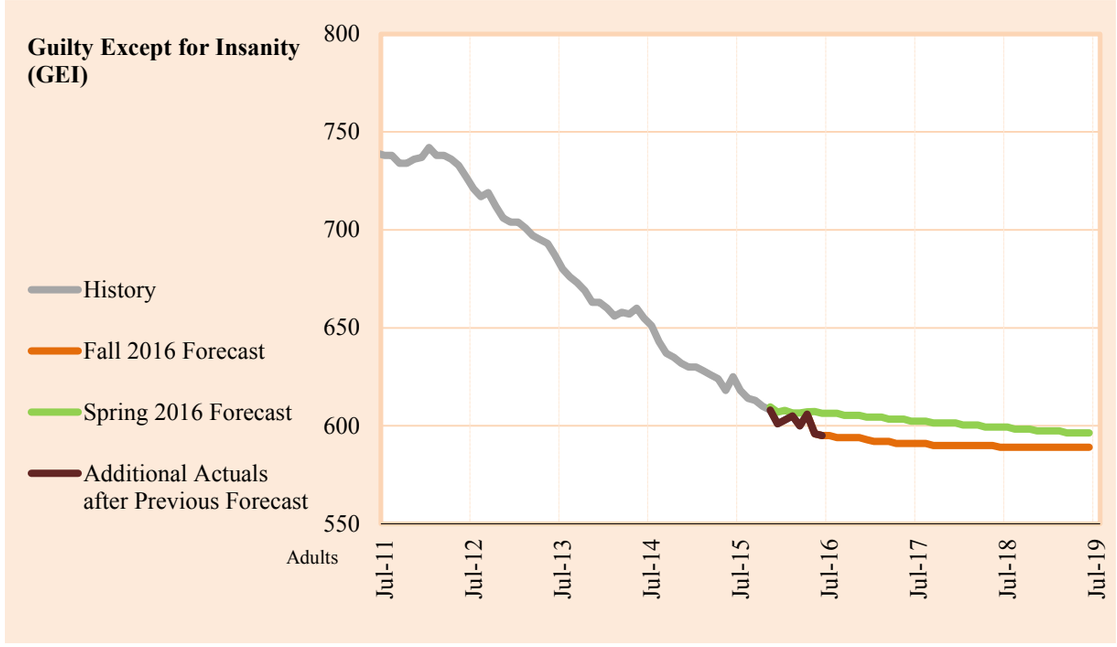
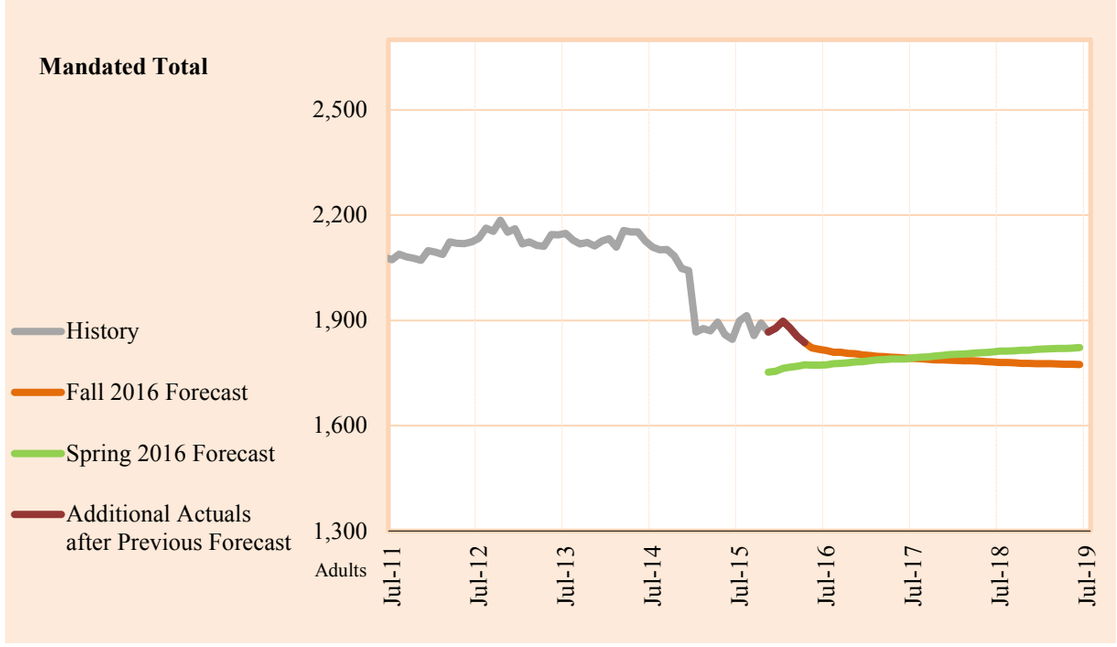
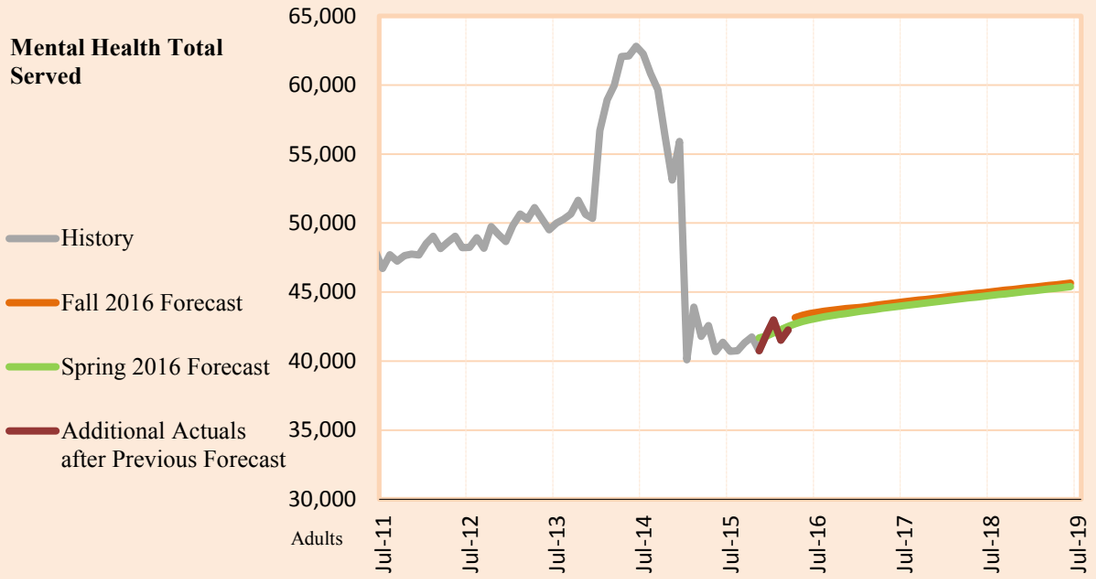
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

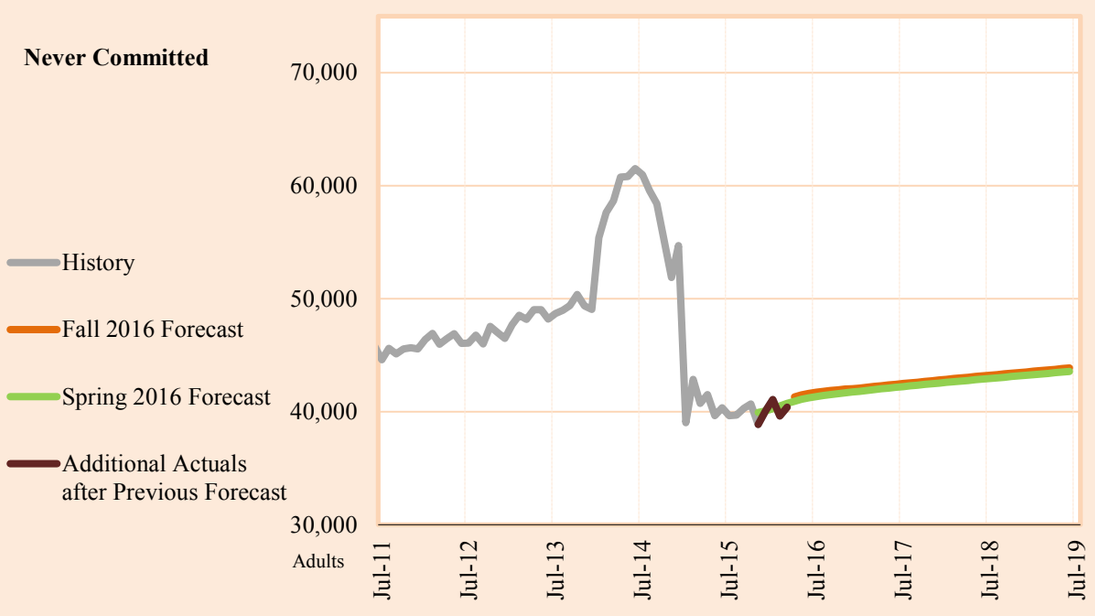

Guilty Except for Insanity (GEI)
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
800
750
700
650
600
550
Adults
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19


Mandated Total
History
Fall 2016 Forecast
Spring 2016 Forecast
Additional Actuals after Previous Forecast
2,500
2,200
1,900
1,600
1,300
Adults
Jul-11
Jul-12
Jul-13
Jul-14
Jul-15
Jul-16
Jul-17
Jul-18
Jul-19

Mental Health Total Served



Never Committed



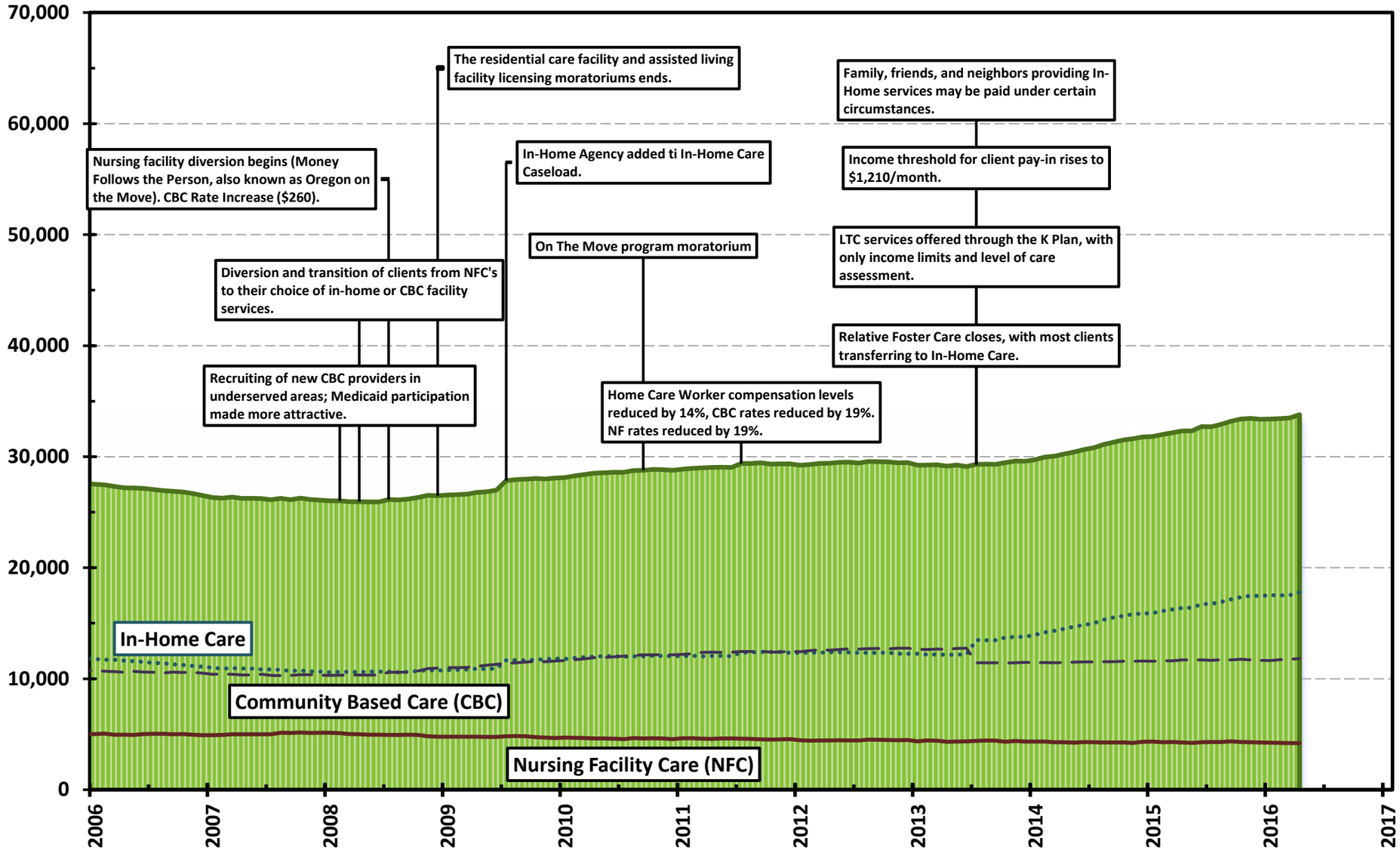
Mental Health Biennial Average Forecast Comparison

Biennial Averages	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
MENTAL HEALTH [1]								
Under Commitment								
Aid and Assist	221	260	39	17.6%	260	271	11	4.2%
Guilty Except for Insanity (GEI)	607	599	-8	-1.3%	599	590	-9	-1.5%
Total Forensic Care	**828**	**859**	**31**	**3.7%**	**859**	**861**	**2**	**0.2%**
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	**45,425**	**45,645**	**220**	**0.5%**	**45,645**	**47,523**	**1,878**	**4.1%**

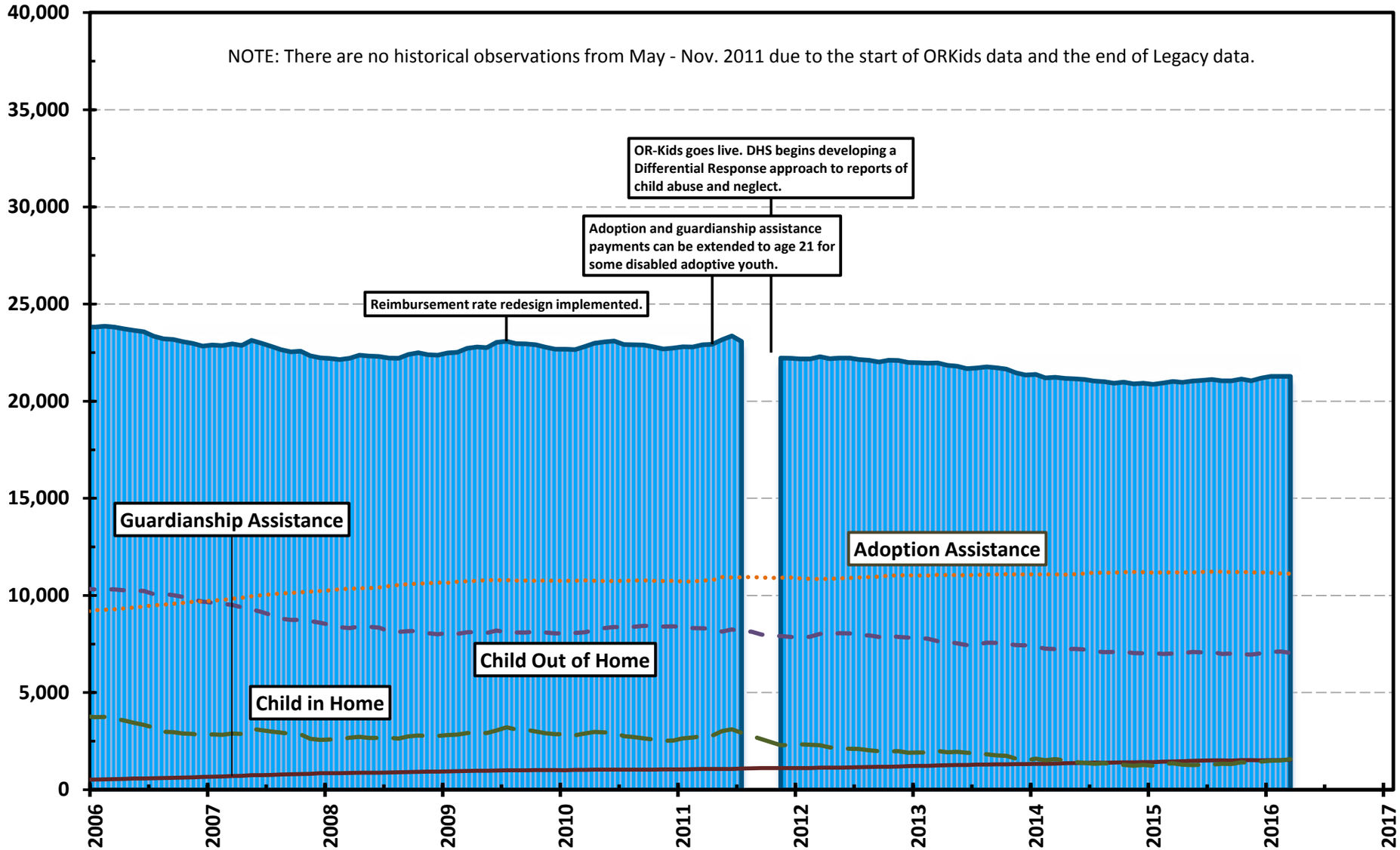
1. Numbers reported represent adults only.

Appendix I
DHS Caseload History & Definitions

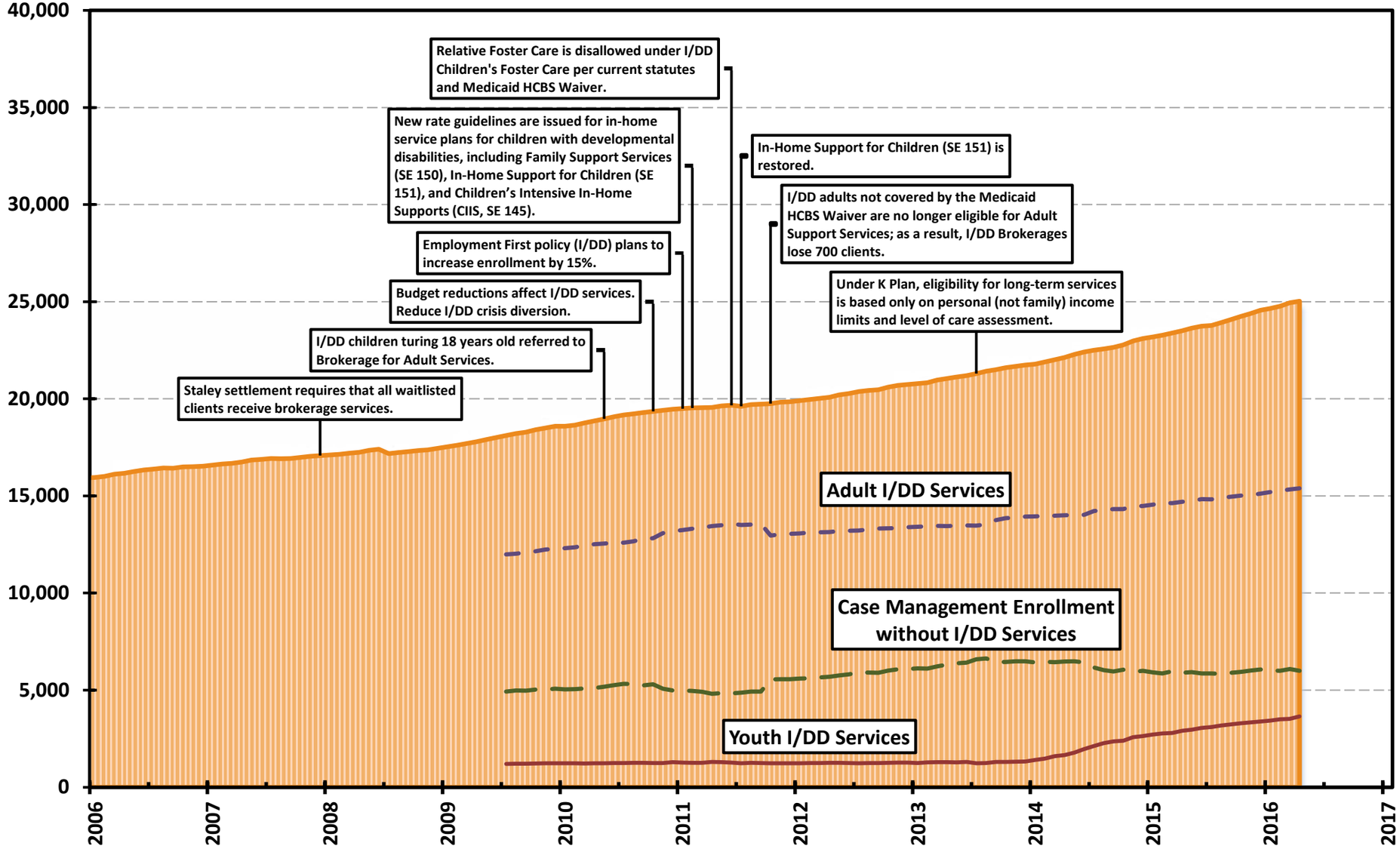
Aging and People with Disabilities (APD) Caseload



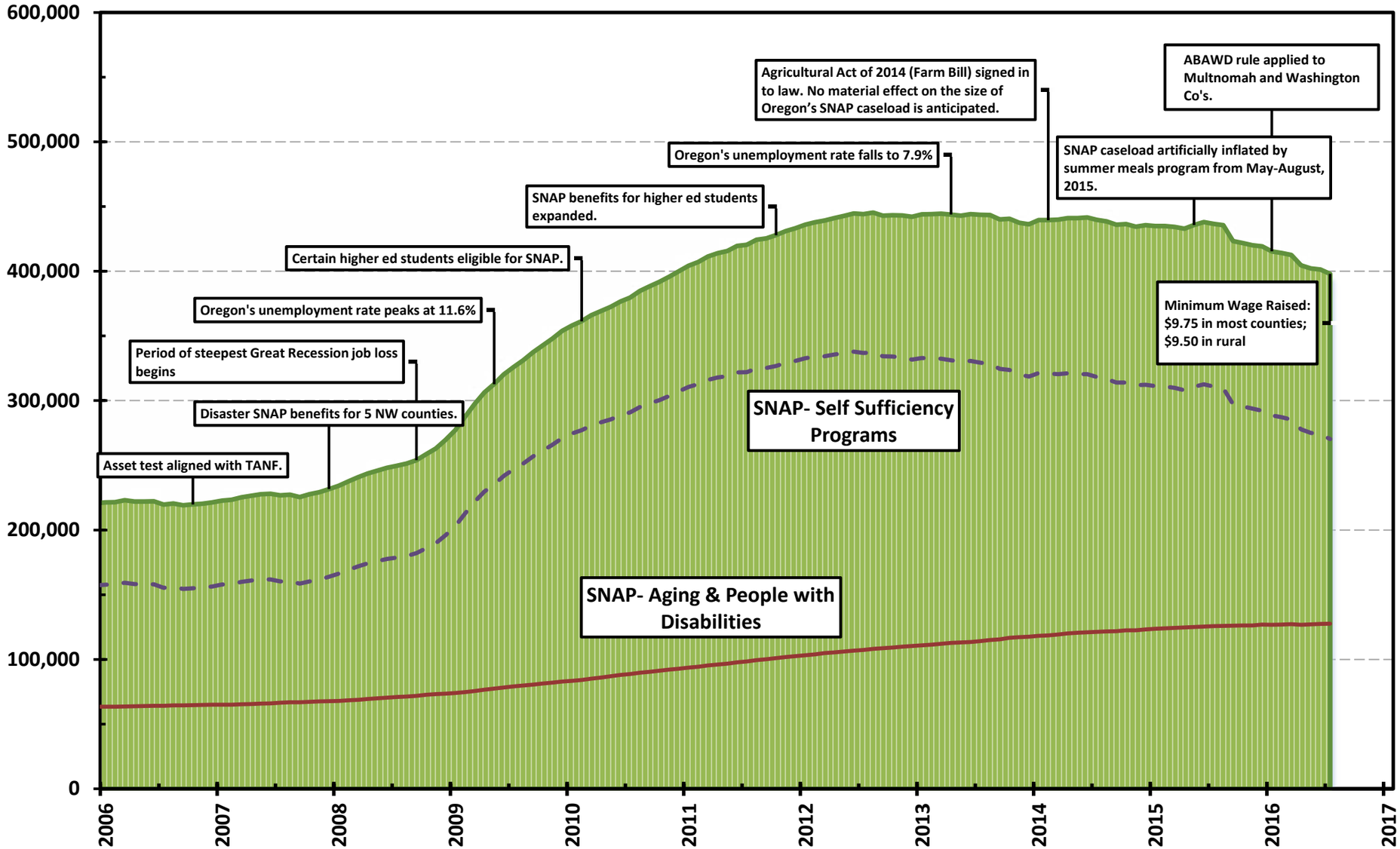
Child Welfare (CW) Caseload



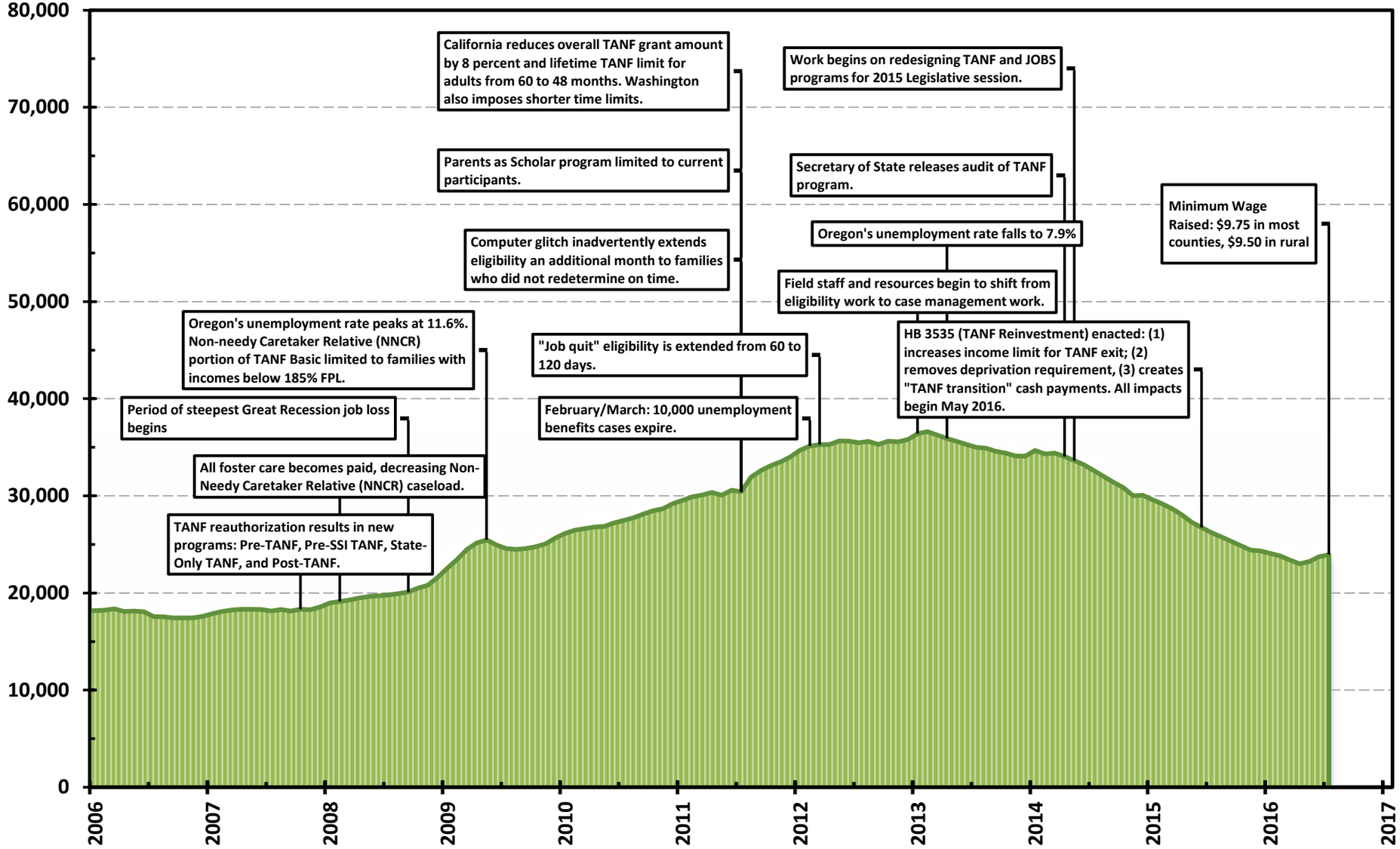
Intellectual & Developmental Disabilities (I/DD): Case Management Enrollment



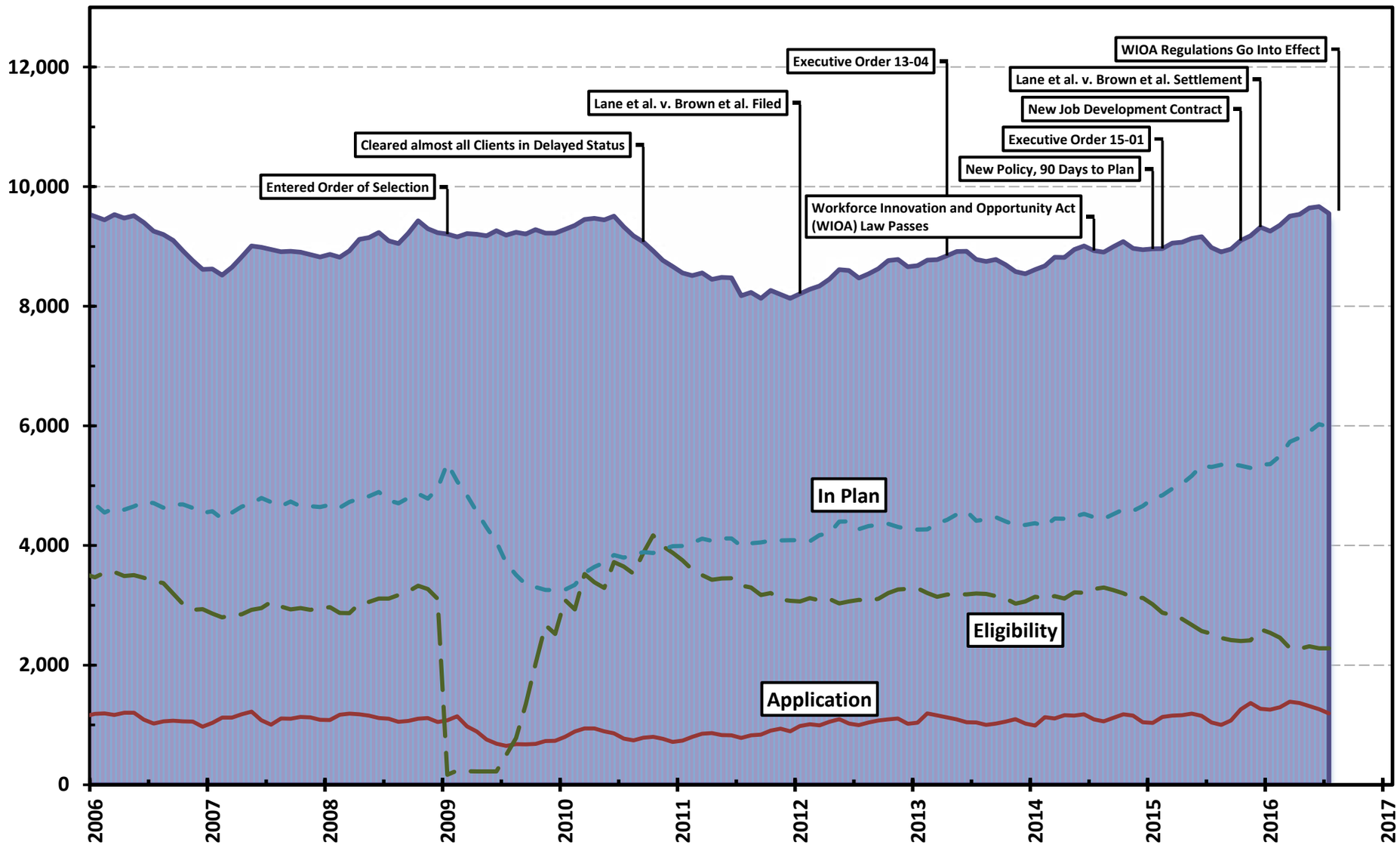
Self Sufficiency Programs (SSP):
Supplemental Nutrition Assistance Program (SNAP) Caseload



Self Sufficiency Programs:
Temporary Assistance for Needy Families (TANF) Caseload



Vocational Rehabilitation



DHS CASELOAD DEFINITIONS

Federal Poverty Level (FPL)

"The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL."

2016 Poverty Guidelines for Oregon

Person in family/ household	Poverty Guideline
1	$11,880
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3	$20,160
4	$24,300
5	$28,440
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8	$40,890

Aging and People with Disabilities (APD)

Aging and People with Disabilities programs provide Long-Term Care (LTC) services to qualifying people who, due to their age or disabilities, need help with their activities of daily living (ADL), including eating, dressing/ grooming, bathing/ personal hygiene, mobility, bowel and bladder management, and cognition.

Area Agencies on Aging (AAA) and DHS staff help clients find the appropriate care settings to meet their needs and determine financial eligibility. To qualify, clients must meet financial and non-financial requirements which vary depending on whether the individual will be covered under K Plan or the HCBS Waiver.

Historically, Oregon's LTC services were provided under the authority of a Medicaid 1915 (c) Home and Community-Based Services (HCBS) Waiver (under the Omnibus Budget Reconciliation Act of 1981), which allows the State to provide home and community-based care alternatives to institutional care such as nursing facilities.

Starting in July 2013, using a new option available under the Patient Protection and Affordable Care Act of 2010 (ACA), Oregon began offering services primarily through the Social Security Act's 1915 (k) Community First Choice Option (referred to as K Plan).

The LTC caseloads are grouped into three major categories: In-Home, Community-Based Care, and Nursing Facilities.

In-Home Programs

In-Home programs provide personal services that help people stay in their homes when they need assistance with Activities of Daily Living (ADL).

In-Home Hourly

In-Home Hourly caseload includes clients who hire hourly workers to assist them in meeting their ADL needs and other common household tasks.

In-Home Agency

In-Home Agency is an alternative way to purchase in-home care. Under this program, clients contract with an agency for the services they need, and those services are delivered in the client's own home by an employee of the agency. Screening and scheduling are often simpler when working with an agency.

Live-In

Live-In Provider caseload includes clients who hire a live-in home care worker to provide 24-hour care.

Spousal Pay

Spousal Pay caseload includes clients who choose to have their paid care provided by their spouse. Spouses are paid for the services they provide.

Independent Choices

Independent Choices allows clients more control in the way they receive their in-home services. Under this program, clients decide for themselves which services they will purchase, but are also required to keep financial records of the services they've purchased.

Specialized Living

Specialized Living provides care in a home-like setting for clients with specialized needs (such as quadriplegics or clients with acquired brain injuries). These clients are eligible for a live-in attendant, but because of their special needs, cannot live independently or be served in other Community-Based Care facilities.

State Plan Personal Care (Non-K Plan Medicaid Services)

State Plan Personal Care services are available to people who are eligible for Medicaid, but not eligible for waivered services. Services supplement the individual's own personal abilities and resources, but are limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living.

Community Based Care (CBC)

Community-Based Care caseload includes clients receiving services in licensed, community-based residential settings. Services include assistance with ADLs, medication oversight, and social activities. Services can also include nursing and behavioral supports to meet complex needs.

Assisted Living Facilities

Assisted Living Facilities are licensed 24-hour care settings serving six or more residents that provide private apartments and focus on resident independence and choice.

Adult Foster Care

Adult Foster Care provides long-term care in home-like settings licensed for five or fewer unrelated people. These facilities are open to clients who are not related to the care provider.

Residential Care Facilities

Residential Care Facilities (Regular or Contract) are licensed 24-hour care settings serving six or more residents. These facilities range in size from six beds to over 100. “Contract” facilities are licensed to provide specialized Alzheimer care.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated Medicare/Medicaid program providing all-inclusive care. Seniors served in this program live in a variety of care settings. PACE is responsible for coordinating their clients’ acute health and long-term care needs.

Nursing Facilities (NF)

Nursing Facilities provide institutional services for seniors and people with disabilities in facilities licensed and regulated by DHS. Nursing facilities provide clients with skilled nursing services, housing, related services and ongoing assistance with activities of daily living.

Basic Care

Basic Care clients need comprehensive, 24-hour care for assistance with ADLs and ongoing nursing care due to either age or physical disability.

Complex Medical Add-On

Complex Medical Add-On clients have medical conditions that require additional nursing services and staff assistance beyond Basic Care.

Enhanced Care

Enhanced Care clients have difficult to manage behavioral issues such as self-endangering behaviors, physical aggression, intrusiveness, intractable psychiatric symptoms, or problematic medication needs that require special care in Nursing Facilities. Some of these clients are also served in community-based care facilities.

Pediatric Care

Pediatric Care clients are children under 21 who receive nursing care in pediatric nursing facility units.

Child Welfare (CW)

Child Welfare programs oversee the safety of children who have been abused or neglected. The Child Protective Services (CPS) program investigates reports of child abuse or neglect. If abuse or neglect is founded, caseworkers prepare an action plan and provide case management to ensure safety for the child using the strengths of the family.

The Child Welfare caseload is an unduplicated count of children served in the various programs listed below. A child is counted only once during a month. For children participating in more than one CW program within a month, they are counted in the program highest on the list below:

Adoption Assistance

Adoption Assistance coordinates and supervises adoption for children in foster care who cannot return safely to the care of their biological parents. Adoption Assistance services can include financial and/or medical help with the costs associated with the adoptive child's needs.

Guardianship Assistance

Guardianship Assistance helps remove financial barriers for individuals who provide a permanent home for children who would otherwise be in Foster Care. Guardianship allows an alternative plan to adoption. Guardianship Assistance services can include financial support for costs associated with the needs of the child (similar to a Foster Care payment).

Out of Home Care

Out of Home Care programs provide a safe, temporary home for abused or neglected children who cannot remain safely in their homes. Children in the program are placed with relatives, foster families, or in residential treatment care settings. The program aims to reunite children with their parents. Out of Home Care services can include financial support and/or medical help for costs associated with the child's needs.

Child In-Home

In-Home Services provide support and safety monitoring services to prevent placement of children in Foster Care and to support reunification with the parents after Foster Care. Caseworkers oversee services and monitor in-home safety plans for children. In-Home Services can include financial support for costs associated with the safety, permanence, and well-being of children, and outside resources to help meet those needs.

Intellectual and Developmental Disabilities (I/DD)

Intellectual and Developmental Disabilities programs provide support to qualified adults and children with intellectual and developmental disabilities through a combination of case management and services. Intellectual and Developmental disabilities include intellectual disabilities, cerebral palsy, Down's syndrome, autism and other impairments of the brain that occur during childhood. Some people with developmental disabilities also have significant medical or mental health needs.

Adults with developmental disabilities may be eligible for services ranging from supports to help individuals live in their own homes to 24-hour comprehensive services. Twenty-four-hour services are provided in a variety of settings including group homes and foster homes. Children with developmental disabilities may be eligible for services ranging from family support to out-of-home placements. Placements include foster homes or residential group home settings.

The forecasted Intellectual and Developmental Disabilities programs are counts of individual clients receiving a program's services within the month. Clients can receive services from more than one program in the same month (for example, from both a residential and a support program).

Case Management Enrollment

Case Management Enrollment provides entry-level eligibility evaluation and coordination services.

The other caseloads are grouped into three broad categories: adult services, children services, and other services.

Adult services

Brokerage Enrollment

Brokerage Enrollment provides planning and coordination of services that allow clients to live in their own home or in their family's home.

24-Hour Residential Care

24-Hour Residential Care provides 24-hour supervised care, training and support services delivered in neighborhood homes.

Supported Living

Supported Living provides individualized support services to clients in their own home based on their Individual Support Plan.

Comprehensive In-Home Services

Comprehensive In-Home Services help individuals aged 18 years or older with intellectual and developmental disabilities to continue to live in their homes.

I/DD Foster Care

Foster Care provides 24-hour care, supervision, provision of room and board, and assistance with activities of daily living for both adults and children (approximately 84 percent and 16 percent respectively).

Stabilization and Crisis Unit

Stabilization and Crisis Unit (previously called State Operated Community Programs) offers safety net services and support to the most vulnerable, intensive, medically and behaviorally challenged I/DD clients when no other community based option is available to them. The program serves both adults and children (approximately 88 percent and 12 percent respectively).

Children's services

In-Home Support for Children

In-Home Support for Children provides services to individuals under the age of 18 in the family home.

Children Intensive In-Home Services

Children Intensive In-Home Services cares for children with intensive medical or behavioral needs in their own homes.

This caseload is composed of three distinct groups: Medically Fragile Children Services, Intensive Behavior Program, and Medically Involved Programs.

Children Residential Care

Children Residential Care provides 24-hour care, supervision, training, and support services to individuals under the age of 18 in neighborhood homes other than the family home or foster care.

Other I/DD services

Employment and Day Support Activities

The caseload previously known as Employment and Day Support has been redefined and given a new title. Employment and Attendant Care Services are out-of-home employment or community training services and related supports provided to individuals 14 or older, to improve the individual's productivity, independence and integration in the community. Examples of services covered within this caseload include: discovery, employment path services, initial and on-going job coaching, individual and small group employment support, and certain types of attendant care.

Transportation

Transportation services have been redefined to include all non-medical transportation services including services provided under Plan of Care (e.g. transit passes and non-medical community transportation).

Self Sufficiency Programs (SSP)

Self Sufficiency programs provide assistance for low-income families to help them become healthy, safe, and economically independent. With the exception of SNAP, self-sufficiency program caseloads count the number of families receiving program benefits within the month. In the SNAP program, caseloads count the number of households receiving the benefit within the month.

Supplemental Nutrition Assistance Program (SNAP)

As of October 1, 2008, the new name for the federal Food Stamp Program is the Supplemental Nutrition Assistance Program (SNAP). Oregon began using the new name on January 1, 2010.

SNAP benefits improve the health and well-being of low-income individuals by providing them a means to meet their nutritional needs. Recipients use SNAP benefits to buy food.

To be eligible for SNAP benefits, applicants provide proof of household composition (living in same dwelling, purchase food and prepare meals together) and have assets and income within program limits. The maximum income limit is 185 percent of Federal Poverty Level (FPL), however most recipients qualify below 130 percent of FPL.

The SNAP forecast includes two caseloads – APD and SSP. Households entering the program through the Self Sufficiency Programs (SSP) are classified as SSP households, while those entering the program through Aging and People with Disabilities (APD) are classified as APD households. The two caseloads share eligibility guidelines and benefits amounts.

Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) program provides case management and cash assistance to very poor families with minor children. The goal of the program is to reduce the number of families living in poverty through employment services and community resources.

Recipients must meet basic TANF asset requirements (including a $2,500 - $10,000 resource limit and income less than 40 percent of FPL) to be eligible for the program. They must also meet non-financial eligibility requirements including dependent children in the case, Oregon residence, citizenship status, parental school attendance, pursuing assets, and pursuing treatment for drug abuse or mental health as needed. As of April 2016 proof of deprivation (death, absence, incapacity, or unemployment of a parent) will no longer be a requirement of TANF enrollment.

The **TANF Basic** program includes one-parent families and two-parent families where at least one parent is unable to care for children, or families headed by an adult relative who is not considered financially needy.

The **TANF UN** program includes families where both parents are able to care for their children, but both are unemployed or underemployed.

TANF Employment Payments (EP) are available to those families exiting TANF due to employment. Transition payments are for three months only. TANF EP is currently authorized for the 2015-17 biennium.

Pre-SSI

The State Family Pre-SSI/SSDI (SFPSS) program provides cash assistance, case management, and professional level support to TANF-eligible adults and their family in pursuing Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI). To be eligible for Pre-SSI, the adult must be found eligible for a TANF grant and must have severe physical or mental impairment(s) that has been assessed and determined to meet the program impairment criteria by the program's disability analyst.

Temporary Assistance to Domestic Violence Survivors (TA-DVS)

The TA-DVS program supports domestic violence survivors by providing temporary financial assistance to flee domestic violence. TA-DVS payments can be issued to meet the family's needs for shelter, food, medical care, relocation, stabilization, or to promote safety or independence from the abuser.

To be eligible for TA-DVS, a survivor must have a current or future risk of domestic violence; be a pregnant woman or a parent or relative caring for a minor child; and must have income not exceeding TANF limits (40 percent of FPL; TA-DVS only considers income on hand that is available to meet emergency needs).

Vocational Rehabilitation (VR)

Vocational Rehabilitation Services assess, plan, and coordinate vocational rehabilitation services for people who have physical or mental disabilities and need assistance to obtain and retain employment that matches their skills, potential, and interest. Services are provided through local VR offices across the state. The program provides counseling, training, job placement, assistive technology, and extended services and supports.

VR services involve four stages, each of which are now being forecast:

Application

Clients in the Application stage have completed an application for VR services.

Eligibility

Clients in the Eligibility stage have been determined eligible for VR services and are developing a plan for employment.

In Plan

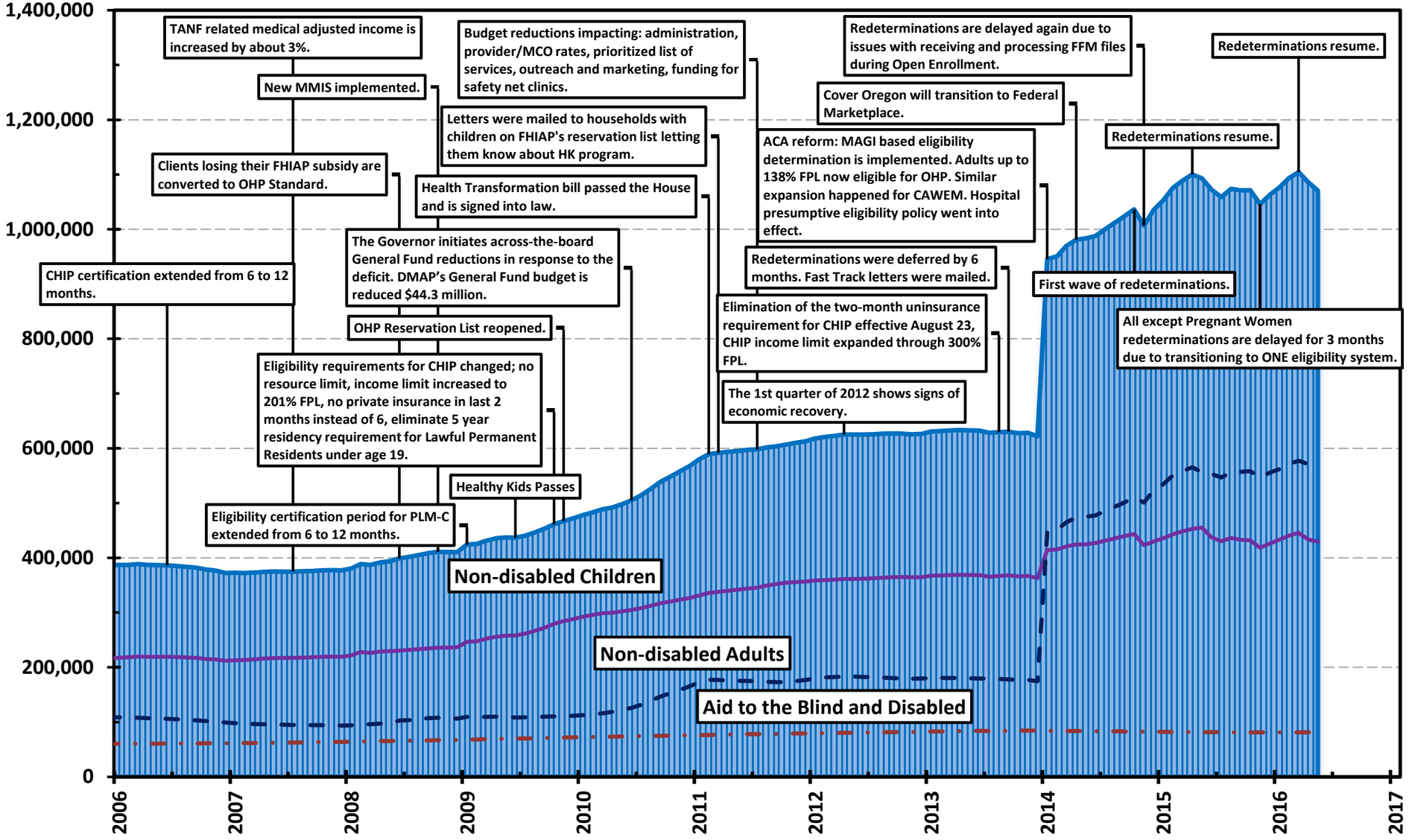
Clients who are In Plan are receiving VR services. After employment and if all is going well, a case is normally closed after 90 days.

Post-Employment Services

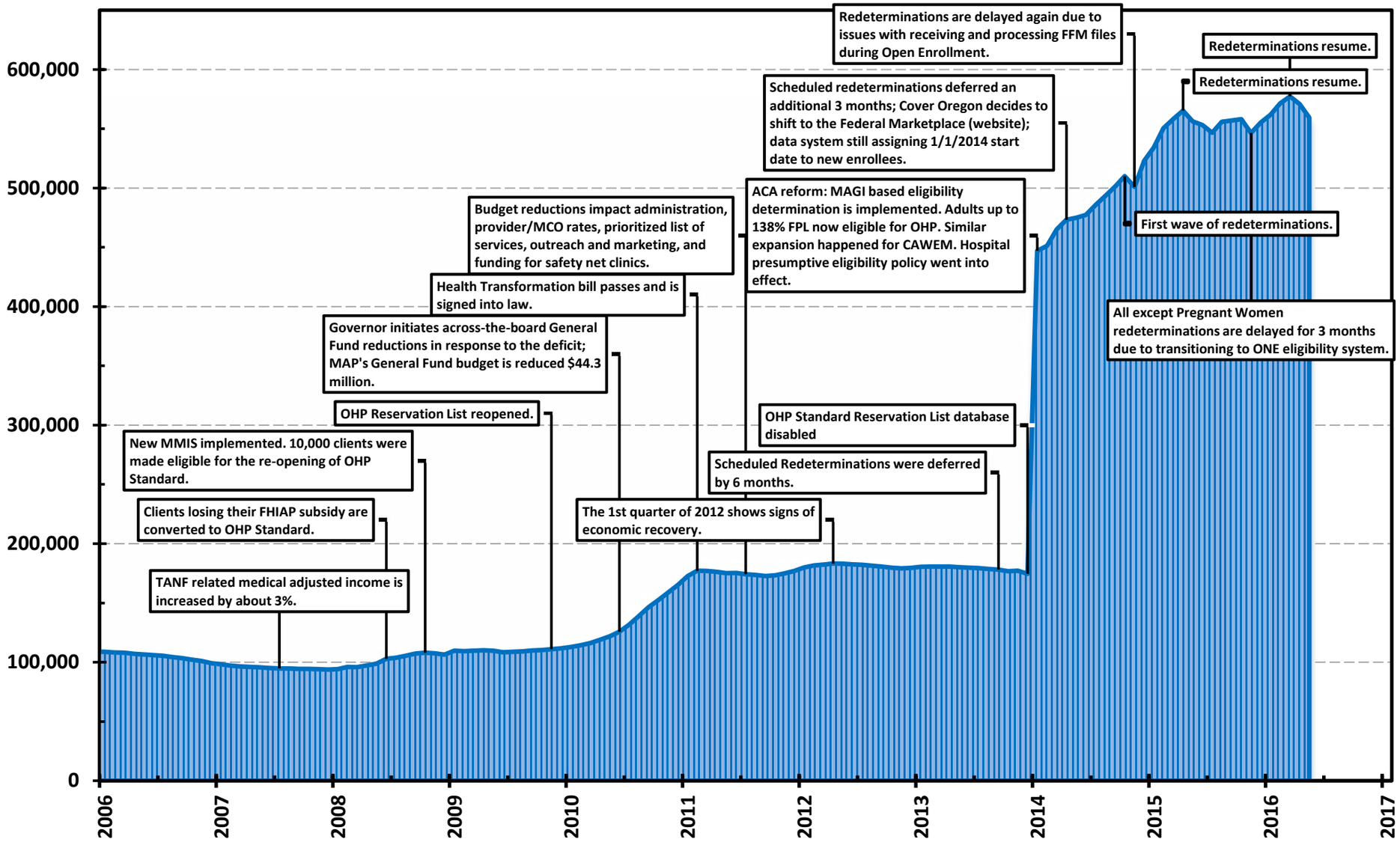
Clients can receive Post-Employment Services after employment if they need help keeping their job or advancing within it. Also, if they need assistance re-obtaining their job if it is lost.

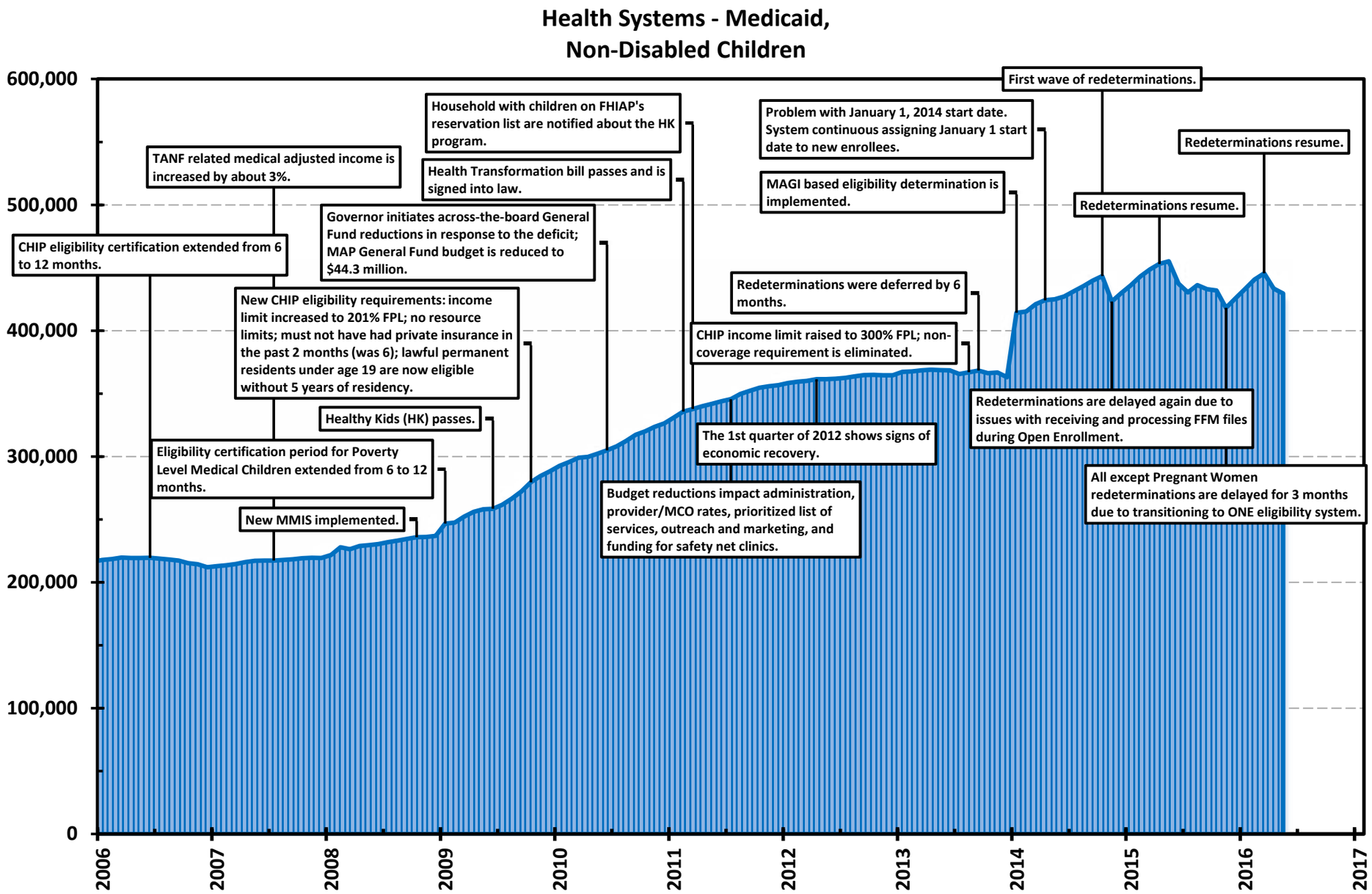
Appendix II
OHA Caseload History & Definitions

Health Systems - Medicaid,
Total Oregon Health Plan - Plus and Standard

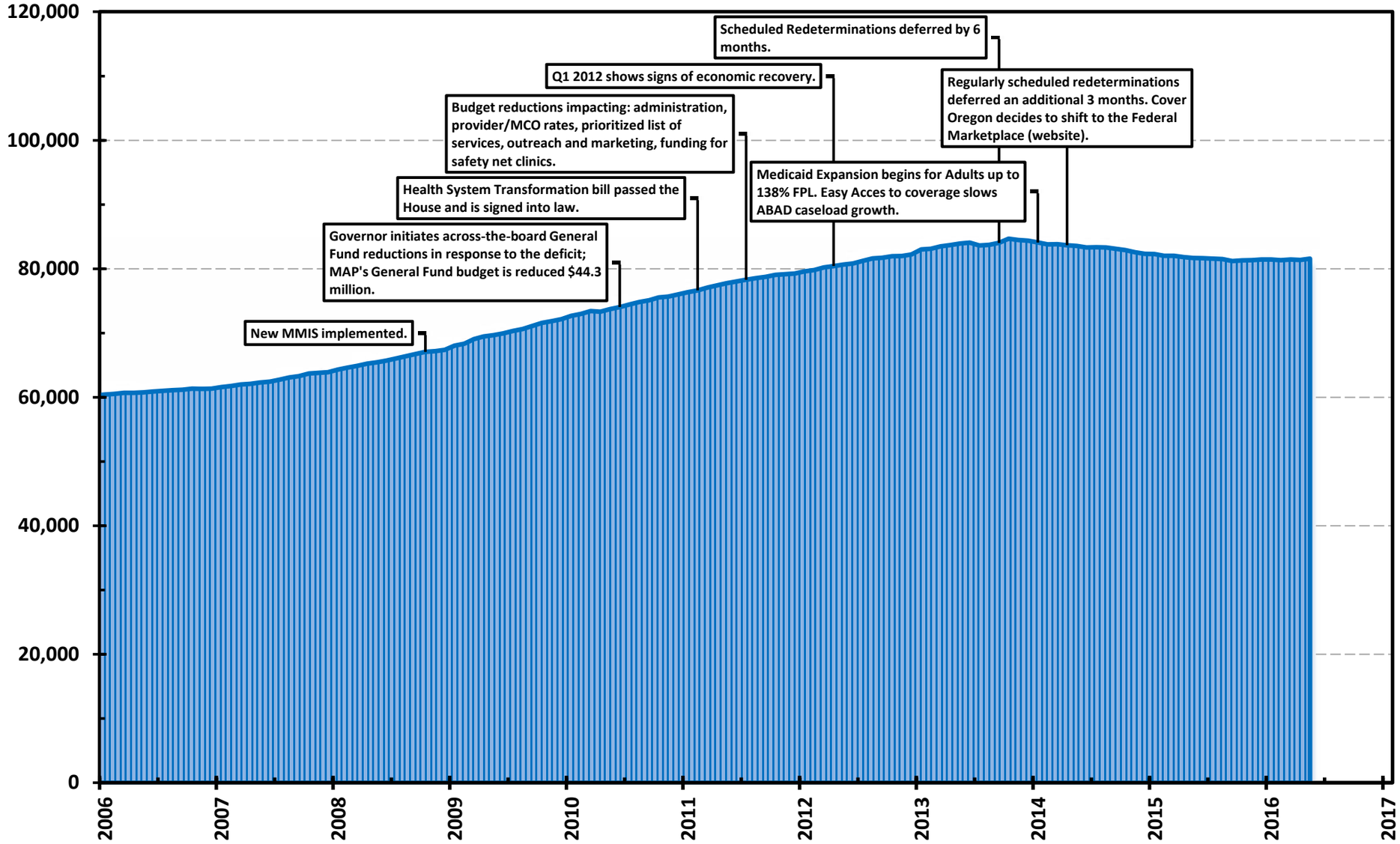


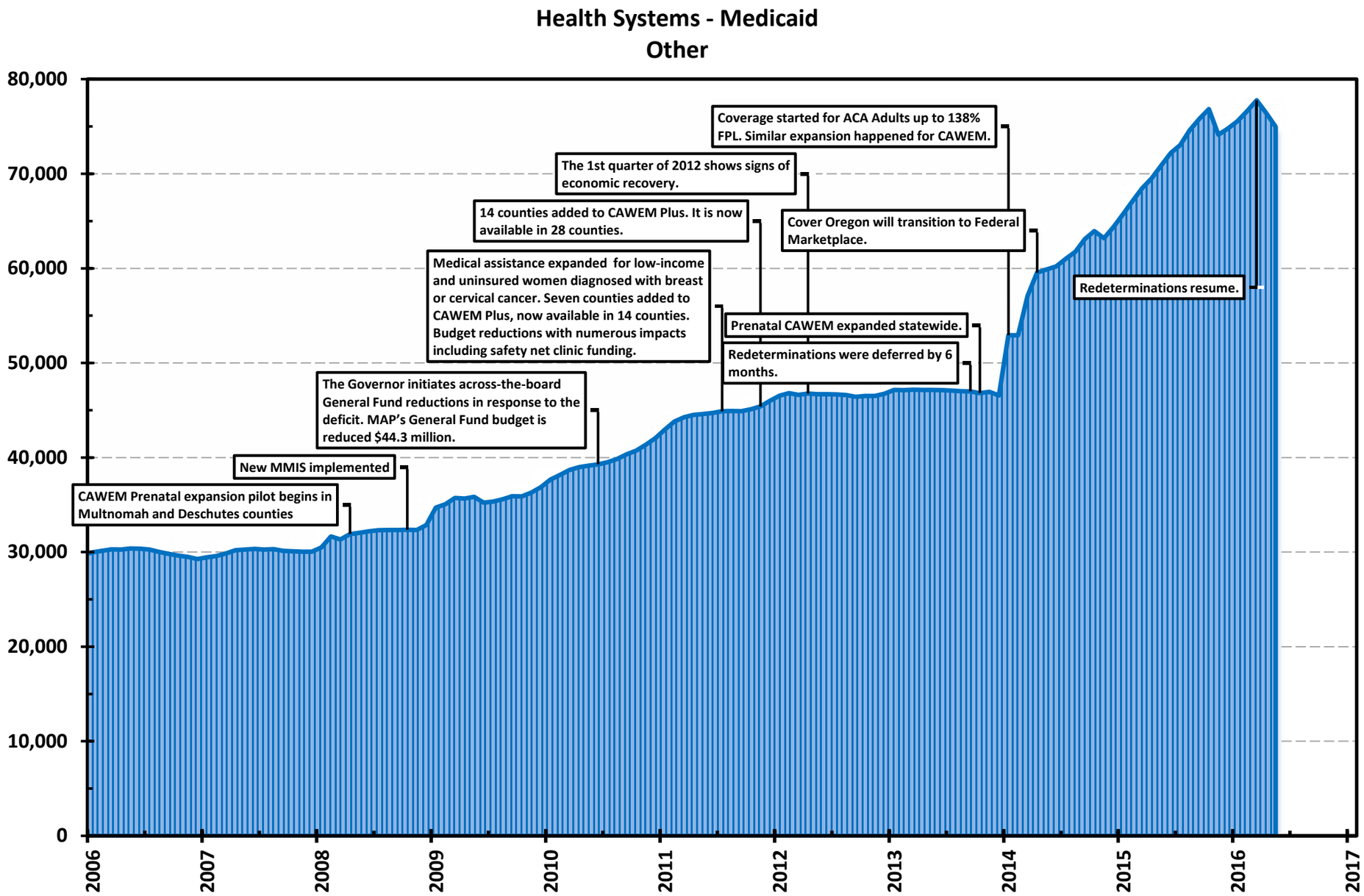
Health Systems - Medicaid, Non-Disabled Adults



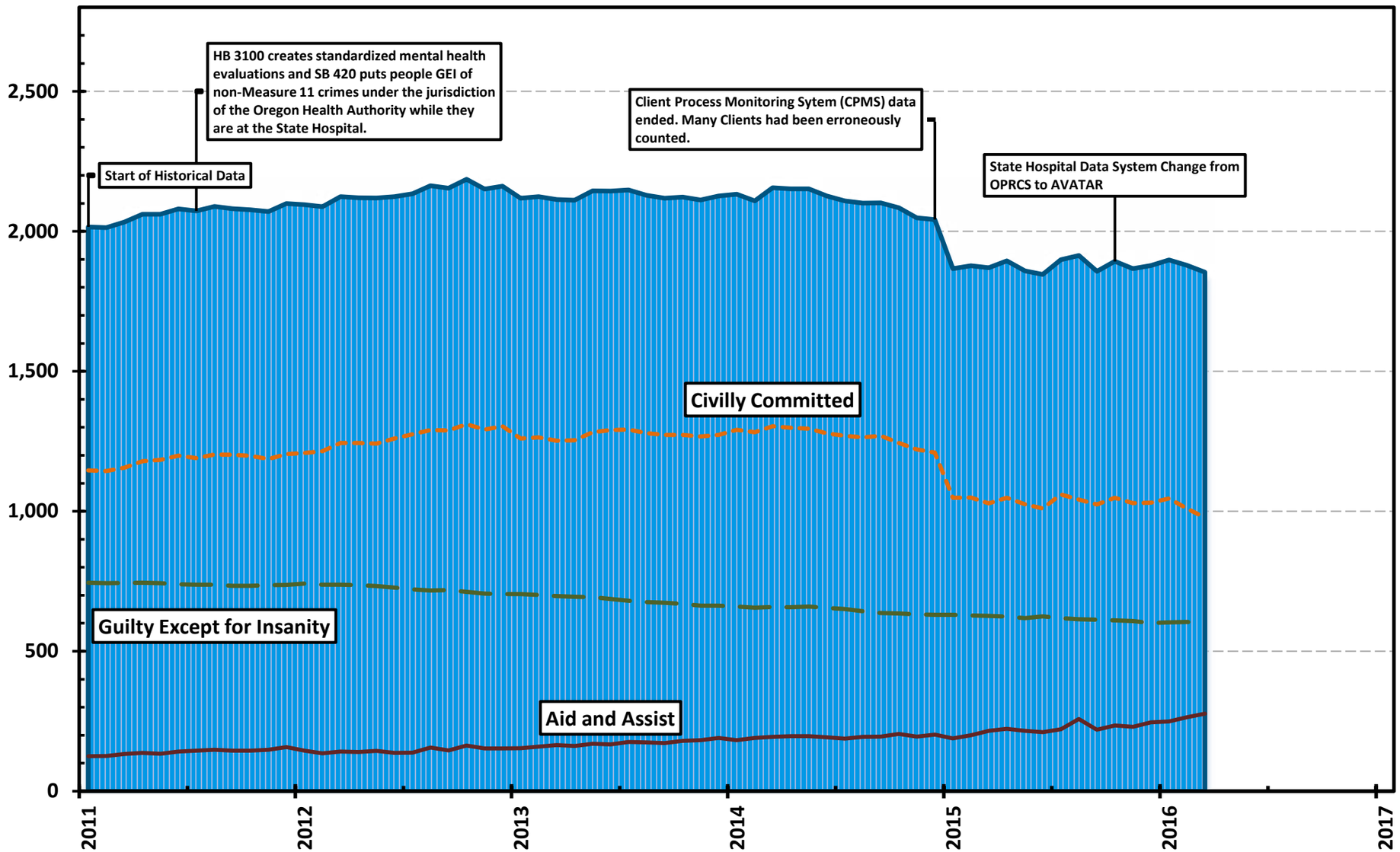

Health Systems - Medicaid,
Non-Disabled Children
600,000
500,000
400,000
300,000
200,000
100,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
First wave of redeterminations.
Household with children on FHIAP's reservation list are notified about the HK program.
Problem with January 1, 2014 start date. System continuous assigning January 1 start date to new enrollees.
Redeterminations resume.
TANF related medical adjusted income is increased by about 3%.
Health Transformation bill passes and is signed into law.
MAGI based eligibility determination is implemented.
Redeterminations resume.
Governor initiates across-the-board General Fund reductions in response to the deficit; MAP General Fund budget is reduced to $44.3 million.
CHIP eligibility certification extended from 6 to 12 months.
Redeterminations were deferred by 6 months.
New CHIP eligibility requirements: income limit increased to 201% FPL; no resource limits; must not have had private insurance in the past 2 months (was 6); lawful permanent residents under age 19 are now eligible without 5 years of residency.
CHIP income limit raised to 300% FPL; non-coverage requirement is eliminated.
Redeterminations are delayed again due to issues with receiving and processing FFM files during Open Enrollment.
Healthy Kids (HK) passes.
The 1st quarter of 2012 shows signs of economic recovery.
Eligibility certification period for Poverty Level Medical Children extended from 6 to 12 months.
Budget reductions impact administration, provider/MCO rates, prioritized list of services, outreach and marketing, and funding for safety net clinics.
All except Pregnant Women redeterminations are delayed for 3 months due to transitioning to ONE eligibility system.
New MMIS implemented.

Health Systems - Medicaid, Aid to the Blind and Disabled




Health Systems - Medicaid
Other
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
CAWEM Prenatal expansion pilot begins in Multnomah and Deschutes counties
New MMIS implemented
The Governor initiates across-the-board General Fund reductions in response to the deficit. MAP's General Fund budget is reduced $44.3 million.
Medical assistance expanded for low-income and uninsured women diagnosed with breast or cervical cancer. Seven counties added to CAWEM Plus, now available in 14 counties. Budget reductions with numerous impacts including safety net clinic funding.
14 counties added to CAWEM Plus. It is now available in 28 counties.
The 1st quarter of 2012 shows signs of economic recovery.
Coverage started for ACA Adults up to 138% FPL. Similar expansion happened for CAWEM.
Prenatal CAWEM expanded statewide.
Redeterminations were deferred by 6 months.
Cover Oregon will transition to Federal Marketplace.
Redeterminations resume.

Mental Health (MH):
Total Mandated Mental Health Caseload (Adults)



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6	$32,580
7	$36,730
8	$40,890

Health Systems - Medicaid (HSM)

The Health Systems Division coordinates physical, oral, and behavioral health services funded by Medicaid.

Historically, Medicaid programs were divided into three major categories based on benefit packages:

- Oregon Health Plan Plus (OHP Plus) – a basic benefit package.
- Oregon Health Plan Standard (OHP Standard) – a reduced set of benefits with additional premiums and co-payments for coverage.
- Other Medicaid – programs that provide medical benefits but are not considered part of OHP.

Starting in January 2014 there are only two major categories since OHP Standard was discontinued. At that time, all OHP Standard clients were moved to the new ACA Adults caseload group, where they became eligible for OHP Plus benefits.

OHP Plus Benefit Package

The OHP Plus package offers comprehensive health care services to adults and children who are eligible under Medicaid or CHIP rules. The new ACA Adults caseload also receives this benefit package.

ACA Adults

This is a new caseload which represents the expansion of Medicaid under the United States Federal Patient Protection and Affordable Care Act of 2010 (ACA). This caseload includes citizens 18 to 64 years old with incomes up to 138 percent of FPL, who are not pregnant or disabled. ACA Adults are currently divided into two subcategories: ACA Adults with Children, and ACA Adults without Children. In the future, the subcategories may be changed to age cohorts.

Pregnant Women

This is the new name for Poverty Level Medical Women (PLMW).

This program provides medical coverage to pregnant women with income levels up to 185 percent of the FPL. Coverage is extended for 60 days after childbirth.

Parent/Caretaker Relative

This is a new caseload comprised of adults who would previously have been included in the Temporary Assistance for Needy Families caseloads (TANF Related Medical and TANF Extended). Parent/Caretaker Relative offers OHP Plus medical coverage to adults with children who have incomes not exceeding approximately 42 percent of Federal Poverty Level (FPL).

Temporary Assistance for Needy Families (TANF)

Clients from this caseload were transferred to two other caseloads: adults were transferred into Parent/Caretaker Relative caseload and children - into Children's Medicaid caseload.

Children's Medicaid

The Children's Medicaid offers OHP Plus medical coverage to children from birth through age 18 living in households with income from 0 to 133 percent of Federal Poverty Level (FPL). This is a new caseload comprised of children who would previously have been included in three other caseloads: children from the Poverty Level Medical Children caseload (PLMC), children from the TANF Medical caseloads (TANF-RM, TANF-EX), and children from lower income CHIP households.

Poverty Level Medical Children (PLMC)

This caseload has been renamed to Children's Medicaid and the income rules were widened to include children previously included in other caseloads.

Children's Health Insurance Program (CHIP)

This caseload has been redefined. This caseload now covers uninsured children from birth through age 18 living in households with income from 134 to 300 percent of FPL.

Previously, this caseload covered children from households with income from 100 to 200 percent of FPL.

Foster, Substitute Care and Adoption Assistance

Foster, Substitute Care and Adoption Assistance provides medical coverage through Medicaid for children in foster or substitute care and children whose adoptive families are receiving adoption assistance services. Clients are served up to age 21, with the possibility of extending coverage to age 26 depending on client eligibility.

Aid to the Blind and Disabled Program (ABAD)

Aid to the Blind and Disabled provides medical coverage through Medicaid to individuals who are blind or disabled and eligible for federal Supplemental Security Income (SSI). The income limit is 100 percent of the SSI level (roughly 75 percent of FPL), unless the client also meets long-term care criteria, in which case the income limit rises to 300 percent of SSI (roughly 225 percent of FPL).

Old Age Assistance (OAA)

Old Age Assistance provides medical coverage through Medicaid for individuals who are age 65 or over and eligible for federal SSI.

OHP Standard Benefit Package (discontinued December 31, 2013)

This program has ended, with clients transferred to the new ACA Adults caseload. Prior to ACA, clients in OHP Standard were not eligible for traditional Medicaid programs. OHP Standard provided a reduced package of services compared to the OHP Plus program. OHP Standard also required participants to share some of the cost of their medical care through premiums and co-payments.

Other Medicaid (Non-OHP Benefit Packages)

Citizen/Alien Waived Emergent Medical (CAWEM)

Citizen/Alien Waived Emergent Medical is a program that covers emergent medical care for individuals who would qualify for Medicaid if they met the citizenship/residency requirements. The program has two subcategories:

- Regular (CAWEM CW) which provides only emergency medical care.
- Plus (CAWEM CX) which also covers all pre-natal medical services (plus up to 2 months postpartum).

Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary clients meet the criteria for both Medicare and Medicaid participation. Clients in this caseload have incomes from 100 percent of SSI (roughly 75 percent of FPL) to 100 percent of FPL, and do not meet the criteria for medical covered long-term care services. OHA pays for any Medicare Part A and Part B premiums as well as any applicable Medicare coinsurance and/or deductible not exceeding the Department's fee schedule.

Breast and Cervical Cancer Treatment Program (BCCTP)

Historically, BCCTP provided medical benefits for women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer Program administered by Public Health through county health departments and tribal health clinics. Effective January 1, 2012, women do not need to be enrolled for screening through the Breast and Cervical Cancer Program in order to access BCCTP. After determining eligibility, the client receives full OHP Plus benefits. Clients are eligible until reaching the age of 65, obtaining other coverage, or ending treatment. This program is available for both citizens and non-citizens/aliens.

Medicare Part A/B Premium Assistance Programs

Medicare Part-A Premium Assistance

Medicare Part A covers *inpatient services*, such as inpatient stays and emergency visits. It is free for Medicare eligible individuals except for those who don't have sufficient work history. Thus, **Medicare Part-A Premium Assistance Program** is a subsidiary program offered by HSM to help low-income individuals (under 100 percent of FPL) to pay for the premiums when free Medicare coverage is not available due to insufficient work history.

Medicare Part B Premium Assistance

Medicare Part B coverage is for outpatient services, such as routine check-ups and physical therapy. Medicare eligible individuals have an option to subscribe, but they are required to pay a premium. **Medicare Part B Premium Assistance Program** offered by HSM is a subsidiary program available to low-income individuals (under 133 percent of FPL) and it pays for the premiums.

Part A and Part B Premium Assistance caseloads are not mutually exclusive. For the most part, those who receive Part A premium assistance also receive Part B premium assistance. Likewise, Medicare Part A/Part B premium assistance caseloads are not grouped under OHP or Other caseloads, because most of the individuals with Part A/Part B premium assistance have already been counted in one of our traditional Medicaid caseloads (OAA, ABAD, and QMB). There is a segment that is not in the traditional Medicaid caseloads. They are in Specified Low Income Medicare Beneficiary (SLIMB) or Qualified Individual (QI) groups that we track, but do not forecast . Lastly, there is a slight discrepancy in counts between people on the Medicaid caseload who have Medicare, and those who receive premium assistance.

Mental Health (MH)

The Mental Health program provides prevention and treatment options for clients with mental illnesses.

The MH caseload forecast is the total number of adult clients receiving government paid mental health services per month. MH provides both Mandated and Non-Mandated mental health services, some of which are residential.

Total Mandated Population

Mandated caseloads include both criminal commitment and civil commitment caseloads. Mandated populations are required to receive mental health services by Oregon law through community settings and State Hospitals. The State Hospitals provide 24-hour supervised care to people with the most severe mental health disorders, many of whom have been committed because they are a danger to themselves or others, including people who have been found guilty except for insanity.

Aid and Assist - State Hospital

Criminal Aid and Assist (or "Fitness to Proceed") caseload serves clients who have been charged with a crime and are placed in the Oregon State Hospital for psychiatric assessment and treatment until they are fit to stand trial. “Fitness to Proceed” means that the client is able to assist the attorney and stand trial.

Guilty Except for Insanity (GEI)

Clients in GEI caseloads have been found “guilty except for insanity” of a crime by a court. The GEI caseload includes clients who are under the jurisdiction of the Psychiatric Security Review Board as well as clients at the State Hospital who are under the jurisdiction of the State Hospital Review Panel. OHA is required by Oregon law to provide treatment and supervision for these individuals, either in the community or in a State Hospital. Clients in this caseload receive a full range of counseling, medication, skills training and supports to assist their progress toward recovery.

Civil Commitment

This caseload includes individuals currently under commitment (although a proxy rule is currently being used to estimate the end date for clients’ mandated service). The Civilly Committed caseload includes people who are found through a civil court process to be dangerous to themselves and/or others or are unable to care for themselves as a result of mental illness, with the court mandating treatment for the individual. They may be served at the State Hospital or in the community.

Previously Committed

The Previously Committed caseload includes people who were previously either civilly or criminally committed but whose commitment period has ended. These clients continue to receive individual services, counseling, training, and/or living supports. About 80 percent of these clients are served in non-residential settings.

Never Committed

The Never Committed caseload includes people who have never been either civilly or criminally committed but who are receiving mental health services either in the community or in a residential setting. About 99 percent of these clients are served in non-residential settings. Clients in the State Hospital are of a voluntary or voluntary by guardian status.

This document can be provided upon request in alternate formats for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact Office of Forecasting Research and Analysis at 503-947-5185 or 503-378-2897 for TTY.

FALL 2016 DHS|OHA REGIONAL FORECASTS BY DISTRICT

Budget, Planning and Analysis
Office of Forecasting, Research and Analysis

DECEMBER 2016

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FALL 2016 DHS|OHA REGIONAL CASELOAD FORECAST

The Regional Forecast is designed to increase the Statewide Caseload Forecast's use as a tool for regional and local policy decisions by breaking down the Statewide Caseload Forecast into smaller geographic units. By developing a regional focus on caseloads and causal factors, we hope to support a wide range of local and community partners as they, in turn, support the diverse needs of Oregonians.

This forecast presents county biennial averages for each DHS service district, as well as district totals. The result is a forecast for all 36 Oregon counties for 15 different caseloads within the Oregon Department of Human Services and the Oregon Health Authority.

The results of the DHS and OHA statewide biennial forecasts are also included in this document in order to provide a contrast to the county and district forecast values. For more information, see the Fall 2016 DHS/OHA Caseload Forecast.

Care must be taken in interpreting some of this forecast's results. Because county-by-county values are presented, small numerical values are forecast and published. As the number of cases in a caseload shrinks, the possibility of forecasting error grows. In general, the forecasts presented here are designed to illustrate the general magnitude of caseloads and trends for each county. They are not presented to conform to a highly specific numerical target for caseloads through June 2019. This is especially true for counties with small populations where a modest increase in caseload represents a major percentage increase.

Changes to Forecasted Caseloads and Risks to Accuracy

Starting in January 2014, the Oregon Health Authority implemented several significant changes in how Medicaid is delivered due to the federal Patient Protection and Affordable Care Act of 2010 (ACA). The ACA mandates that eligibility for Medicaid caseloads be extended to higher income levels. As a result of this expansion, several programmatic changes occurred in Oregon Health Plan (OHP) Plus.

There are multiple unknowns at play when estimating participation in a new program and reformulating existing ones. Chief among them is the rate at which new clients will choose to take advantage of expanded eligibility. Another challenge is the fact that the historical patterns normally utilized for forecasting are disrupted and new patterns may take several years to emerge. The likelihood of forecast error, therefore, is larger than for established programs – particularly given the scale of change. Under these circumstances, error at the county level is magnified.

Changes in the economy are a persistent risk to the accuracy of all forecasted caseloads. The State of Oregon's Office of Economic Analysis has stopped using the term "full throttle growth" to describe the state of Oregon's economy. Employment is still expected to continue to grow in 2017, but in a less vigorous way than the previous two years. Growth is expected to moderate from mid-2017 through 2019 as baby-boomers retire. The influence of an expanding economy can in many ways be as difficult to predict as a recession. The economy of the Portland Metro area is expanding strongly, as it usually does in good times. In other parts of the state, expansion is more uneven. In some areas, expansion is modest at best. This is understandable given that different parts of the state have different economic and employment resources to draw on. These local differences add another level of risk to forecast accuracy at the county level.

Special Section

There is a two-part special section in this document that looks at the future of Long Term Care (LTC). The first section estimates the increase in LTC that will occur in the next 30 years based on demographics alone. The second half looks at variables other than demographics that can influence Long Term Care, such as average retirement income and the number of people age 50 and older on SNAP. The point of this section is not to create a Long Term forecast, but instead show how much demographics and other variables will influence LTC, especially in the next 15 years, when the number of seniors in Oregon will double.

Regional forecast methodology

Each forecast was developed using time series models; however, different methods were used for different programs based on goodness-of-fit. For the current forecast, several programs used the Statewide Forecast as an independent variable. This controlled for the inability of local time series models to detect the variation caused by the recession and recovery. However, it also means that, in the future, counties that do not follow the statewide trend could be distorted to match the expected statewide pattern. As patterns at the county level are better understood, forecasts will become more accurate.

Goodness-of-fit was determined for each program's forecast by summing the total county values and comparing the result to the official Statewide Forecast. Generally, if the Regional Forecast was within 5 percent of the Statewide Forecast, it was accepted as valid. There will be some inherent error because regional values used for the analysis will never total the exact amount of the statewide historic values. In addition, statewide forecasts use different forecast methods not available to the regional forecasts.

To avoid internal discrepancies, each forecast is apportioned to the official Statewide Forecast. Thus, the critical information from the regional forecast becomes the forecast direction of caseload change and the magnitude of change in comparison to the state as a whole.

Data from multiple sources were used in order to interpret the forecast for each county and provide basic demographic and economic information. Information was included from:

- The U.S. Census Bureau, "American Community Survey" 5 year (2011-2015) estimates;
- The Oregon Employment Department's "Oregon Labor Market Information System," "Current Employment Statistics" and "Labor Force and Unemployment by Area" data, November, 2016;
- The Portland State University Population Research Center, "Population Estimates by Age Group (less than 18 Years, 18-64 Years, and 65 Years and Older)": July 1, 2013;
- Oregon Economic and Revenue Forecast December, 2016, Volume XXXVI, No.4.

The Furture of Long Term Care

Around the office we've been getting more and more questions about the impact of demographics on our caseloads – most especially the Long Term Care caseload. "Long Term Care" is the broad term for aid to people with rather severe disabilities that qualify them for nursing facility care. Not everyone finds a nursing home desirable, however. A lot of people in Long Term Care are receiving services in their own homes; others are in settings like adult foster care. When we get questions about the relationship between demographics and Long Term Care, it's always with the assumption that age-related disabilities drives the caseload. That requires a "yes, but…" kind of answer. First, a third of all people in Long Term Care are non-elderly – that is, they are under age 65 (see Table 1). So age-related disabilities only drives a portion of this caseload. Second, the number of people in care through the Department of Human Services is a portion of the overall number of people who receive Long Term Care. According to the Census Bureau, over 140,000 Oregonians reported "self-care difficulty."[1] Although that's an imperfect measure of the number of people who need Long Term Care, it is indicative of the fact that our agency provides services to the disabled and needy – a subset of a larger population.

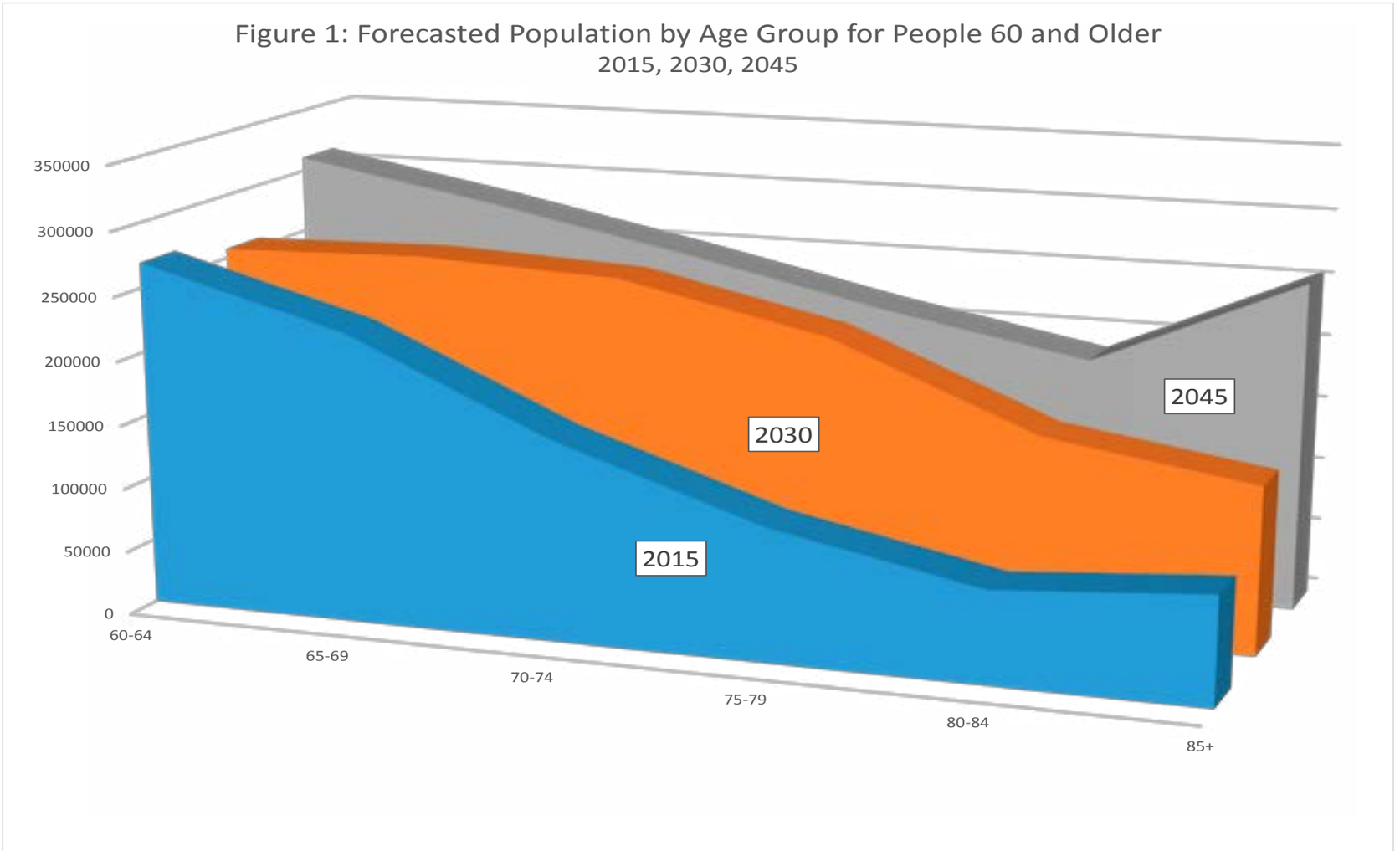
Table 1: Long Term Care Average Monthly Caseload, 2015

Age Group	Count	Percent
Under 50	3,383	10.2%
50-64	8,106	24.4%
65-74	7,817	23.5%
75-79	3,704	11.1%
80-84	3,629	10.9%
85+	6,646	20.0%
TOTAL	33,286	100.0%

The third thing to keep in mind is that there is no consensus as to the relative health of people who are currently moving toward old age. Some data suggests they will be healthier than ever before, others suggest they will be quite unhealthy. For example, baby boomers are 50% less likely to smoke than previous generations, while they are 55% more likely to have diabetes.[2]

Regardless of health status in their senior years, the fact remains that the number of seniors will grow a great deal in the next 15 years, to an unprecedented level. Figure 1 shows the forecasted demographic change for Oregonians over age 60 in 2015, 2030, and 2045, taken from the state demographer's official long term forecast.[3]

1. American Community Survey five year estimate, 2011-2015.
2. United Health Foundation, "America's Health Rankings, a call for action for individuals and their communities, 2016 report" http://cdnfiles.americashealthrankings.org/SiteFiles/PressReleases/Final%20Report-Seniors-2016-Edition.pdf
3. See "Oregon's Long Termcounty population forecast, 2010-2050" and other demographic information for Oregon at http://www.oregon.gov/das/OEA/Pages/forecastdemographic.aspx



What is most obvious about this graphic is the "bulge" of people between ages 60 and 80 that the state will experience in 2030. These are baby boomers entering old age and "near old age." This phenomenal rise will continue to influence the demographics fifteen years later, in 2045, as the baby boom cohort exits their 70s. The spike in people over 80 seen at the far right of the graph in 2045 is a testament both to the size of the baby-boom cohort and to the expected longevity of people in old age. These two things coupled together will in essence permanently increase the size of Oregon's Long Term Care population.

These increases won't happen overnight. Figure 1 shows change in 15 year increments Demographic changes like this build up over time. Figure 2 shows the steady increase in the population of Oregonians entering their senior years.

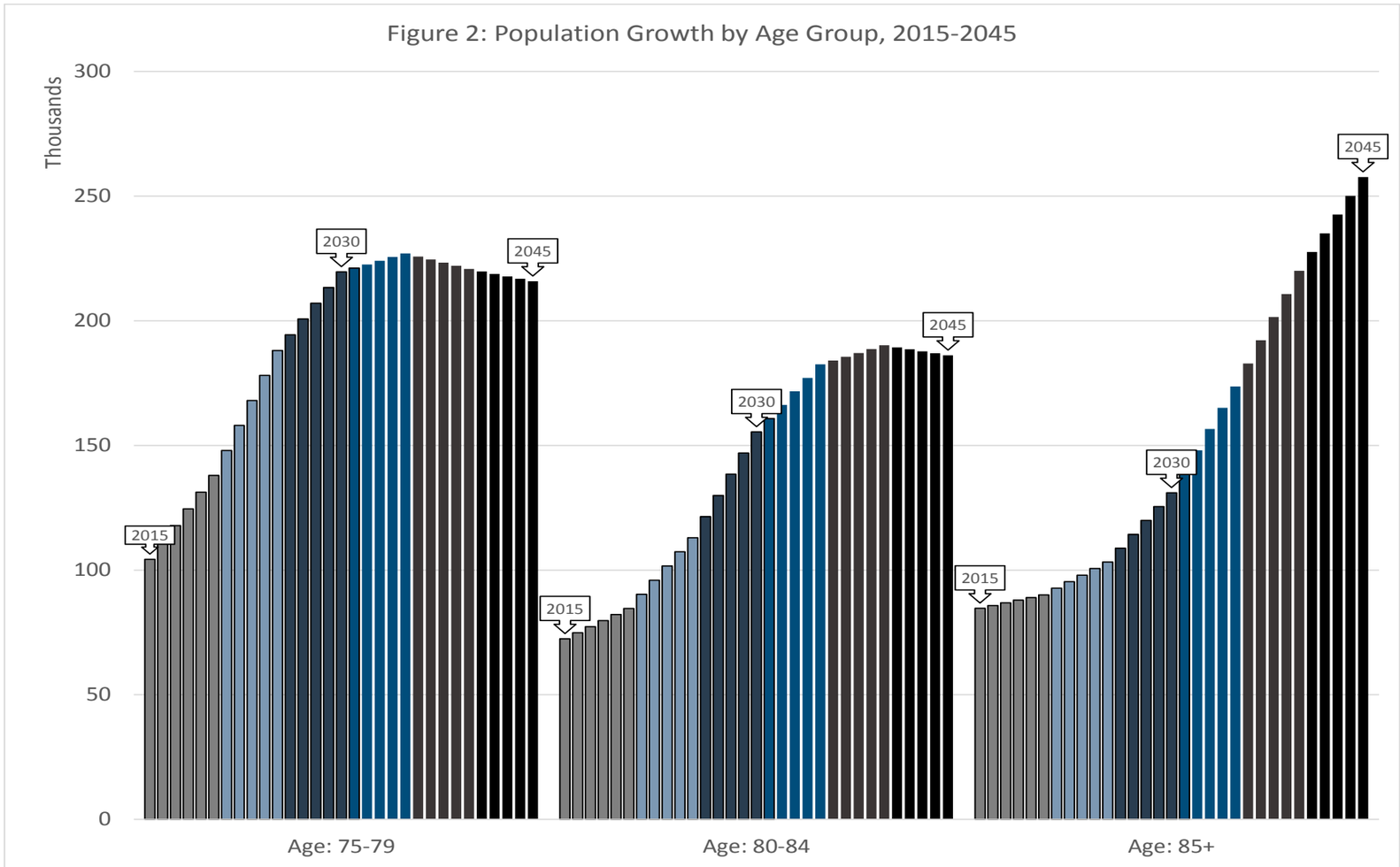


Figure 2 shows the steady growth of people between age 75 and 79, which will essentially double in size between 2015 and 2030. The same will happen for people between age 80 and 85, though on a smaller scale. By 2035, the increases for these two groups will plateau. Because we expect more and more Oregonians to live through this period of their lives, the 85 and older group will experience accelerated growth, especially after the year 2025. This growth will continue for the next 20 years.

This doubling of people in their senior years between now and 2030, and the looming challenges of caring for them as they become disabled, has been called "the 2030 problem" and is a problem for the whole country. How it looks in Oregon – based on what we know now – is the purpose of this special section.

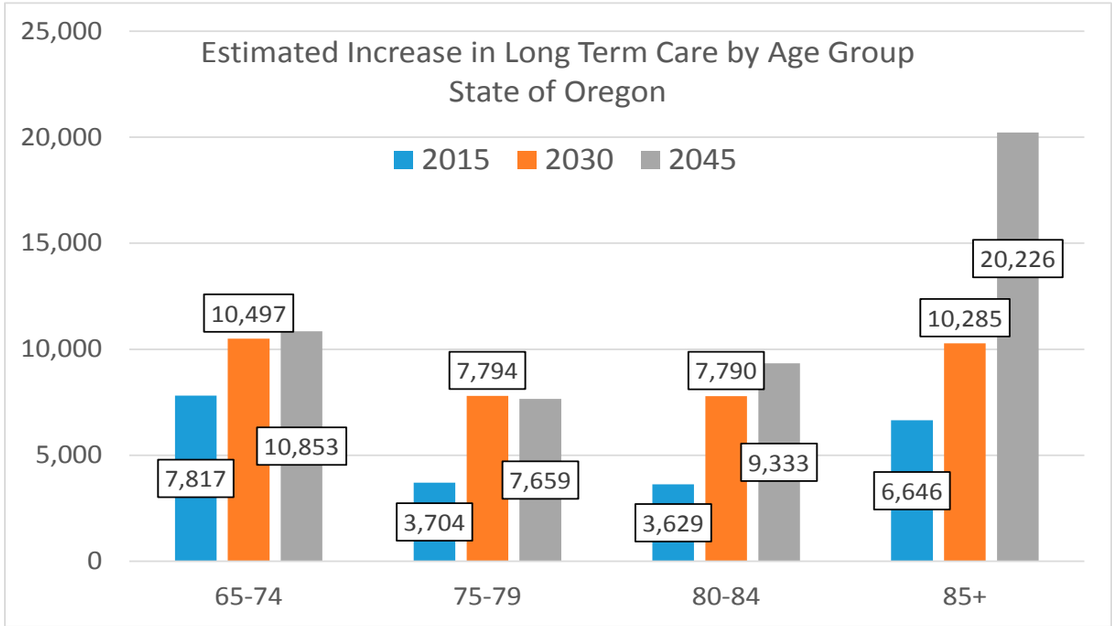
Long Term Forecasts for Long Term Care

The folly of engaging in Long Term forecasts is widely known – just look at the weather forecast. For short term forecasts, many of the variables that can influence the future are known and can be accounted for. Get farther out and everything becomes more unstable. In the world of Human Services, these issues are compounded. Public policy changes can influence the size of caseloads far more than demographics. Public policy isn't only just a matter of stated goals – what we may want to do based on our values or what we consider a priority – it's also a matter of money. What the economy does between now and 2045, and whether that will allow us the revenue to do the things we want to do for seniors in poverty is impossible to know. And that doesn't include the public policy and budget considerations of our federal partners. Still, it is important to show the scope of the "2030 problem,"[4] and one way to do that is by estimating (I won't even call it forecasting) the number of persons who will need Long Term Care as the number of seniors grows. It is also important to keep in mind that demographics in one part of the state are not the same as another part. So these estimates will be done at the county level.

The estimates presented here are based on the Long Term forecast of county population prepared by the Oregon Office of Economic Analysis in 2013. They assume that the proportion of the county (by age group) that are currently in long term care will remain the same, so that changes in long term care will be purely demographic-driven. This estimate only includes the persons we might expect to see in DHS-compensated Long Term Care, not the total population of persons in care (in other words, it doesn't include long term care that is privately paid). All the estimates are based on the average monthly caseload for each county in the year 2015.

Figure 3 shows the estimated increases in DHS Long Term Care by age group, isolating people age 65 and older. The total estimate (including all age groups) shows an increase in the caseload from 33,286 in 2015 to 48,329 in 2030. That's an increase of 45 percent. A large increase, but not the doubling that we're expecting of seniors overall.

4. See Knickman JR and Snell, EK (2002) The 2030 Problem: Caring for Aging Baby Boomers. Health Services Research, 37(4): 849-884.



The number of people in Long Term Care will double among people between age 75 and 84; but that's only a subset of all the people in Long Term Care. Because other age groups will grow much more slowly, the growth in LTC won't be as dramatic as the growth of seniors in Oregon overall. By 2045, the number of people in LTC is expected to reach 62,392 – almost doubling the number in 2015. Put another way, although the number of seniors will double in Oregon between 2015 and 2030, it will take an additional 15 years for the Long Term Care population to double.

On the following pages, county-based estimates are shown for the expansion of Long Term Care in 2030 and 2045, for people aged 65 and over. It does not include estimates for counties whose Long Term Care caseload never exceeds 100 cases. Very small counts are even more prone to inaccuracy than the ones presented, so I shied away from producing them. The map also includes the percent increase in long term care (overall, regardless of age) from 2015 to 2030.

For more information on the regional forecast, contact:

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Regional Forecaster

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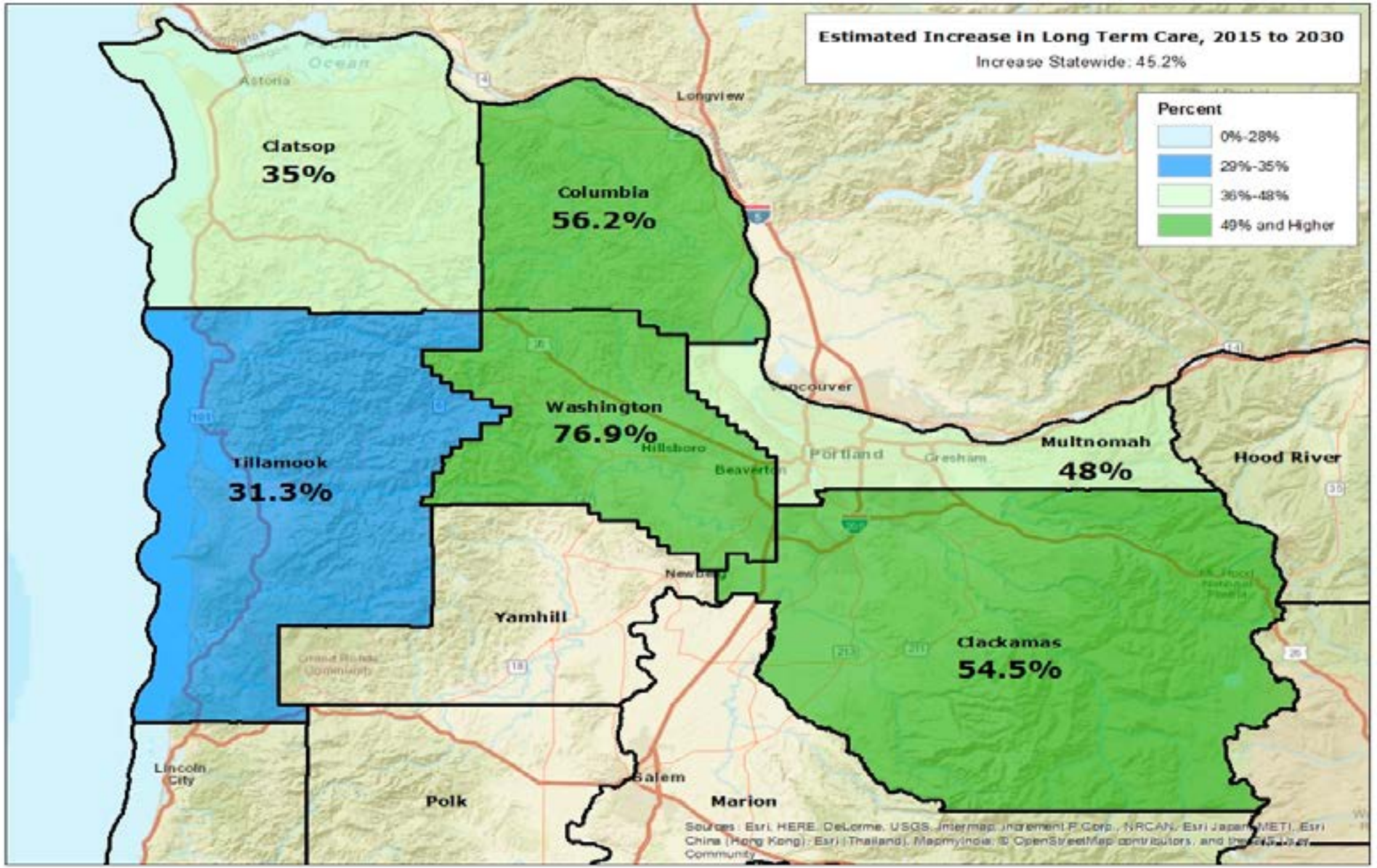
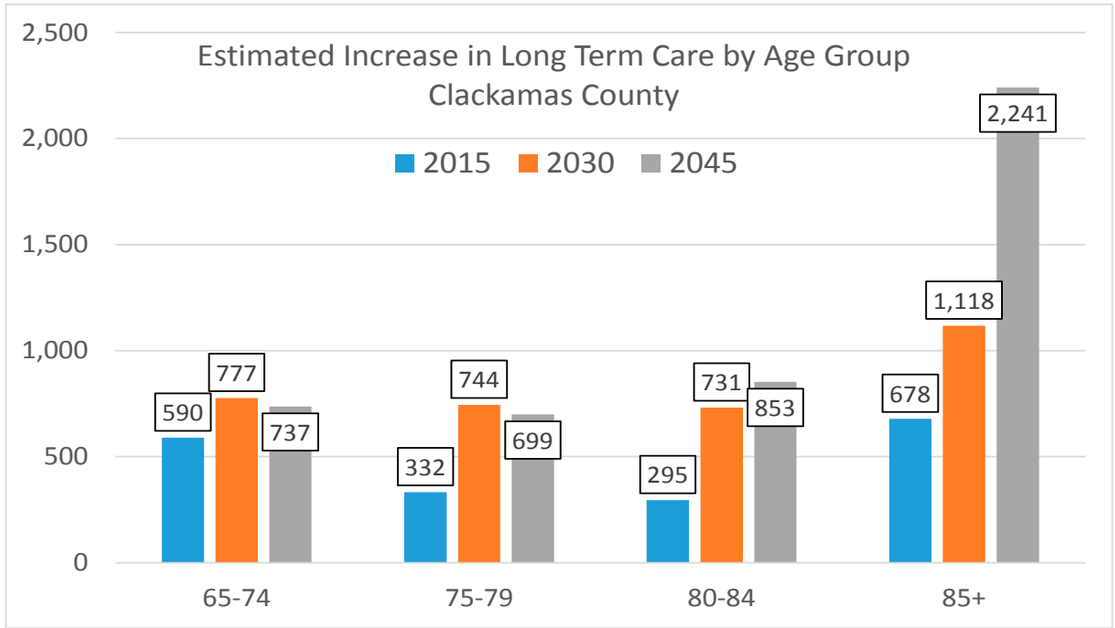
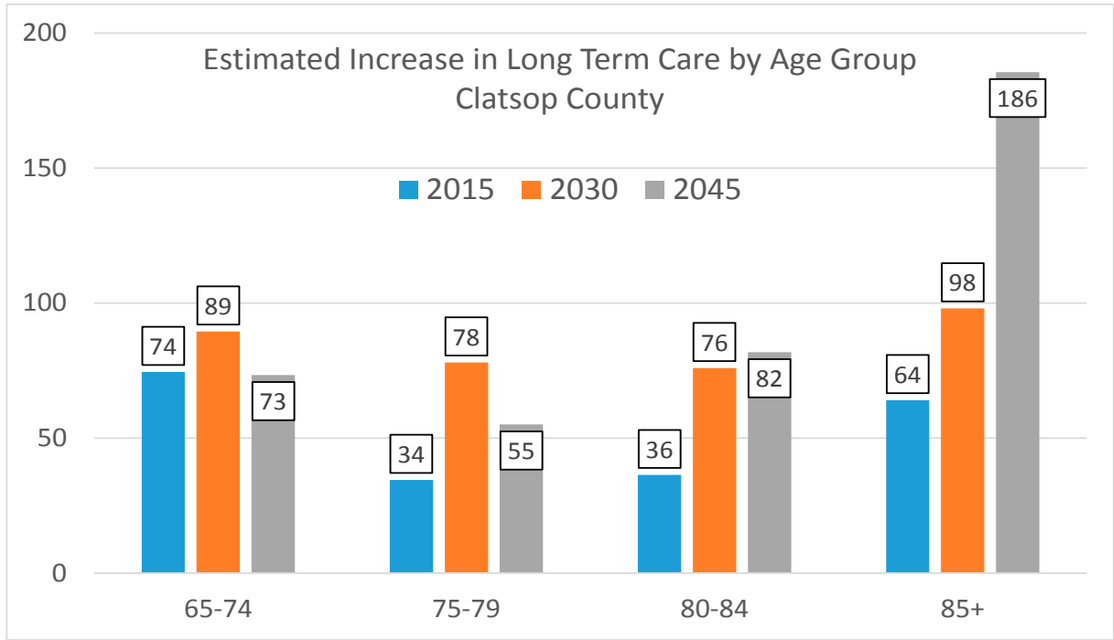
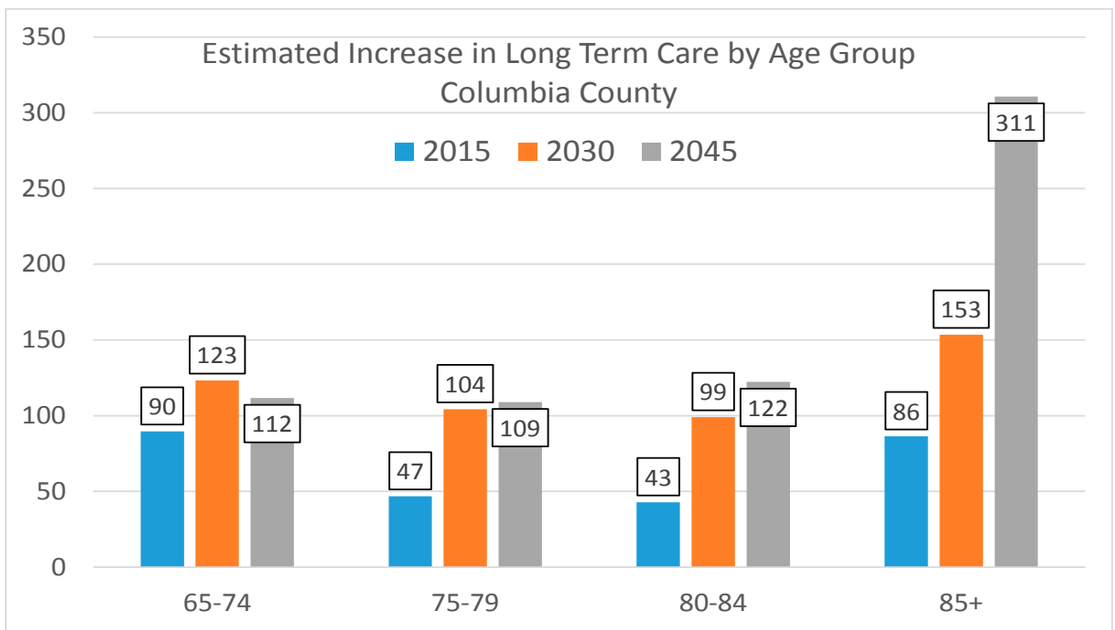
503-945-6239

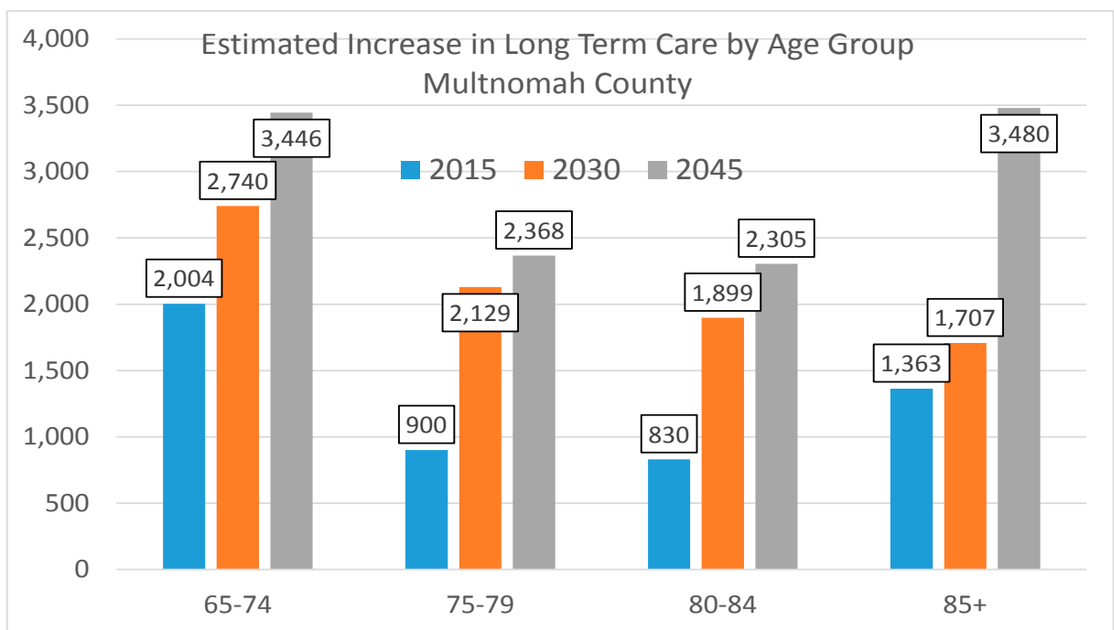
Estimated Increase in Long Term Care by County, Northwestern Oregon

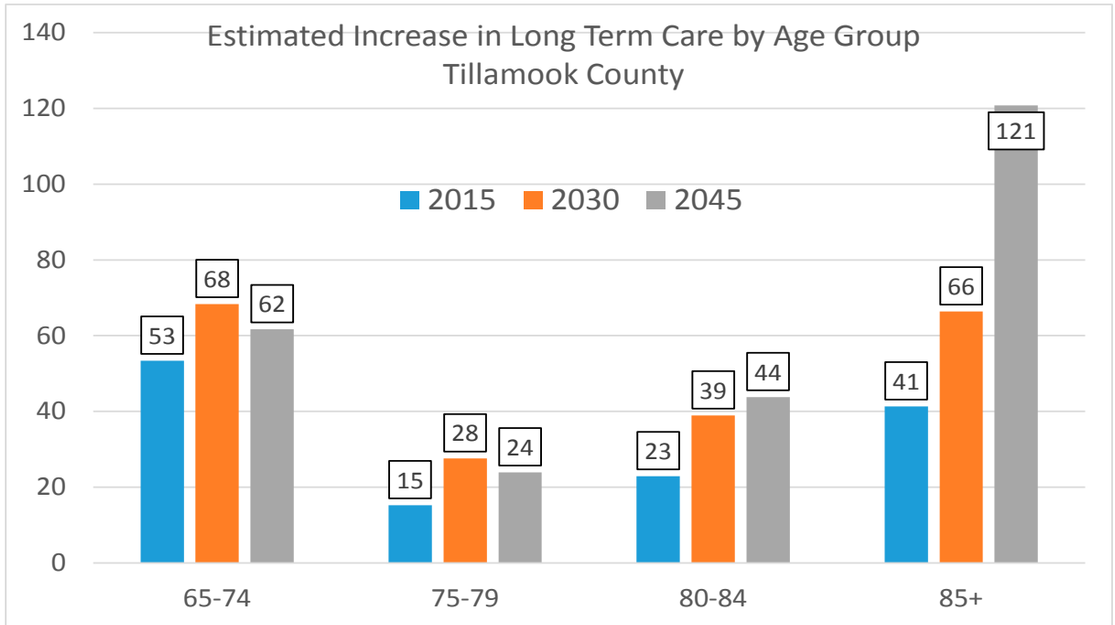


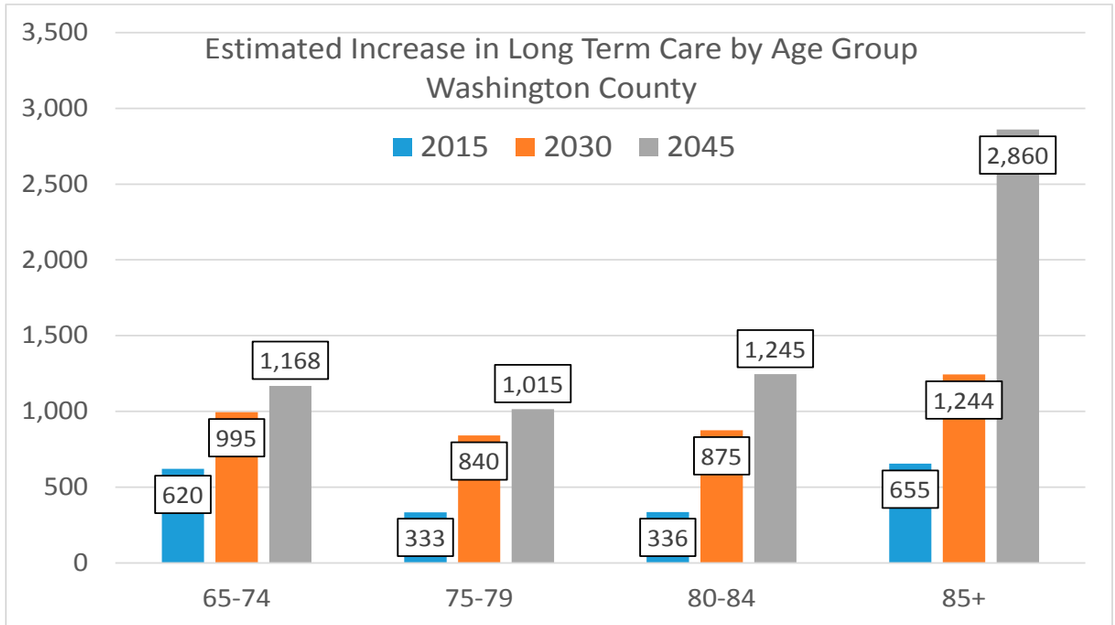

Estimated Increase in Long Term Care by Age Group
Clackamas County
2015
2030
2045
2,500
2,000
1,500
1,000
500
0
590
777
737
332
744
699
295
731
853
678
1,118
2,241
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Clatsop County
2015
2030
2045
200
150
100
50
0
74
89
73
34
78
55
36
76
82
64
98
186
65-74
75-79
80-84
85+

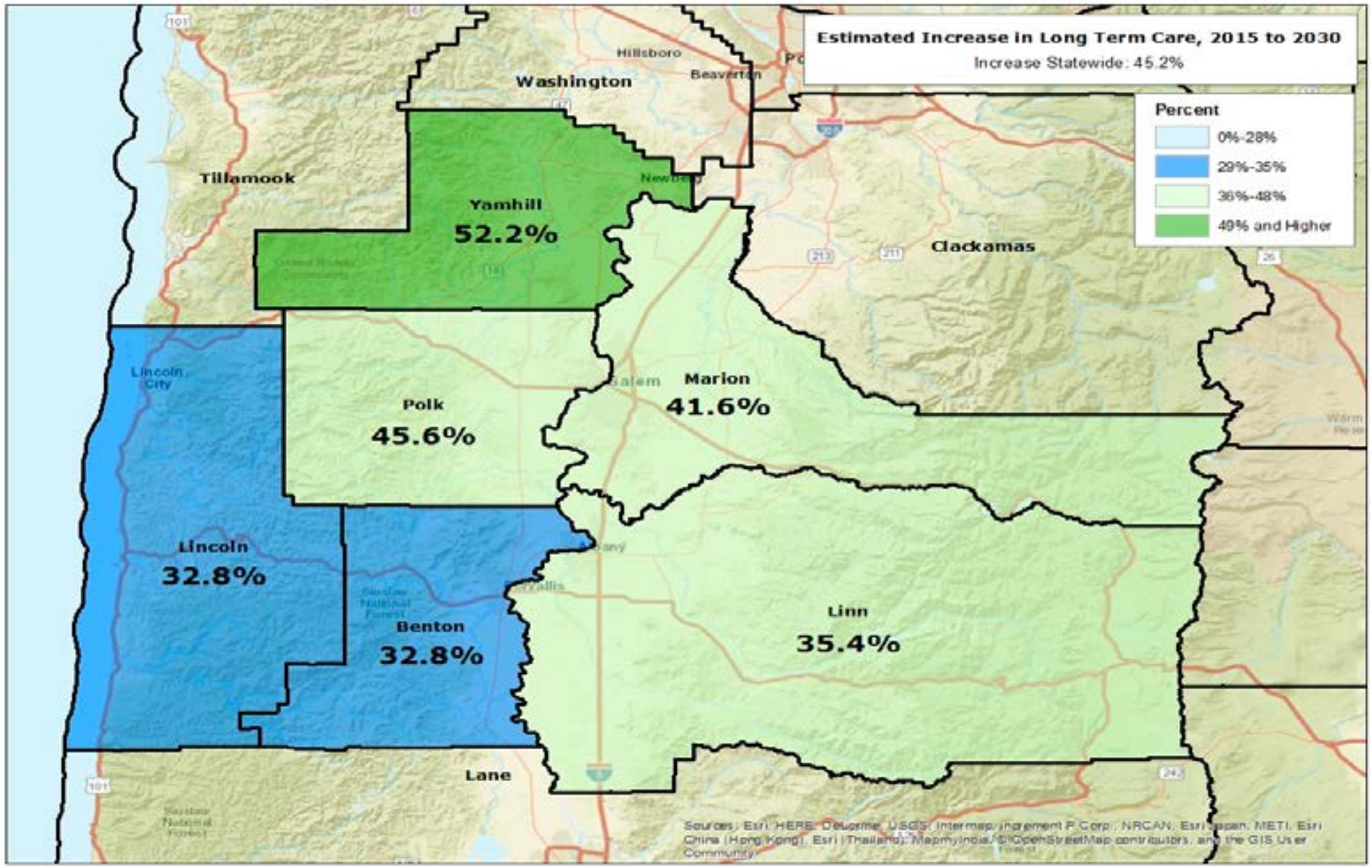

Estimated Increase in Long Term Care by Age Group
Columbia County
2015
2030
2045
350
300
250
200
150
100
50
0
90
123
112
47
104
109
43
99
122
86
153
311
65-74
75-79
80-84
85+

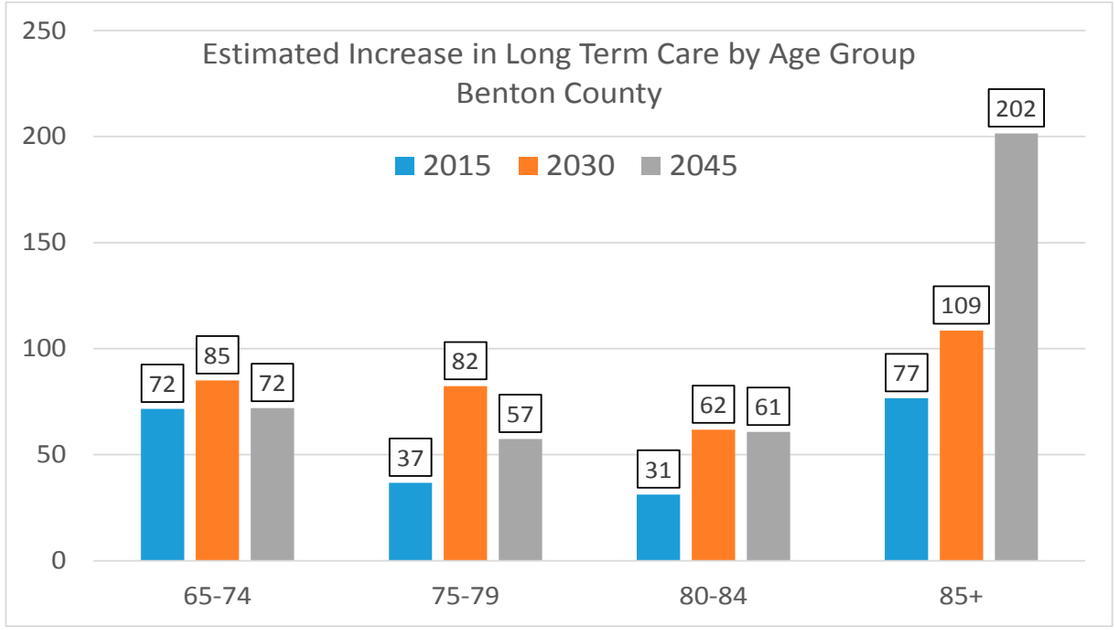

Estimated Increase in Long Term Care by Age Group
Multnomah County
2015
2030
2045
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2,004
2,740
3,446
900
2,129
2,368
830
1,899
2,305
1,363
1,707
3,480
65-74
75-79
80-84
85+

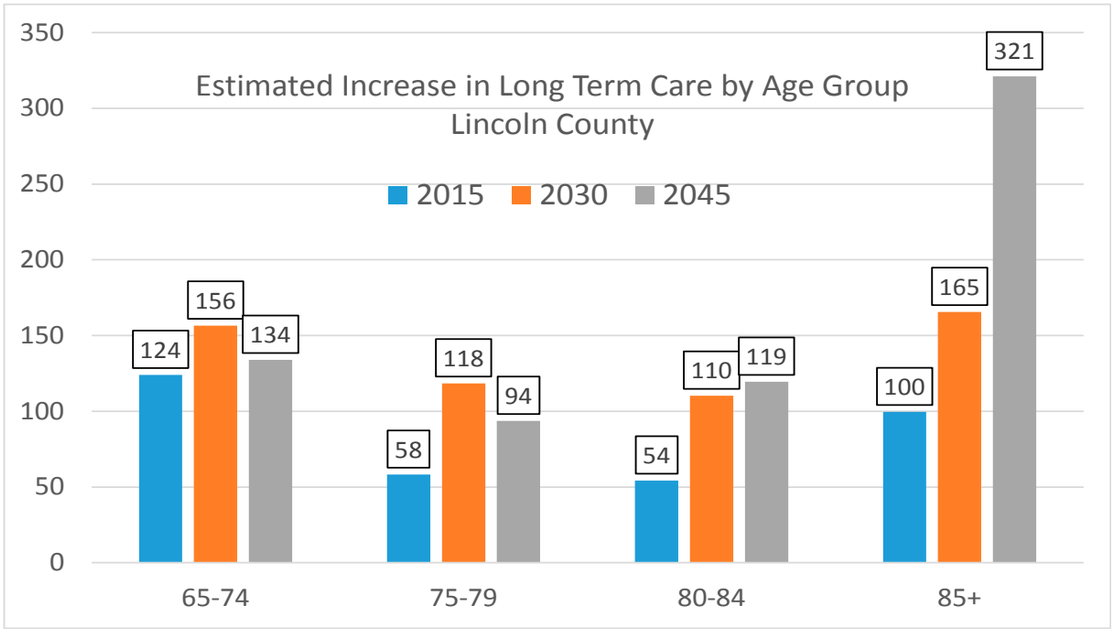

Estimated Increase in Long Term Care by Age Group
Tillamook County
2015
2030
2045
140
120
100
80
60
40
20
0
53
68
62
15
28
24
23
39
44
41
66
121
65-74
75-79
80-84
85+

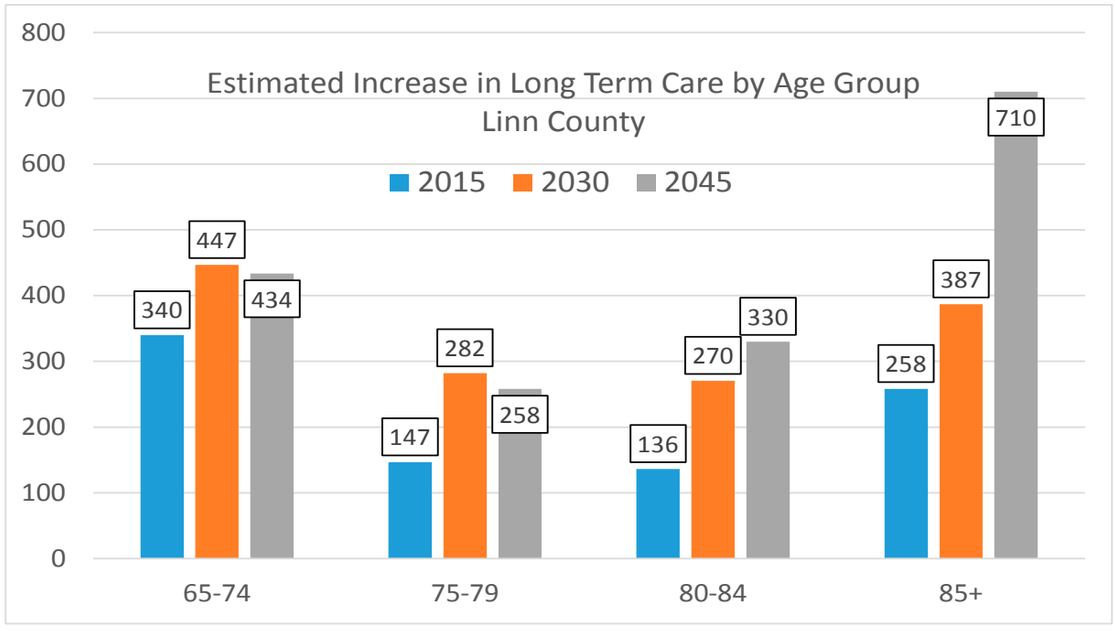

Estimated Increase in Long Term Care by Age Group
Washington County
2015
2030
2045
3,500
3,000
2,500
2,000
1,500
1,000
500
0
620
995
1,168
333
840
1,015
336
875
1,245
655
1,244
2,860
65-74
75-79
80-84
85+

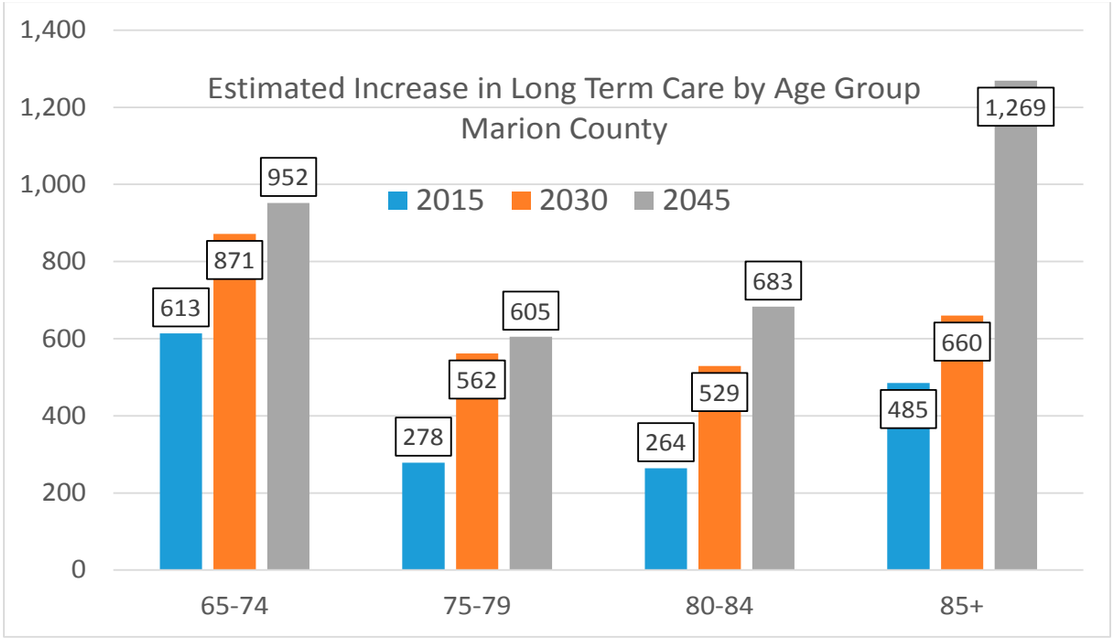
Estimated Increase in Long Term Care by County, Mid-Valley Region

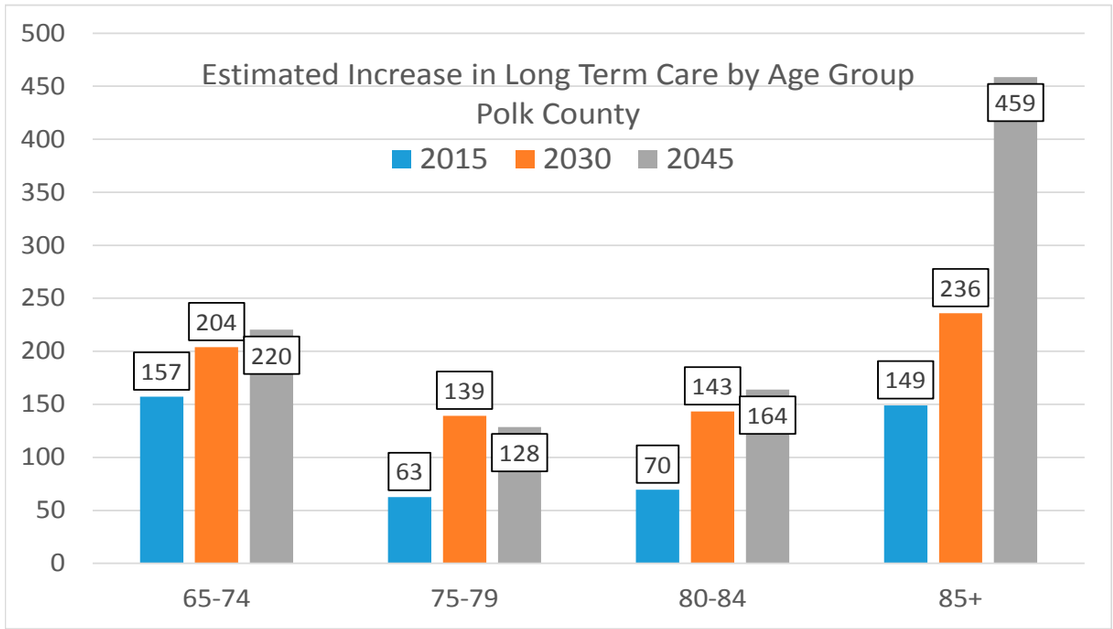


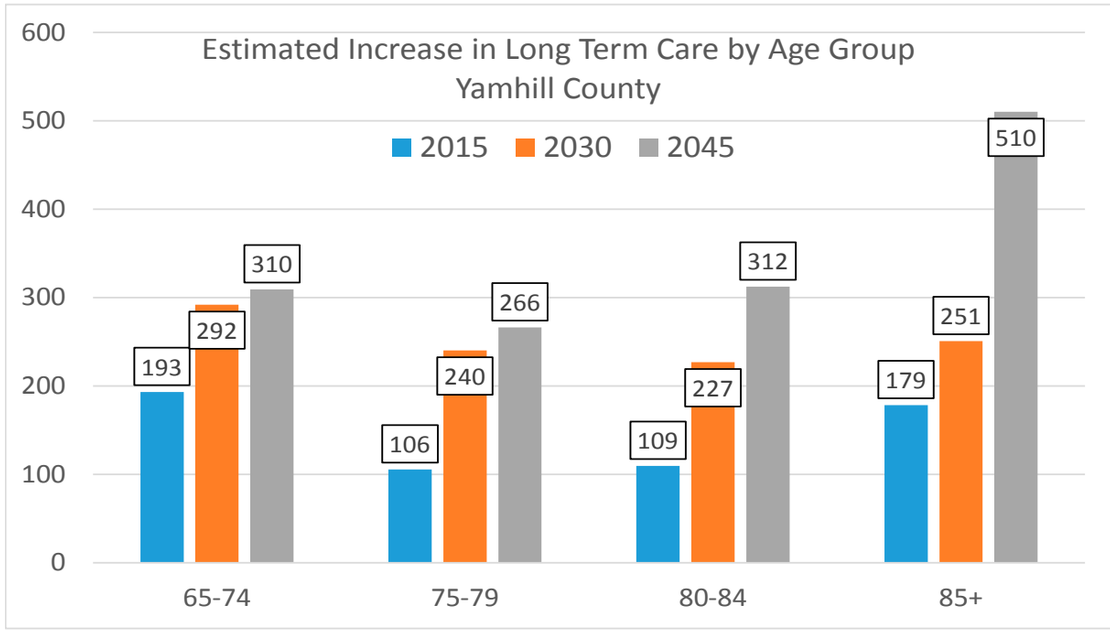

Estimated Increase in Long Term Care by Age Group
Benton County
2015
2030
2045
250
200
150
100
50
0
72
85
72
37
82
57
31
62
61
77
109
202
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Lincoln County
2015
2030
2045
350
300
250
200
150
100
50
0
124
156
134
58
118
94
54
110
119
100
165
321
65-74
75-79
80-84
85+

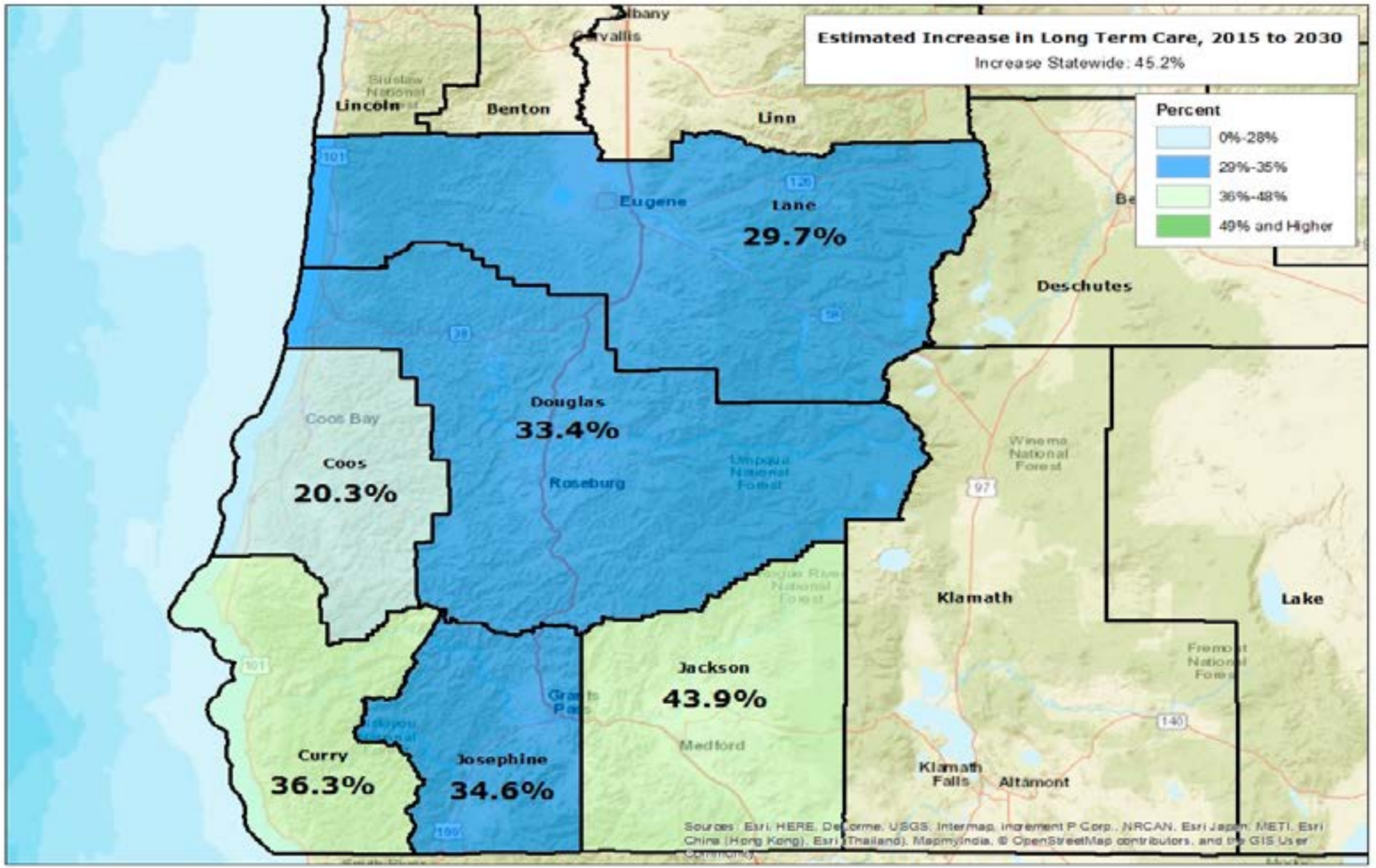

Estimated Increase in Long Term Care by Age Group
Linn County
2015
2030
2045
800
700
600
500
400
300
200
100
0
340
447
434
147
282
258
136
270
330
258
387
710
65-74
75-79
80-84
85+

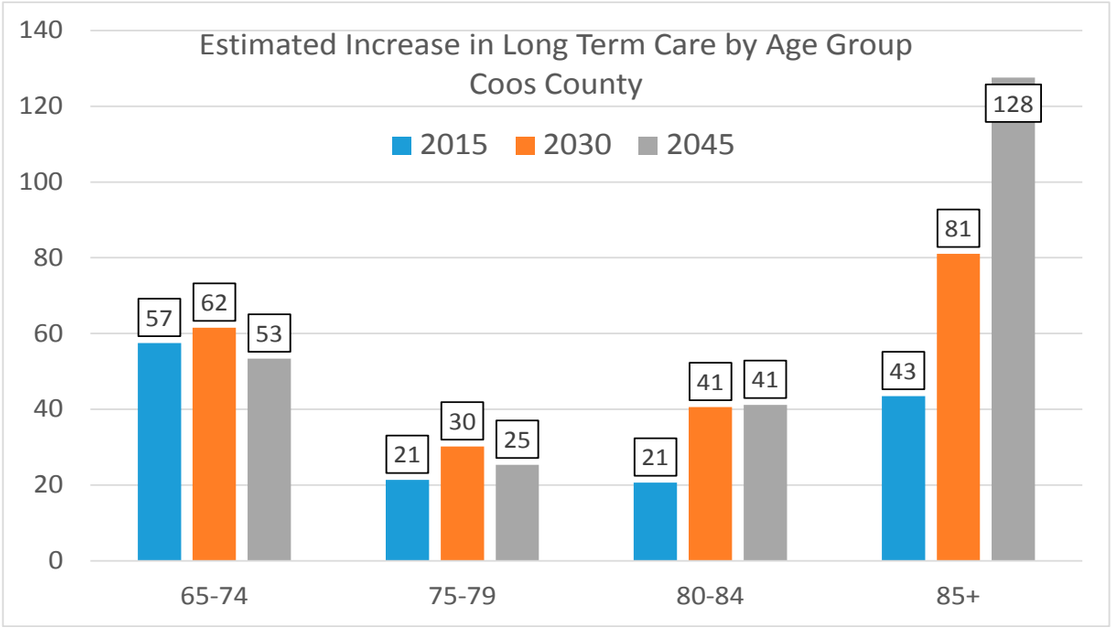

Estimated Increase in Long Term Care by Age Group
Marion County
2015
2030
2045
1,400
1,200
1,000
800
600
400
200
0
613
871
952
278
562
605
264
529
683
485
660
1,269
65-74
75-79
80-84
85+

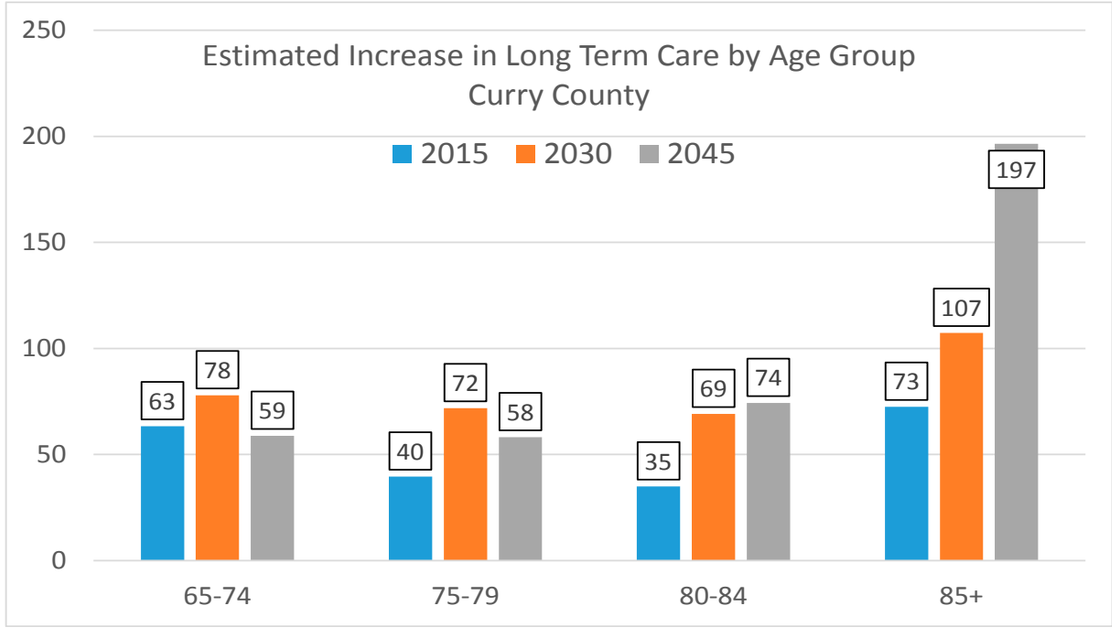

Estimated Increase in Long Term Care by Age Group
Polk County
2015
2030
2045
500
450
400
350
300
250
200
150
100
50
0
157
204
220
63
139
128
70
143
164
149
236
459
65-74
75-79
80-84
85+

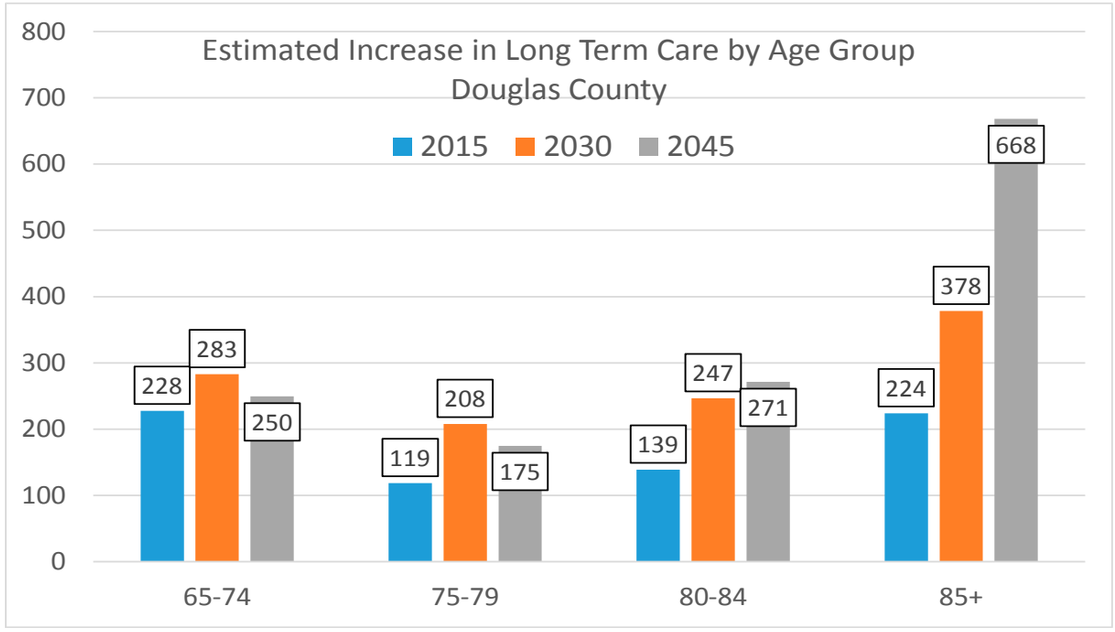

Estimated Increase in Long Term Care by Age Group
Yamhill County
2015
2030
2045
600
500
400
300
200
100
0
193
292
310
106
240
266
109
227
312
179
251
510
65-74
75-79
80-84
85+

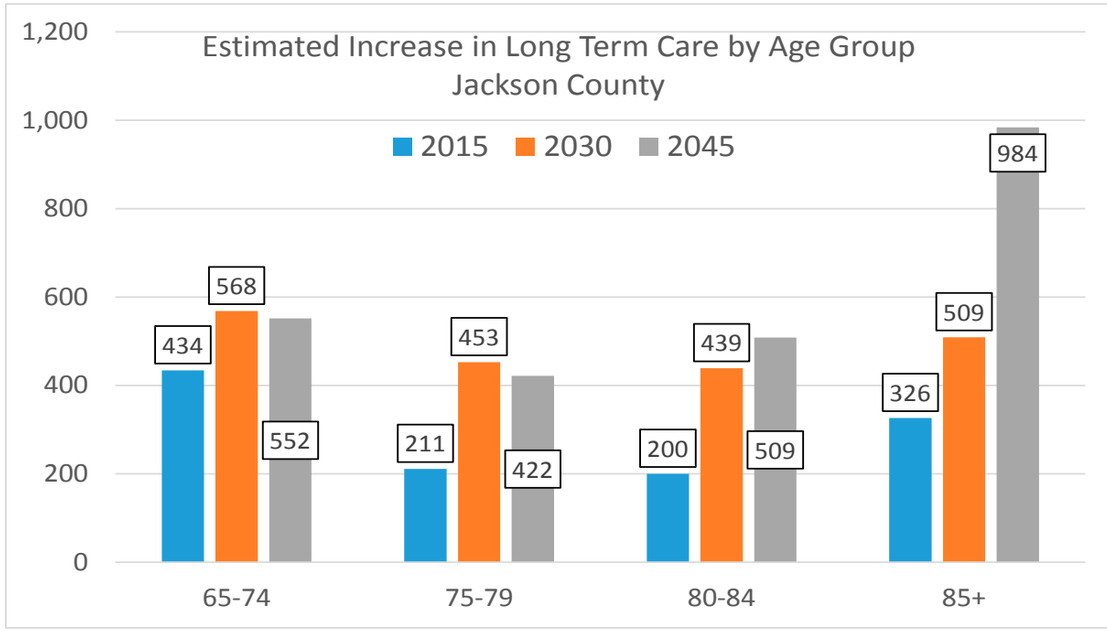
Estimated Increase in Long Term Care by County, Southwest Region

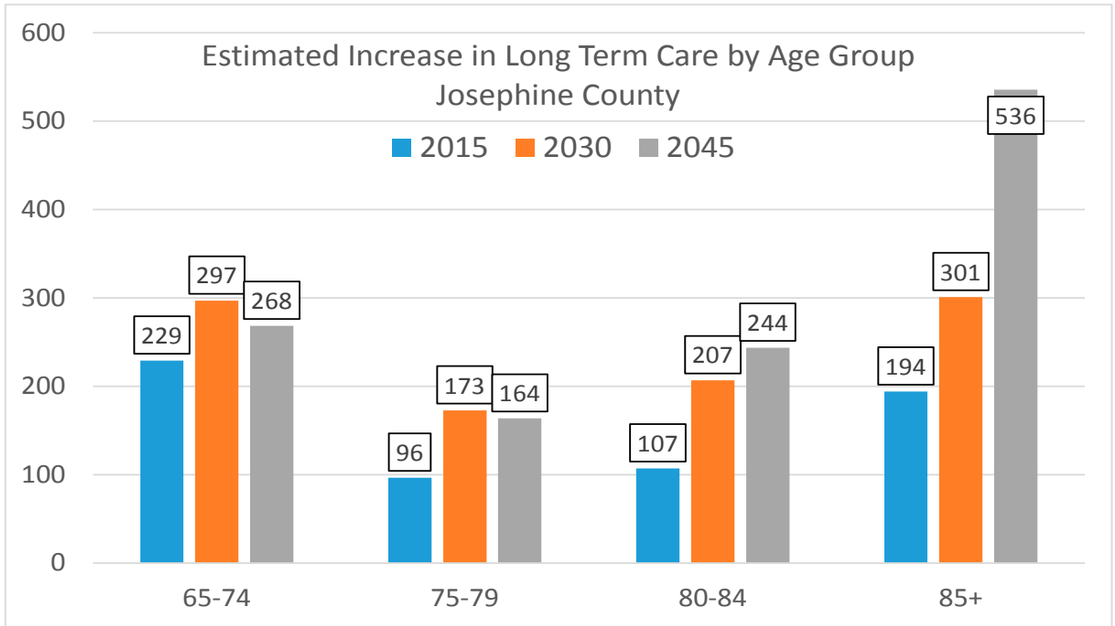


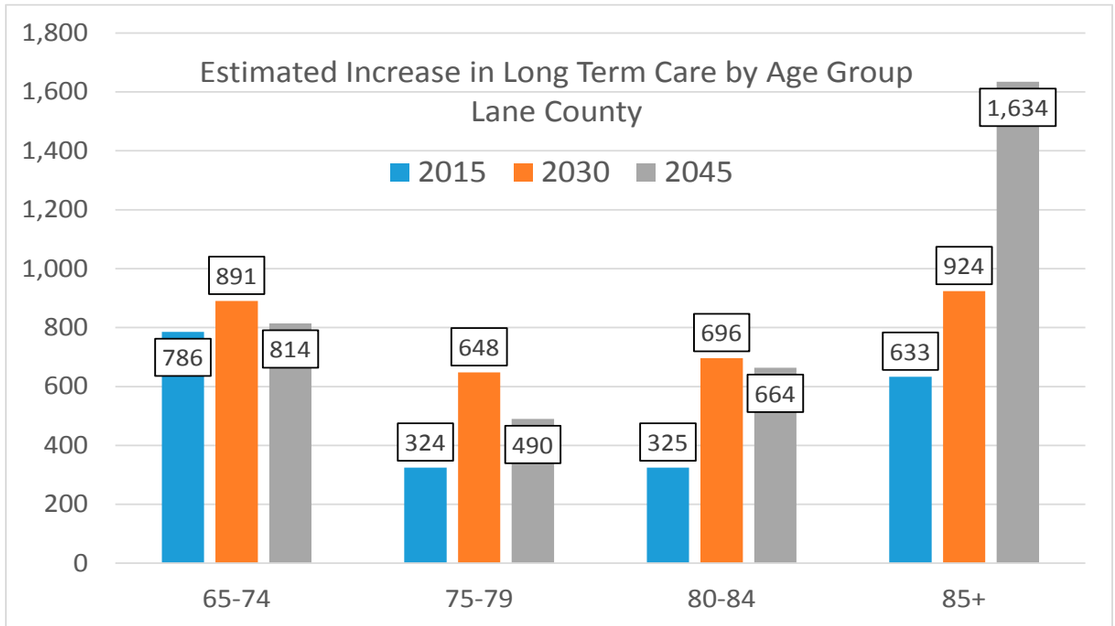

Estimated Increase in Long Term Care by Age Group
Coos County
2015
2030
2045
140
120
100
80
60
40
20
0
57
62
53
21
30
25
21
41
41
43
81
128
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Curry County
2015
2030
2045
250
200
150
100
50
0
63
78
59
40
72
58
35
69
74
73
107
197
65-74
75-79
80-84
85+

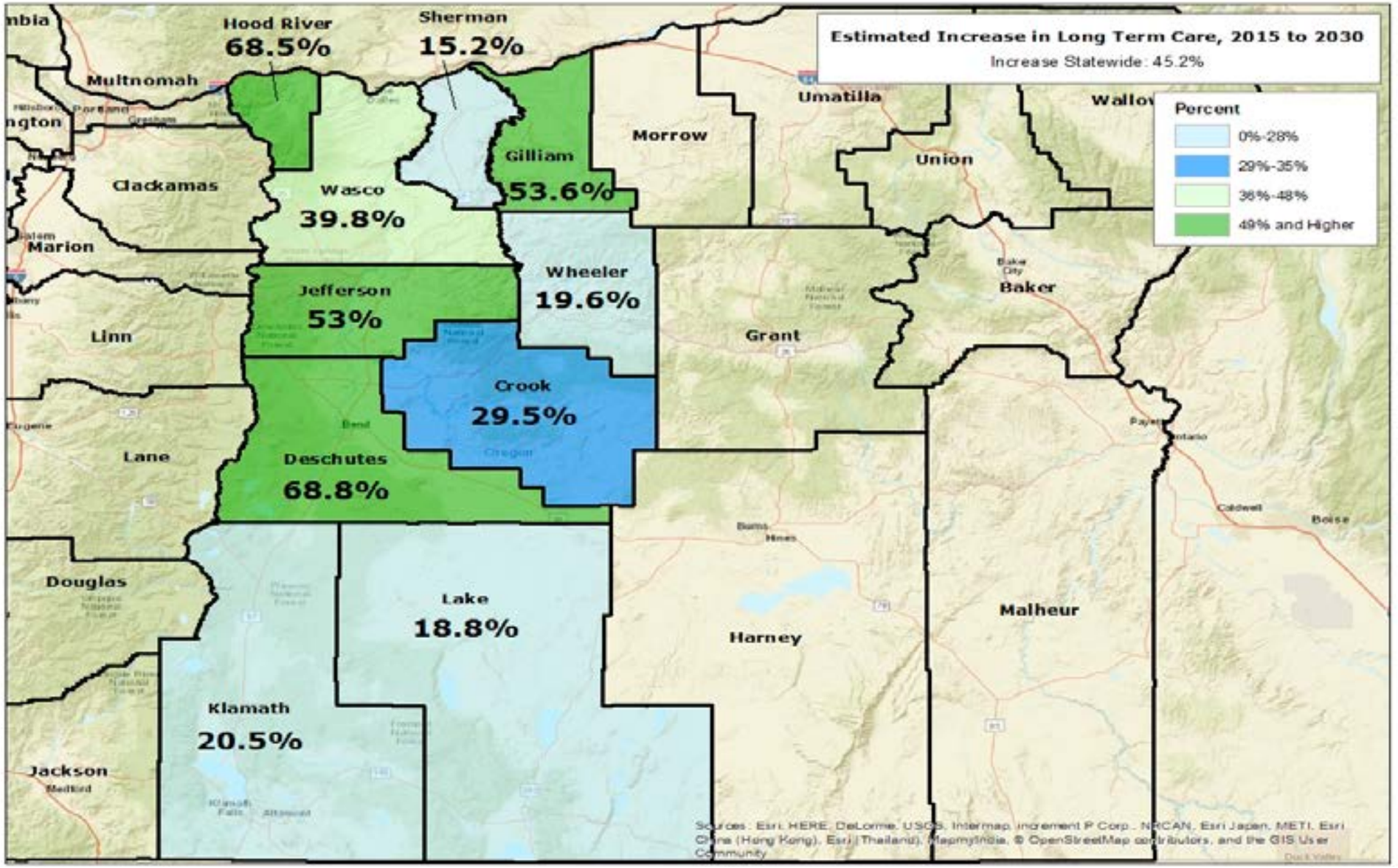

Estimated Increase in Long Term Care by Age Group
Douglas County
2015
2030
2045
800
700
600
500
400
300
200
100
0
228
283
250
119
208
175
139
247
271
224
378
668
65-74
75-79
80-84
85+

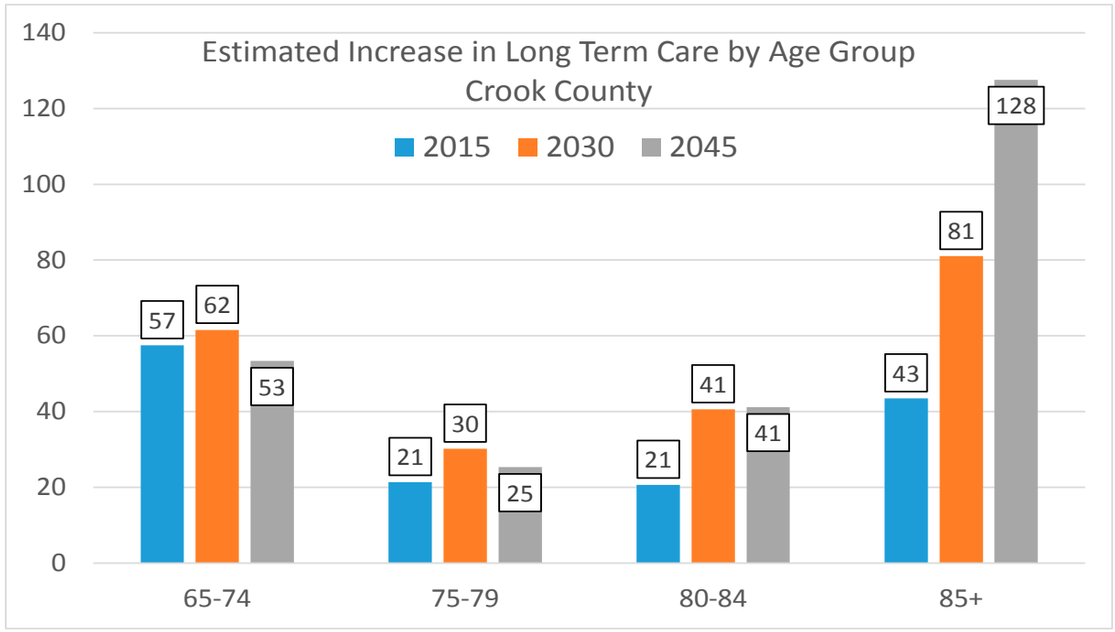

Estimated Increase in Long Term Care by Age Group
Jackson County
2015
2030
2045
1,200
1,000
800
600
400
200
0
434
568
552
211
453
422
200
439
509
326
509
984
65-74
75-79
80-84
85+

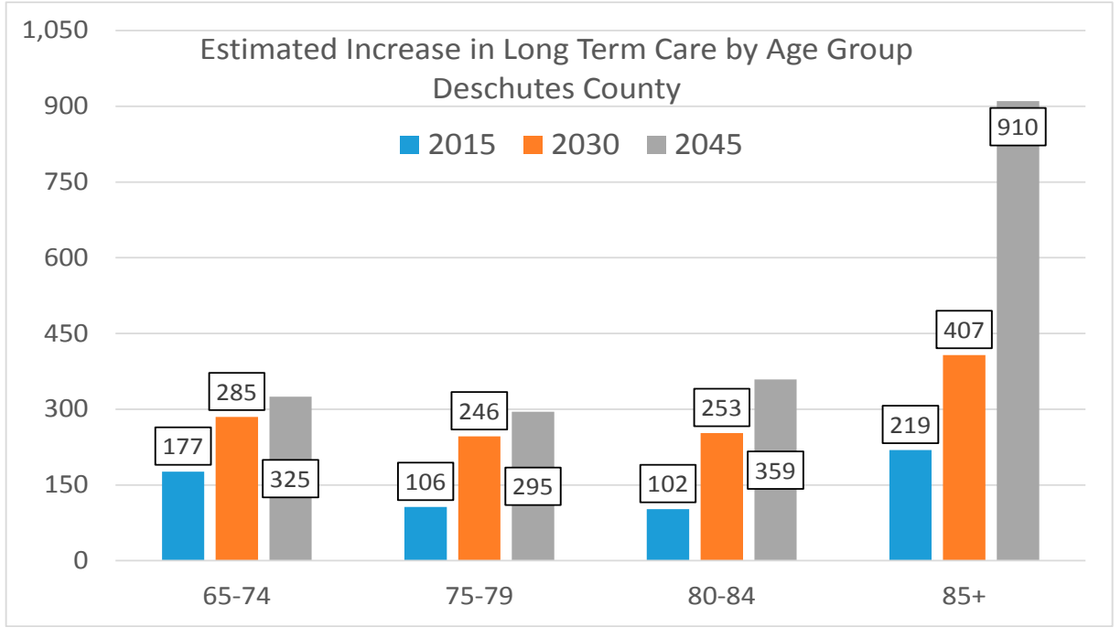

Estimated Increase in Long Term Care by Age Group
Josephine County
2015
2030
2045
600
500
400
300
200
100
0
229
297
268
96
173
164
107
207
244
194
301
536
65-74
75-79
80-84
85+

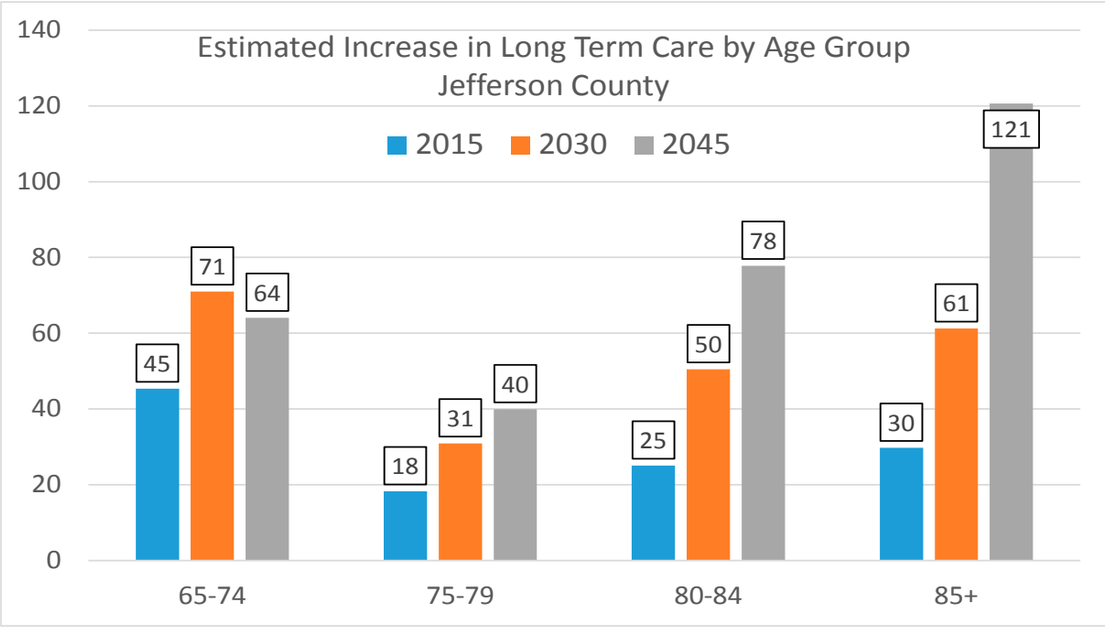

Estimated Increase in Long Term Care by Age Group
Lane County
2015
2030
2045
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
786
891
814
324
648
490
325
696
664
633
924
1,634
65-74
75-79
80-84
85+

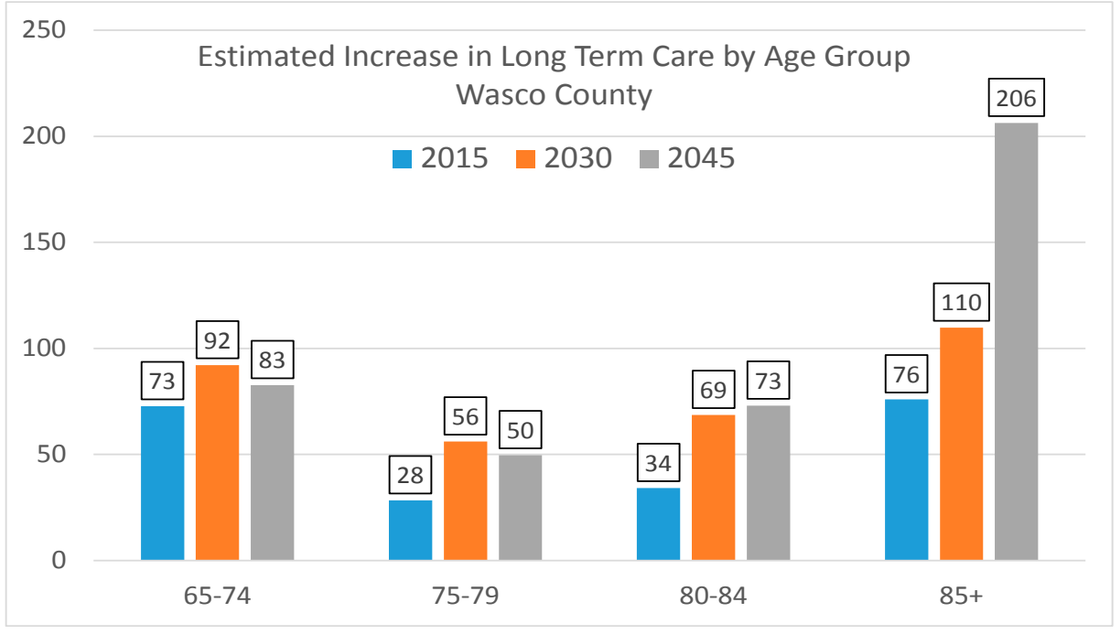
Estimated Increase in Long Term Care by County, Central Oregon



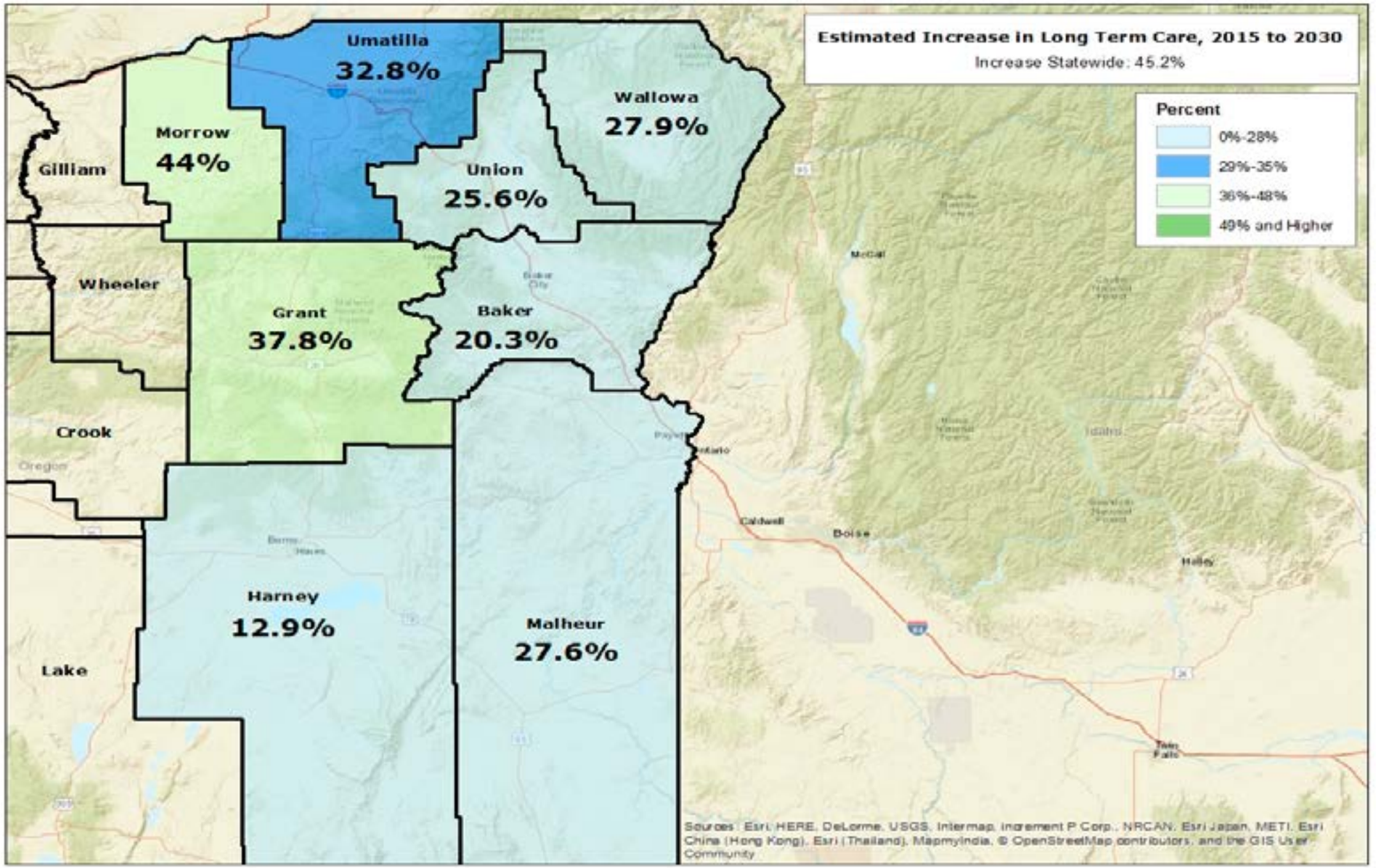

Estimated Increase in Long Term Care by Age Group
Crook County
2015
2030
2045
140
120
100
80
60
40
20
0
57
62
53
21
30
25
21
41
41
43
81
128
65-74
75-79
80-84
85+

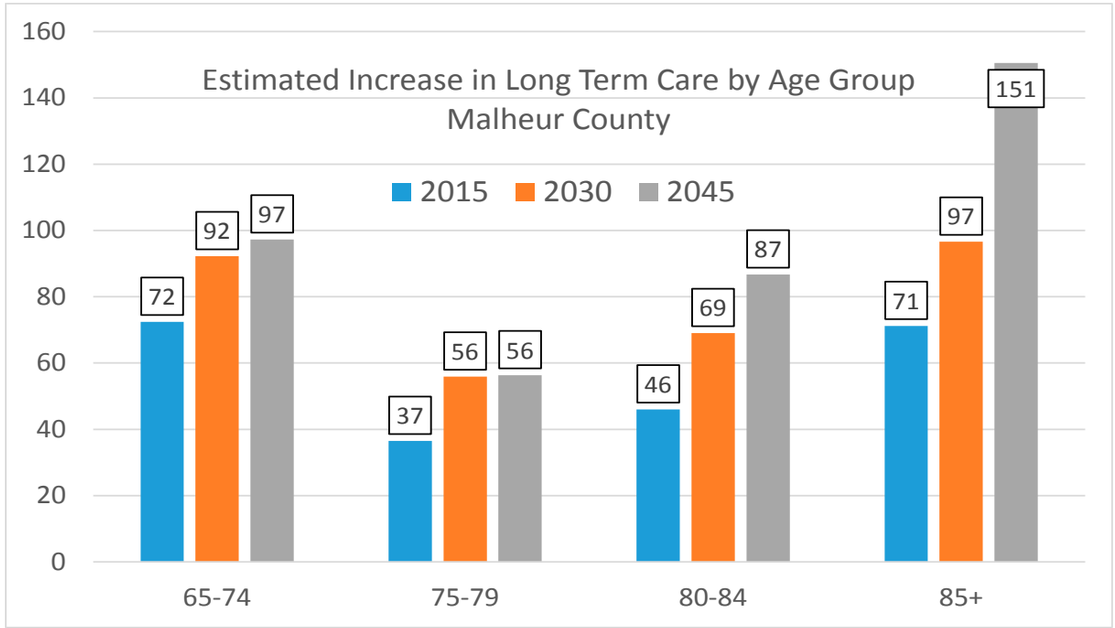

Estimated Increase in Long Term Care by Age Group
Deschutes County
2015
2030
2045
1,050
900
750
600
450
300
150
0
177
285
325
106
246
295
102
253
359
219
407
910
65-74
75-79
80-84
85+

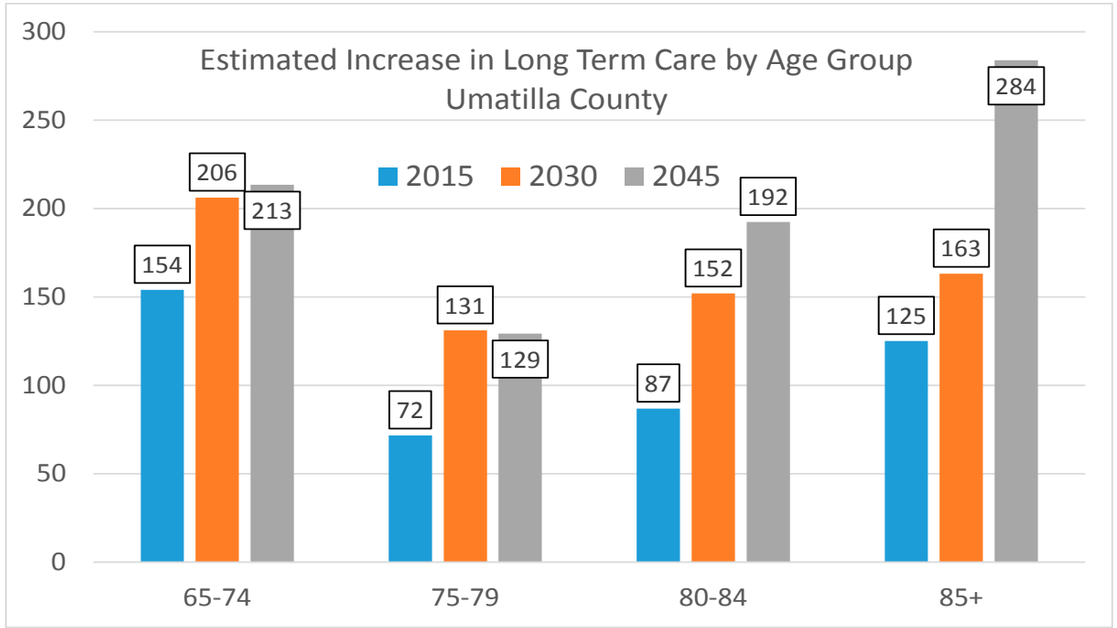

Estimated Increase in Long Term Care by Age Group
Jefferson County
2015
2030
2045
140
120
100
80
60
40
20
0
45
71
64
18
31
40
25
50
78
30
61
121
65-74
75-79
80-84
85+

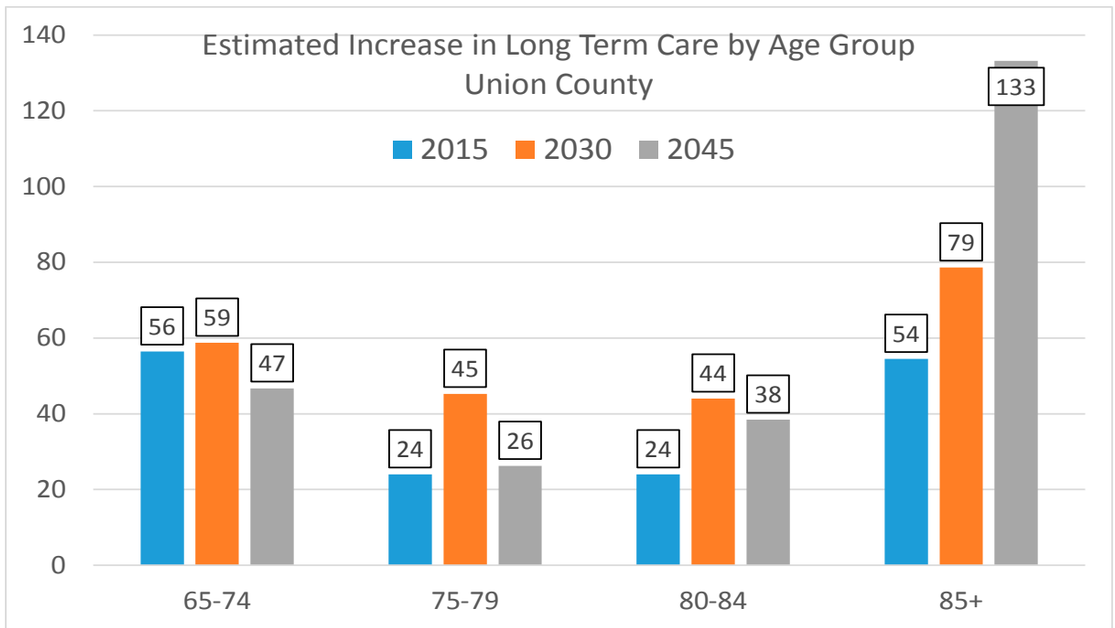

Estimated Increase in Long Term Care by Age Group
Wasco County
2015
2030
2045
250
200
150
100
50
0
73
92
83
28
56
50
34
69
73
76
110
206
65-74
75-79
80-84
85+

Estimated Increase in Long Term Care by County, Eastern Oregon




Estimated Increase in Long Term Care by Age Group
Malheur County
2015
2030
2045
160
140
120
100
80
60
40
20
0
72
92
97
37
56
56
46
69
87
71
97
151
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Umatilla County
2015
2030
2045
300
250
200
150
100
50
0
154
206
213
72
131
129
87
152
192
125
163
284
65-74
75-79
80-84
85+


Estimated Increase in Long Term Care by Age Group
Union County
2015
2030
2045
140
120
100
80
60
40
20
0
56
59
47
24
45
26
24
44
38
54
79
133
65-74
75-79
80-84
85+

The Future of Long Term Care - Part 2

In order to know the future, you need to appreciate the past and the present. In forecasting, we do that first by looking at the history of a caseload – the near future is almost always related to the recent past. Sometimes, we must look at other variables that we can use to help us understand the future. For example, variables like overall employment rate and how it relates to self-sufficiency. If more people are going to be employed, the need for SNAP will probably go down. Economists often do that with the overall economy using what they call "leading indicators." An example of a leading indicator would be industrial output, which is related to the future of our Gross Domestic Product, and can be given a number. Collect a handful of these indicators, sum them (or something more complicated, because economists like math) and you have a single index score that is an indication of how things are going to go.

I've created an index score for the future of Long Term Care. This isn't a forecast or even an "estimation," like in Part 1 of this section. Instead, it's a way of looking at variables other than demographics that can show how ready a county is for the increase in LTC that is inevitably coming. The index contains four variables – three from the Census Bureau's American Community Survey 5-year estimate (2011-2015), and the fourth from our own data here at DHS. The variables are:

1. **Self-Reported "Independent Living Difficulty" for people age 35 and older.** Those who report difficulties with living independently yield a wider measure than people needing Long Term Care. It can include people who are currently getting by with family help and other supports, but who will perhaps need Long Term Care in the future. By looking at people age 35 and older, I hope to show the volume of people who may be in the caseload in the next 15 to 20 years, rather than people who are already in the caseload.

2. **Labor Force Participation.** Labor force participation has been in the news a bit over the last year or so. Usually, the number of persons age 16-65 in the workforce is about 65 percent. That number has been lower than is typical ever since the "Great Recession." This is an issue at the national level because the ratio of people working to number of people receiving taxpayer-financed services (like Social Security and Medicare) should be at about 7-to-1 in order to pay for all the entitlements seniors have come to count on. Demographics suggests that this ratio will go down, and if current labor force participation is suppressed, it could be worse. At the county level, labor force participation is important because working-age people need to be available to provide aid to those with disabilities that make up the Long Term Care population. Without a good ratio of people in the workforce to people who need LTC aid, needs in the community may not be met.

3. **Mean Retirement Income.** The number of people retiring with a good income is related to the number of people who need Long Term Care from us in an obvious way – the higher the income, the more likely people are to be able to afford their own care without turning to the state for assistance. Indirectly, it can be an indicator of home ownership and other signs of economic well-being that can spare people from needing our services.

4. **SNAP Usage.** Because Oregon has such good outreach to getting people the food aid they need, use of SNAP is a good indicator of general economic health in a community. For this variable, I isolated those people age 50 and older on SNAP. These are people who, in the next 15 to 20 years may need Long Term Care, and may not be in a good position to finance it, given their economic condition now.

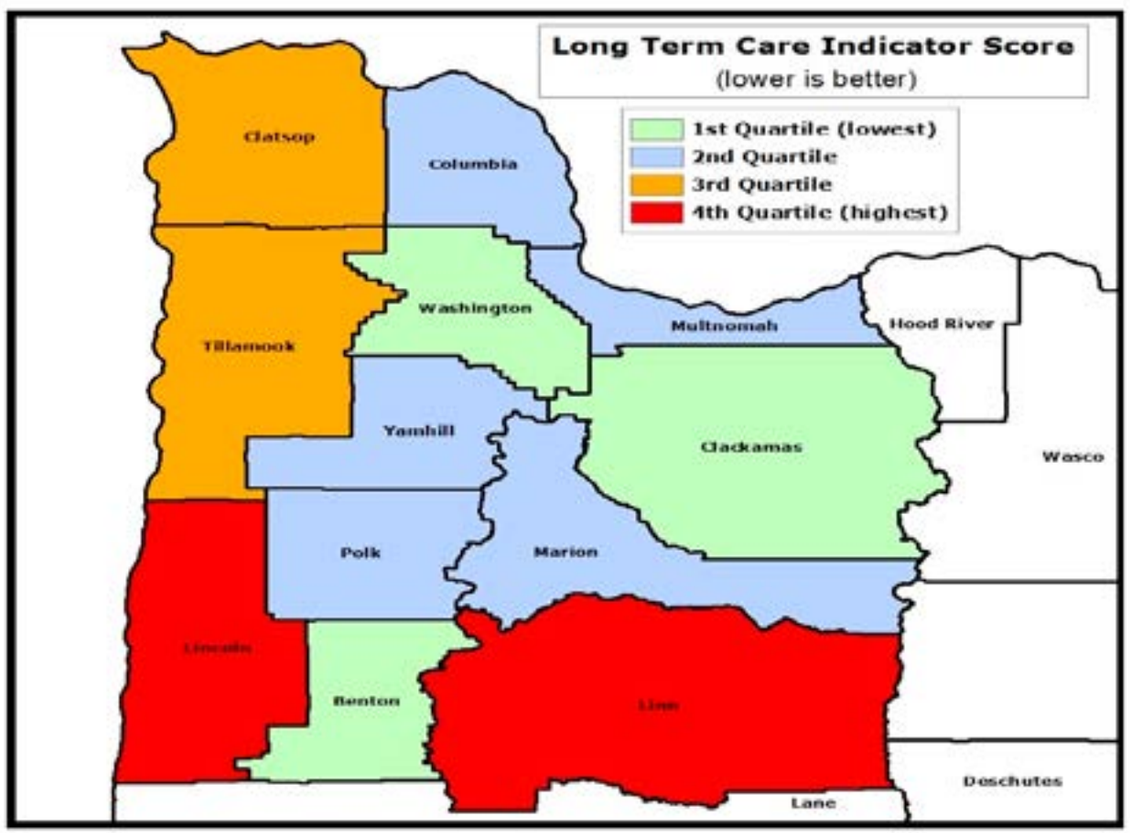
On the next few pages you'll see a table with the four indicator variables, and the "LTC Indicator" Sscore. The scores (and accompanying map) are color-coded – green for counties in the lowest quartile (lower is better on this scale), blue for counties in the second-lowest quartile, yellow for counties in the third lowest quartile, and red for counties in the highest (worst) quartile. Of course, Oregon is a dynamic state experiencing a good deal of economic growth and population increase over the past few years. Things could change between now and 2030, when the number of seniors in Oregon will double. But this is at least a good snapshot of where we are now, as we prepare for a future of greater need for our seniors.

Northwest Oregon

(Columbia, Clatsop, Tillamook, Multnomah, Clackamas, Washington, Polk, Yamhill, Marion, Benton, Lincoln, Linn)

No map on these pages shows the value of urban areas better than this one. Benton County (also known as the "Corvallis metro area" has the best score in the state (that is, lowest). It has achieved this with the lowest percentage of people not in the labor force and lowest percentage of people over 50 on SNAP. Other urban areas like Washington County (Hillsborough/Beaverton) and Clackamas also scored in the top five on the indicator. These counties have a large population, lots of resources, and high income jobs.

This is contrasted with Lincoln and Linn counties, which are among the lowest scoring counties in the state. Both of these counties have relatively high scores on all the measures that go into the indicator. As usual with looking at demographics in Multnomah County, it is about in the middle on the indicator. Multnomah County (e.g. Portland) is the most densely populated county in the state, with a highly diverse population. It ranks among the lowest counties in percent of people not in the workforce, but among the highest in people over 50 on SNAP.

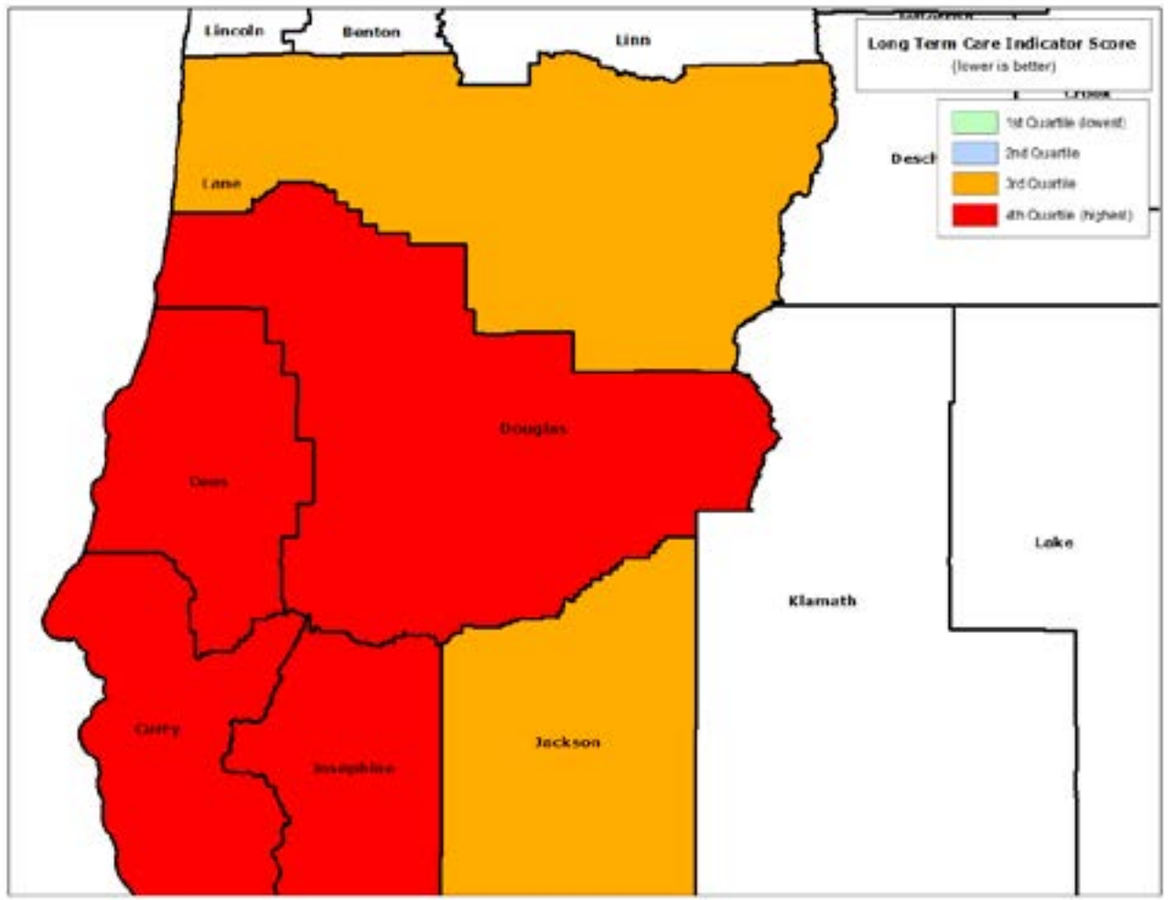


DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Mean Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
1	Columbia	8.2%	41.6%	$21,783	5.5%	156	15
1	Clatsop	9.2%	38.0%	$29,149	6.8%	168	21
1	Tillamook	9.2%	48.1%	$23,538	5.4%	171	26
2	Multnomah	7.7%	31.4%	$24,438	7.5%	159	16
15	Clackamas	6.3%	35.1%	$26,730	3.7%	108	4
16	Washington	5.6%	30.6%	$24,182	3.9%	101	3
3	Polk	8.0%	40.0%	$26,252	5.2%	146	10
3	Yamhill	8.5%	38.7%	$24,290	5.4%	154	12
3	Marion	7.9%	38.0%	$25,568	6.4%	155	14
4	Benton	5.3%	40.6%	$33,467	3.2%	93	1
4	Lincoln	8.8%	44.3%	$23,304	7.0%	179	30
4	Linn	8.7%	41.9%	$19,455	7.0%	179	31
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Southwest Oregon

(Lane, Douglas, Curry, Coos, Jackson, Josephine)

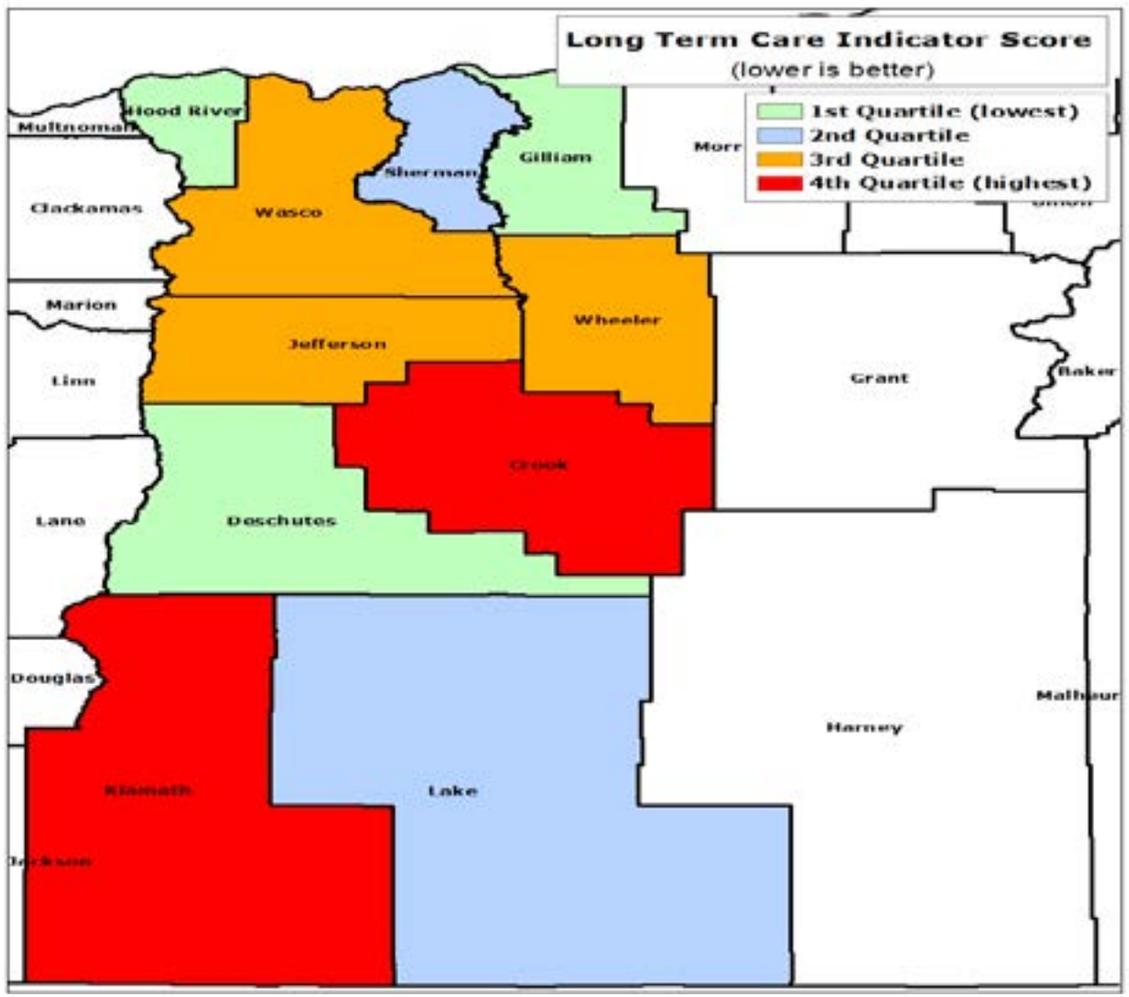
One of the more persistent themes in regional analysis has been the economic and demographic troubles of Southwest Oregon. Although Medford (Jackson County) and Eugene (Lane County) have improving economies, other parts of the area continue to lag. Beyond the economics, the area has the demographic problem of an aging population and a falling number of replacement workers. Less than half the adults are in the labor force in Curry and Josephine counties. Coos County has the highest indicator score in the state, driven by a very high number of people with independent living problems and a very low average retirement income.



DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Mean Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
5	Lane	8.8%	40.3%	$23,731	6.2%	167	20
6	Douglas	8.4%	48.7%	$21,386	6.7%	179	29
7	Curry	9.2%	52.3%	$25,932	6.0%	178	28
7	Coos	12.0%	48.7%	$19,986	8.3%	231	36
8	Jackson	8.4%	41.3%	$23,876	6.7%	169	25
8	Josephine	10.1%	52.3%	$23,455	7.3%	202	34
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Central Oregon

Central Oregon has the most rural counties in the state, which usually means fewer resources for disabled seniors and more poverty. But central Oregon also has some of the best places to grow old in, based on the Long Term Care Indicator Scores. Crook and Klamath have some of the highest scores in the state, influenced by a high percentage of people over age 50 receiving SNAP and a relatively high number of people over 35 experiencing difficulty living independently. Hood River and Deschutes County (the Bend metro area) have among the best scores, with high percentages of adults in the workforce.

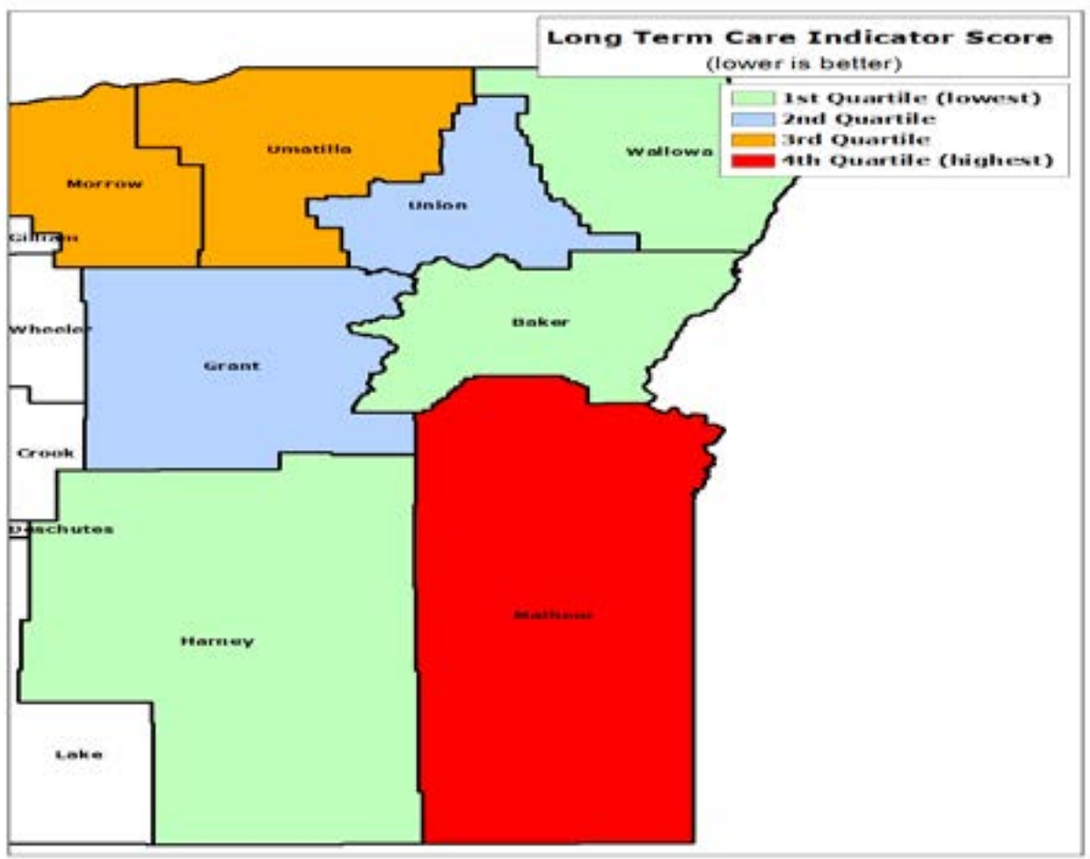


DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Average Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
9	Hood River	5.1%	32.1%	$25,242	3.9%	97	2
9	Gilliam	4.9%	38.3%	$18,770	4.0%	108	5
9	Sherman	8.0%	43.0%	$16,622	4.8%	154	11
9	Wheeler	10.1%	45.3%	$20,854	3.9%	165	19
9	Wasco	8.4%	42.1%	$21,112	6.4%	169	23
10	Deschutes	6.0%	38.5%	$32,799	5.1%	116	6
10	Jefferson	6.7%	44.3%	$24,767	8.7%	173	27
10	Crook	9.0%	46.2%	$18,903	7.0%	188	32
11	Lake	7.3%	44.1%	$17,432	6.3%	162	17
11	Klamath	11.0%	43.1%	$20,282	7.4%	207	35
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Eastern Oregon

Rural counties in eastern Oregon often fare poorly when creating index scores based on demographics and economics, but not this time. Baker, Wallowa, and Harney counties have among the best scores in the state on measures contained in the Long Term Care Indicator. Union and Grant have fairly good scores as well. Malheur County does not fare so well, however, with a high percentage of people with difficulty living independently and a high SNAP participation among people aged 50 and over.

Some individual scores are troublesome in the east – Grand County has a large percentage of people with difficulty living independently, while Harney has a very low average retirement income. But strong scores on other measures make up for that. Malheur doesn't have that feature – all the more worrisome in that Malheur has the second highest population (after Union) in the area.



DHS Service District	County	People over 35 w/Difficulty Living Independently	People Not in Labor Force	Average Retirement Income (Dollars)	Age 50+ Receiving SNAP	LTC "Indicator" Score (Lower is Better)	Ranking
12	Morrow	8.2%	37.5%	$18,990	6.8%	169	22
12	Umatilla	7.6%	39.6%	$19,876	7.3%	169	24
13	Baker	7.1%	46.9%	$28,233	5.5%	145	8
13	Wallowa	7.9%	43.1%	$20,046	4.4%	146	9
13	Union	8.5%	43.2%	$22,042	4.9%	155	13
14	Harney	7.1%	43.3%	$19,460	4.8%	143	7
14	Grant	9.6%	47.7%	$23,834	4.3%	163	18
14	Malheur	9.2%	48.9%	$22,133	8.2%	201	33
	STATEWIDE	**7.6%**	**37.8%**	**$24,856**	**5.9%**	**149**	

Total Department of Human Services Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 16 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Self-Sufficiency								
Supplemental Nutrition Assistance Program (Households)	405,818	405,142	-676	-0.2%	405,142	371,503	-33,640	-8.3%
Temporary Assistance for Needy Families - Basic & UN (Families: Cash Assistance)	23,508	23,299	-209	-0.9%	23,299	21,241	-2,057	-8.8%
Child Welfare (children served)								
Adoption Assistance	11,245	11,141	-104	-0.9%	11,141	11,135	-6	-0.1%
Guardianship Assistance	1,585	1,555	-30	-1.9%	1,555	1,690	135	8.7%
Out of Home Care[1]	7,004	7,092	88	1.3%	7,092	7,173	81	1.1%
Child In-Home	1,375	1,505	130	9.5%	1,505	1,586	81	5.4%
Vocational Rehabilitation	9,310	9,570	260	2.8%	9,570	10,275	705	7.4%
Aging & Physical Disabilities								
Long-Term Care: In Home	18,155	17,959	-196	-1.1%	17,959	19,982	2,023	11.3%
Long-Term Care: Community Based	11,834	11,886	52	0.4%	11,886	12,456	570	4.8%
Long-Term Care: Nursing Facilities	4,184	4,241	57	1.4%	4,241	4,123	-118	-2.8%
Intellectual and Developmental Disabilities								
Total Case Management Enrollment[2]	25,281	25,309	28	0.1%	25,309	28,218	2,909	11.5%
Total I/DD Services	19,141	19,254	113	0.6%	19,254	21,009	1,755	9.1%

1. Includes residential and foster care.

2. Some clients enrolled in Case Management do not receive any additional I/DD services.

Total Oregon Health Authority Biennial Average Forecast Comparison

	2015-17 Biennium			*% Change Between Forecasts*	Fall 2016 Forecast			*% Change Between Biennia*
	Spring 2016 Forecast	**Fall 16 Forecast**	**Change**		**2015-17**	**2017-19**	**Change**	
Medical Assistance								
OHP Plus								
ACA Adults	418,438	409,098	-9,340	-2.2%	409,098	355,149	-43,555	-10.4%
Aid to the Blind & Disabled	82,045	82,008	-37	0.0%	82,008	84,313	2,305	2.8%
Children's Health Insurance Program (CHIP)	60,485	61,706	1,221	2.0%	61,706	57,587	-4,119	-6.7%
Children's Medicaid	345,519	342,797	-2,722	-0.8%	342,797	336,831	-5,966	-1.7%
Foster, Substitute & Adoption Care	19,573	19,689	116	4.2%	19,689	20,215	526	2.7%
Old Age Assistance	41,872	42,338	466	0.6%	42,338	46,763	4,425	10.5%
Parent/Caretaker Relative	64,601	68,770	4,169	1.1%	68,770	68,273	-497	-0.7%
Pregnant Women	15,964	16,639	675	6.5%	16,639	13,530	-3,109	-18.7%
Total OHP Plus	**1,048,498**	**1,043,045**	**-5,453**	**-0.5%**	**1,043,045**	**982,661**	**-60,384**	**-5.8%**
Other Medical Assistance Total	73,016	73,765	749	1.0%	73,765	74,384	619	0.8%
Total Medical Assistance	**1,121,514**	**1,116,810**	**-4,704**	**-0.4%**	**1,116,810**	**1,057,045**	**-59,765**	**-5.4%**
Mental Health [1]								
Under Commitment								
Total Forensic Care	828	859	31	3.7%	859	861	2	0.2%
Civilly Committed	948	975	27	2.8%	975	921	-54	-5.5%
Previously Committed	2,548	2,567	19	0.7%	2,567	2,543	-24	-0.9%
Never Committed	41,101	41,244	143	0.3%	41,244	43,198	1,954	4.7%
Total Served	45,425	45,645	220	0.5%	45,645	47,523	1,878	4.1%

1. Numbers reported represent adults only.

Forecasted Biennial Average Totals by County

	SNAP Total			TANF			Long Term Care Total			Oregon Health Plan Total		
Counties	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia
Baker	1,965	1,843	-6.2%	121	113	-6.6%	127	131	3.1%	4,719	4,548	-3.6%
Benton	5,693	5,149	-9.6%	263	260	-1.1%	336	347	3.3%	14,915	14,225	-4.6%
Clackamas	25,397	22,170	-12.7%	1,160	1,071	-7.7%	2,761	2,952	6.9%	74,679	71,372	-4.4%
Clatsop	4,351	4,061	-6.7%	100	83	-17.0%	330	354	7.3%	10,745	10,291	-4.2%
Columbia	5,243	4,977	-5.1%	238	206	-13.4%	390	419	7.4%	12,017	11,490	-4.4%
Coos	10,150	9,545	-6.0%	464	459	-1.1%	1,071	1,187	10.8%	20,650	19,344	-6.3%
Crook	2,537	2,222	-12.4%	117	103	-12.0%	220	237	7.7%	6,699	6,444	-3.8%
Curry	2,883	2,740	-5.0%	71	71	0.0%	283	303	7.1%	6,475	6,233	-3.7%
Deschutes	14,734	12,480	-15.3%	452	272	-39.8%	927	990	6.8%	44,552	42,484	-4.6%
Douglas	15,106	14,633	-3.1%	867	752	-13.3%	1,101	1,119	1.6%	33,996	32,123	-5.5%
Gilliam	148	145	-2.0%	7	7	0.0%	14	15	7.1%	434	438	0.9%
Grant	642	595	-7.3%	17	16	-5.9%	64	67	4.7%	1,640	1,577	-3.8%
Harney	818	803	-1.8%	29	23	-20.7%	60	60	0.0%	2,049	1,966	-4.1%
Hood River	1,528	1,374	-10.1%	51	47	-7.8%	97	97	0.0%	6,621	6,341	-4.2%
Jackson	26,833	25,147	-6.3%	1,669	1,576	-5.6%	1,846	1,964	6.4%	66,838	63,716	-4.7%
Jefferson	3,705	3,670	-0.9%	313	266	-15.0%	185	190	2.7%	9,479	9,503	0.3%
Josephine	13,796	13,290	-3.7%	965	919	-4.8%	953	960	0.7%	30,534	28,787	-5.7%
Klamath	9,867	9,522	-3.5%	473	448	-5.3%	582	626	7.6%	22,352	21,170	-5.3%
Lake	841	782	-7.0%	18	19	5.6%	52	57	9.6%	2,045	1,978	-3.3%
Lane	45,895	44,206	-3.7%	2,083	2,025	-2.8%	3,559	3,968	11.5%	101,207	96,036	-5.1%
Lincoln	6,666	6,433	-3.5%	294	273	-7.1%	580	601	3.6%	14,970	14,196	-5.2%

Forecasted Biennial Average Totals by County (Cont'd)

	SNAP Total			TANF			Long Term Care Total			Oregon Health Plan Total		
Counties	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia	Fall 16 2015-17	Fall 16 2017-19	% Change between Biennia
Linn	15,594	15,041	-3.5%	817	709	-13.2%	1,458	1,611	10.5%	36,044	33,029	-8.4%
Malheur	4,201	3,840	-8.6%	315	295	-6.3%	327	344	5.2%	11,032	10,603	-3.9%
Marion	36,595	34,587	-5.5%	2,508	2,272	-9.4%	2,788	3,103	11.3%	98,203	88,837	-9.5%
Morrow	1,081	997	-7.8%	85	80	-5.9%	68	78	14.7%	3,404	3,270	-3.9%
Multnomah	82,803	72,853	-12.0%	5,784	5,197	-10.1%	7,933	8,471	6.8%	207,862	193,255	-7.0%
Polk	7,732	7,349	-5.0%	590	556	-5.8%	718	782	8.9%	20,140	18,968	-5.8%
Sherman	150	154	2.7%	4	4	0.0%	9	9	0.0%	371	381	2.7%
Tillamook	2,620	2,423	-7.5%	67	52	-22.4%	208	225	8.2%	6,897	6,606	-4.2%
Umatilla	7,950	7,264	-8.6%	568	551	-3.0%	688	705	2.5%	22,222	20,826	-6.3%
Union	2,681	2,654	-1.0%	226	217	-4.0%	231	242	4.8%	7,122	6,595	-7.4%
Wallowa	596	589	-1.2%	39	40	2.6%	87	99	13.8%	1,940	1,914	-1.3%
Wasco	2,999	2,727	-9.1%	99	99	0.0%	284	292	2.8%	8,195	7,859	-4.1%
Washington	31,386	26,375	-16.0%	1,774	1,636	-7.8%	2,850	3,020	6.0%	105,674	100,830	-4.6%
Wheeler	153	150	-2.0%	2	2	0.0%	12	16	33.3%	360	362	0.6%
Yamhill	9,522	8,713	-8.5%	548	523	-4.6%	887	913	2.9%	25,960	25,066	-3.4%

Regional Forecasts by District

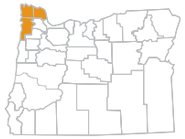
District 1 Regional Forecast

Employment in District 1 has essentially returned to pre-recession levels. As with many parts of the state, however, employment is somewhat restructured. For example, logging and other natural resource-related jobs have not returned, nor have manufacturing jobs related to wood and paper products. In their place are jobs in healthcare, leisure, hospitality, and food service. These tend to be lower-paying jobs than the ones lost during the Great Recession.

Unemployment in Oregon was at 5.4 percent as of August 2016, which is higher than the nation. Oregon unemployment has gone up a bit since the low values seen in the spring, but that is not due to an economic downturn. Instead, the increase is due to more people looking for work – a sign of a healthy economy. The current rate is still in the ballpark of what economists refer to as "full employment." Tillamook and Clatsop counties are employing more people than before the Great Recession. Columbia County is close to that milestone, but is behind its neighbors due to the dramatic loss of logging, construction, and manufacturing jobs after 2007.

Due to the higher unemployment rate in Columbia County, the number of families receiving SNAP benefits is expected to fall slower than statewide. The TANF caseload is expected to fall more quickly in District 1 than the state overall.

DISTRICT 1	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Clatsop	37,652	19.9%	18.1%	$47,337	15.8%	5.9%	5.4%
Columbia	50,882	23.0%	15.5%	$54,605	13.1%	7.5%	6.7%
Tillamook	27,897	19.1%	21.9%	$43,037	17.6%	6.1%	5.6%



District 1 Regional Forecast, Oregon Department of Human Services

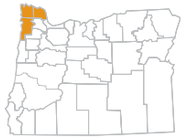
Counties served: Clatsop, Columbia and Tillamook

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Clatsop	2,754	2,662	-3.3%	2,662	2,226	-16.4%
Columbia	3,460	3,422	-1.1%	3,422	3,067	-10.4%
Tillamook	1,715	1,674	-2.4%	1,674	1,428	-14.7%
District 1 Total	**7,929**	**7,758**	**-2.2%**	**7,758**	**6,721**	**-13.4%**
SNAP - Aid to People with Disabilities						
Clatsop	1,683	1,689	0.4%	1,689	1,835	8.6%
Columbia	1,846	1,821	-1.4%	1,821	1,910	4.9%
Tillamook	934	946	1.3%	946	995	5.2%
District 1 Total	**4,463**	**4,456**	**-0.2%**	**4,456**	**4,740**	**6.4%**
TANF						
Clatsop	114	100	-12.3%	100	83	-17.00%
Columbia	254	238	-6.3%	238	206	-13.45%
Tillamook	79	67	-15.2%	67	52	-22.39%
District 1 Total	**447**	**405**	**-9.4%**	**405**	**341**	**-15.8%**

District 1 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Clatsop, Coulumbia and Tillamook

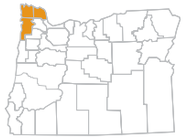
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Clatsop	145	147	1.4%	147	162	10.2%
Columbia	206	194	-5.8%	194	210	8.2%
Tillamook	100	96	-4.0%	96	101	5.2%
District 1 Total	**451**	**437**	**-3.1%**	**437**	**473**	**8.2%**
Community-Based Care						
Clatsop	154	153	-0.6%	153	165	7.8%
Columbia	134	134	0.0%	134	149	11.2%
Tillamook	85	96	12.9%	96	110	14.6%
District 1 Total	**373**	**383**	**2.7%**	**383**	**424**	**10.7%**
Nursing Care						
Clatsop	34	30	-11.8%	30	27	-10.0%
Columbia	60	62	3.3%	62	60	-3.2%
Tillamook	18	16	-11.1%	16	14	-12.5%
District 1 Total	**112**	**108**	**-3.6%**	108	101	**-6.5%**



District 1 Regional Forecast, Oregon Health Authority (clients)

Counties served: Clatsop, Coulumbia and Tillamook

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Clatsop	606	634	4.6%	634	643	1.4%
Columbia	887	977	10.1%	977	987	1.0%
Tillamook	408	440	7.8%	440	440	0.0%
District 1 Total	**1,901**	**2,051**	**7.9%**	**2,051**	**2,070**	**0.9%**
Children's Medicaid Program						
Clatsop	3,441	3,318	-3.6%	3,318	3,385	2.0%
Columbia	3,737	3,710	-0.7%	3,710	3,845	3.6%
Tillamook	2,392	2,292	-4.2%	2,292	2,331	1.7%
District 1 Total	**9,570**	**9,320**	**-2.6%**	**9,320**	**9,561**	**2.6%**
Children's Health Insurance Program (CHIP)						
Clatsop	569	596	4.7%	596	555	-6.9%
Columbia	617	617	0.0%	617	510	-17.3%
Tillamook	365	373	2.2%	373	353	-5.4%
District 1 Total	**1,551**	**1,586**	**2.3%**	**1,586**	**1,418**	**-10.6%**
Pregnant Women Program						
Clatsop	173	183	5.8%	183	158	-13.7%
Columbia	174	182	4.6%	182	151	-17.0%
Tillamook	87	100	14.9%	100	88	-12.0%
District 1 Total	**434**	**465**	**7.1%**	**465**	**397**	**-14.6%**



District 1 Regional Forecast, Oregon Health Authority (continued)

Counties served: Clatsop, Coulumbia and Tillamook

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Clatsop	229	212	-7.4%	212	206	-2.8%
Columbia	350	353	0.9%	353	368	4.2%
Tillamook	111	107	-3.6%	107	109	1.9%
District 1 Total	**690**	**672**	**-2.6%**	**672**	**683**	**1.6%**
Aid to the Blind/Disabled						
Clatsop	859	853	-0.7%	853	860	0.8%
Columbia	1,083	1,082	-0.1%	1,082	1,119	3.4%
Tillamook	598	592	-1.0%	592	621	4.9%
District 1 Total	**2,540**	**2,527**	**-0.5%**	**2,527**	**2,600**	**2.9%**
Old Age Assistance						
Clatsop	371	377	1.6%	377	401	6.4%
Columbia	453	446	-1.5%	446	489	9.6%
Tillamook	236	242	2.5%	242	256	5.8%
District 1 Total	**1,060**	**1,065**	**0.5%**	**1,065**	**1,146**	**7.6%**
ACA Adults						
Clatsop	4,679	4,572	-2.3%	4,572	4,083	-10.7%
Columbia	4,765	4,650	-2.4%	4,650	4,021	-13.5%
Tillamook	2,804	2,751	-1.9%	2,751	2,408	-12.5%
District 1 Total	**12,248**	**11,973**	**-2.2%**	**11,973**	**10,512**	**-12.2%**

Portland Area - Dritricts 2, 15 and 16 Regional Forecast

Previously, we have presented Multnomah County (District 2), Clackamas County (District 15), and Washington County (District 16) in three separate sections. Starting in the spring of 2016 these three districts were presented together as the "Portland Area." The primary reason for the change is to simplify the report, and remove one-county districts. Furthermore, since these counties are linked economically, presenting them together makes sense for readers wanting to understand the Portland Area.

Unemployment is five percent or less for each of the three counties that make up the Portland area. That rate is considered by economists to be essentially "full employment." Over 78,000 more people are employed in the Portland area than were employed before the Great Recession; an increase of 9.2 percent. The economy is not only providing jobs for locals newly entering the workforce, but it is also creating jobs for migrants moving to Portland. Migration to the Portland area has been increasing steadily, and is now at levels not seen since the 1990s. A downside to Portland's population increase is a housing shortage – especially affordable housing.

Despite the good news concerning job growth in the Portland area, there are still soft spots in construction, some types of manufacturing employment, and transportation. Retail sales, leisure, and other service-sector jobs have surged. High-paying professional services and management jobs are also on the rise.

The federal government has reinstated the "Able Bodied Adults without Dependents" or ABAWD rule for SNAP clients in Clackamas County starting in October 2016. The ABAWD rule cuts off SNAP for non-disabled adults without children after three months of assistance (see the special section on ABAWD in the Spring 2016 Regional Forecast for more information). This is the third Oregon county to have the rule reinstated – it was applied to Multnomah and Washington counties in early 2016. It is estimated that as a result of this exclusion, 4.7% of the cases in Clackamas County will close in January 2017 after the three month period ends. This calculation is based on the percentage of single-person cases in Clackamas County (which are the most likely type of case to close as a result of application of ABAWD) and an analysis of the volume of case closures in Multnomah and Washington counties when ABAWD was re-applied there.

TANF and SNAP Self-Sufficiency are likely to fall faster in the Portland Metro Area than the state overall through mid-2019, while Long Term Care is expected to grow more slowly, given that the area has a population skewed toward younger adults.

Portland Area	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Clackamas (District 15)	424,648	22.9%	14.9%	$64,700	9.7%	5.5%	5.0%
Multnomah (District 2)	735,445	20.1%	11.2%	$52,845	18.5%	5.3%	4.8%
Washington (District 16)	599,377	24.9%	11.0%	$65,272	11.8%	5.0%	4.6%

Portland Area Regional Forecast, Oregon Department of Human Services

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Multnomah (District 2)	56,006	54,769	-2.2%	54,769	44,231	-19.2%
Clackamas (District 15)	17,344	17,288	-0.3%	17,288	13,742	-20.5%
Washington (District 16)	23,053	22,795	-1.1%	22,795	17,630	-22.7%
SNAP - Aid to People with Disabilities						
Multnomah (District 2)	28,100	28,034	-0.2%	28,034	28,622	2.1%
Clackamas (District 15)	8,116	8,109	-0.1%	8,109	8,428	3.9%
Washington (District 16)	8,665	8,591	-0.9%	8,591	8,745	1.8%
TANF						
Multnomah (District 2)	5,876	5,784	-1.6%	5,784	5,197	-10.1%
Clackamas (District 15)	1,175	1,160	-1.3%	1,160	1,071	-7.7%
Washington (District 16)	1,773	1,774	0.1%	1,774	1,636	-7.8%

Portland Area Regional Forecast, Oregon Department of Human Services

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Multnomah (District 2)	4,173	4,147	-0.6%	4,147	4,581	10.5%
Clackamas (District 15)	1,361	1,376	1.1%	1,376	1,515	10.1%
Washington (District 16)	1,373	1,310	-4.6%	1,310	1,434	9.5%
Community-Based Care						
Multnomah (District 2)	2,536	2,574	1.5%	2,574	2,699	4.9%
Clackamas (District 15)	1,046	1,024	-2.1%	1,024	1,085	6.0%
Washington (District 16)	1,177	1,166	-0.9%	1,166	1,230	5.5%
Nursing Care						
Multnomah (District 2)	1,211	1,212	0.1%	1,212	1,191	-1.7%
Clackamas (District 15)	355	361	1.7%	361	352	-2.5%
Washington (District 16)	379	374	-1.3%	374	356	-4.8%

Portland Area Regional Forecast, Oregon Health Authority

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Multnomah (District 2)	10,996	12,119	10.2%	12,119	11,498	-5.1%
Clackamas (District 15)	5,010	5,092	1.6%	5,092	5,320	4.5%
Washington (District 16)	6,563	6,658	1.4%	6,658	6,590	-1.0%
Children's Medicaid Program						
Multnomah (District 2)	59,362	60,578	2.0%	60,578	58,800	-2.9%
Clackamas (District 15)	24,429	23,881	-2.2%	23,881	24,347	2.0%
Washington (District 16)	38,496	38,913	1.1%	38,913	39,403	1.3%
Children's Health Insurance Program (CHIP)						
Multnomah (District 2)	9,714	9,896	1.9%	9,896	9,237	-6.7%
Clackamas (District 15)	5,315	5,429	2.1%	5,429	5,099	-6.1%
Washington (District 16)	8,180	8,285	1.3%	8,285	7,750	-6.5%
Pregnant Women Program						
Multnomah (District 2)	3,011	3,064	1.8%	3,064	2,396	-21.8%
Clackamas (District 15)	1,201	1,216	1.2%	1,216	960	-21.1%
Washington (District 16)	1,578	1,643	4.1%	1,643	1,322	-19.5%
Foster Care & Adoption Services						
Multnomah (District 2)	3,322	3,270	-1.6%	3,270	3,271	0.0%
Clackamas (District 15)	1,403	1,469	4.7%	1,469	1,520	3.5%
Washington (District 16)	1,562	1,589	1.7%	1,589	1,633	2.8%

Portland Area Regional Forecast, Oregon Health Authority (continued)

Counties served: Multnomah (District 2); Washington (District 15); Clackamas (District 16)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Multnomah (District 2)	17,675	17,695	0.1%	17,695	18,083	2.2%
Clackamas (District 15)	5,555	5,600	0.8%	5,600	5,807	3.7%
Washington (District 16)	6,198	6,217	0.3%	6,217	6,501	4.6%
Old Age Assistance						
Multnomah (District 2)	10,648	10,754	1.0%	10,754	11,843	10.1%
Clackamas (District 15)	3,185	3,165	-0.6%	3,165	3,441	8.7%
Washington (District 16)	4,605	4,661	1.2%	4,661	5,273	13.1%
ACA Adults						
Multnomah (District 2)	93,039	90,486	-2.7%	90,486	78,127	-13.7%
Clackamas (District 15)	29,573	28,827	-2.5%	28,827	24,878	-13.7%
Washington (District 16)	38,785	37,708	-2.8%	37,708	32,358	-14.2%

District 3 Regional Forecast

Employment conditions have improved in Marion and Polk counties, where unemployment rates are now comparable to statewide numbers. Yamhill County has historically enjoyed unemployment lower than the state overall. Employment is well above pre-recession levels with over 9,200 new jobs created in District 3 between August 2015 and 2016. This represents a growth in employment of almost five percent, second highest in the state.

Manufacturing and construction employment are still below pre-recession levels in Yamhill County, while service-sector jobs in health care and leisure are surging. Marion and Polk counties have seen an increase in construction employment of over 12 percent in one year, an increase that moves construction back to pre-recession levels.

The improved economy is expected to move families off the SNAP and TANF rolls faster in Marion County than in the other District 3 counties, and faster than the state overall. Polk and Yamhill counties will also experience reductions, but at a slower pace.

DISTRICT 3	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Marion	344,443	25.9%	13.6%	$47,360	19.1%	6.6%	5.6%
Polk	83,338	23.8%	15.9%	$51,880	17.0%	6.1%	5.8%
Yamhill	108,812	24.1%	14.5%	$53,864	16.7%	5.6%	5.2%

District 3 Regional Forecast, Oregon Department of Human Services

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Marion	27,101	27,178	0.3%	27,178	24,601	-9.5%
Polk	5,650	5,585	-1.2%	5,585	5,092	-8.8%
Yamhill	6,847	6,885	0.6%	6,885	5,947	-13.6%
District 3 Total	**39,598**	**39,648**	**0.1%**	**39,648**	**35,640**	**-10.1%**
SNAP - Aid to People with Disabilities						
Marion	9,350	9,417	0.7%	9,417	9,986	6.0%
Polk	2,103	2,147	2.1%	2,147	2,257	5.1%
Yamhill	2,646	2,637	-0.3%	2,637	2,766	4.9%
District 3 Total	**14,099**	**14,201**	**0.7%**	**14,201**	**15,009**	**5.7%**
TANF						
Marion	2,593	2,508	-3.3%	2,508	2,272	-9.4%
Polk	615	590	-4.1%	590	556	-5.8%
Yamhill	570	548	-3.9%	548	523	-4.6%
District 3 Total	**3,778**	**3,646**	**-3.5%**	**3,646**	**3,351**	**-8.1%**

District 3 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Marion	1,450	1,519	4.8%	1,519	1,803	18.7%
Polk	365	368	0.8%	368	419	13.9%
Yamhill	339	357	5.3%	357	376	5.3%
District 3 Total	**2,154**	**2,244**	**4.2%**	**2,244**	**2,598**	**15.8%**
Community-Based Care						
Marion	937	973	3.8%	973	1,033	6.2%
Polk	250	272	8.8%	272	297	9.2%
Yamhill	415	409	-1.4%	409	416	1.7%
District 3 Total	**1,602**	**1,654**	**3.2%**	**1,654**	**1,746**	**5.6%**
Nursing Care						
Marion	260	296	13.8%	296	267	-9.8%
Polk	81	78	-3.7%	78	66	-15.4%
Yamhill	120	121	0.8%	121	121	0.0%
District 3 Total	**461**	**495**	**7.4%**	**495**	**454**	**-8.3%**

District 3 Regional Forecast, Oregon Health Authority (clients)

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Marion	5,721	6,143	7.4%	6,143	5,984	-2.6%
Polk	1,520	1,545	1.6%	1,545	1,545	0.0%
Yamhill	1,660	1,812	9.2%	1,812	2,027	11.9%
District 3 Total	**8,901**	**9,500**	**6.7%**	**9,500**	**9,556**	**0.6%**
Children's Medicaid Program						
Marion	40,033	39,362	-1.7%	39,362	34,526	-12.3%
Polk	7,533	7,374	-2.1%	7,374	7,232	-1.9%
Yamhill	9,694	9,407	-3.0%	9,407	9,374	-0.4%
District 3 Total	**57,260**	**56,143**	**-2.0%**	**56,143**	**51,132**	**-8.9%**
Children's Health Insurance Program (CHIP)						
Marion	6,076	6,169	1.5%	6,169	5,640	-8.6%
Polk	1,177	1,227	4.2%	1,227	1,133	-7.7%
Yamhill	1,812	1,858	2.5%	1,858	1,731	-6.8%
District 3 Total	**9,065**	**9,254**	**2.1%**	**9,254**	**8,504**	**-8.1%**
Pregnant Women Program						
Marion	1,579	1,574	-0.3%	1,574	1,290	-18.0%
Polk	268	297	10.8%	297	244	-17.8%
Yamhill	441	453	2.7%	453	351	-22.5%
District 3 Total	**2,288**	**2,324**	**1.6%**	**2,324**	**1,885**	**-18.9%**

District 3 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Marion, Polk and Yamhill

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Marion	1,751	1,747	-0.2%	1,747	1,786	2.2%
Polk	382	392	2.6%	392	402	2.6%
Yamhill	423	411	-2.8%	411	417	1.5%
District 3 Total	**2,556**	**2,550**	**-0.2%**	**2,550**	**2,605**	**2.2%**
Aid to the Blind/Disabled						
Marion	7,024	7,065	0.6%	7,065	7,312	3.5%
Polk	1,570	1,574	0.3%	1,574	1,618	2.8%
Yamhill	1,732	1,751	1.1%	1,751	1,864	6.5%
District 3 Total	**10,326**	**10,390**	**0.6%**	**10,390**	**10,794**	**3.9%**
Old Age Assistance						
Marion	3,500	3,579	2.3%	3,579	4,112	14.9%
Polk	671	689	2.7%	689	721	4.6%
Yamhill	983	1,005	2.2%	1,005	1,131	12.5%
District 3 Total	**5,154**	**5,273**	**2.3%**	**5,273**	**5,964**	**13.1%**
ACA Adults						
Marion	33,381	32,564	-2.4%	32,564	28,187	-13.4%
Polk	7,191	7,042	-2.1%	7,042	6,073	-13.8%
Yamhill	9,438	9,263	-1.9%	9,263	8,171	-11.8%
District 3 Total	**50,010**	**48,869**	**-2.3%**	**48,869**	**42,431**	**-13.2%**

District 4 Regional Forecast

District 4 is the most economically diverse region in this report, with coastal tourism dominating Lincoln County, agriculture and manufacturing dominating Linn County, and university employment dominating Benton County.

Employment in District 4 has finally returned to pre-recession levels, due mostly to the strength of Benton and Linn Counties – Lincoln County still has a way to go. Lincoln experienced a sharp drop in construction and leisure/hospitality jobs, and has yet to fully recover.

Manufacturing is improving in Linn County, which created over 400 new jobs in August 2016 compared to the previous year.

Unemployment in Benton County continues to be among the lowest in the state, while Linn and Lincoln counties have unemployment over six percent – a great improvement over recession-era numbers, but still higher than the state overall.

The caseload for SNAP Self-Sufficiency is expected to decline through the forecast horizon in District 4, but more slowly than statewide. The TANF caseload in Benton County is expected to remain relatively flat, given that it has fallen to a relatively low "floor," and isn't likely to fall further. Linn County is expected to reduce TANF cases at a faster rate than the state overall.

Long Term Care caseloads in Benton and Lincoln Counties are likely to increase slowly through the forecast horizon, with Linn County expected to increase faster.

DISTRICT 4	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Benton	88,995	17.2%	13.2%	$49,338	22.7%	4.6%	4.6%
Lincoln	48,776	17.3%	23.2%	$42,429	17.1%	7.0%	6.1%
Linn	115,156	23.7%	16.2%	$44,965	19.5%	7.3%	6.5%

District 4 Regional Forecast, Oregon Department of Human Services

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Benton	4,344	4,295	-1.1%	4,295	3,623	-15.6%
Lincoln	4,135	4,213	1.9%	4,213	3,912	-7.1%
Linn	10,955	10,865	-0.8%	10,865	10,127	-6.8%
District 4 Total	**19,434**	**19,373**	**-0.3%**	**19,373**	**17,662**	**-8.8%**
SNAP - Aid to People with Disabilities						
Benton	1,398	1,398	0.0%	1,398	1,526	9.2%
Lincoln	2,498	2,453	-1.8%	2,453	2,521	2.8%
Linn	4,745	4,729	-0.3%	4,729	4,914	3.9%
District 4 Total	**8,641**	**8,580**	**-0.7%**	**8,580**	**8,961**	**4.4%**
TANF						
Benton	260	263	1.2%	263	260	-1.1%
Lincoln	291	294	1.0%	294	273	-7.1%
Linn	856	817	-4.6%	817	709	-13.2%
District 4 Total	**1,407**	**1,374**	**-2.3%**	**1,374**	**1,242**	**-9.6%**

District 4 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Benton	173	176	1.7%	176	181	2.8%
Lincoln	430	396	-7.9%	396	412	4.0%
Linn	900	866	-3.8%	866	984	13.6%
District 4 Total	**1,503**	**1,438**	**-4.3%**	**1,438**	**1,577**	**9.7%**
Community-Based Care						
Benton	115	120	4.3%	120	128	6.7%
Lincoln	123	135	9.8%	135	141	4.4%
Linn	415	408	-1.7%	408	444	8.8%
District 4 Total	**653**	**663**	**1.5%**	**663**	**713**	**7.5%**
Nursing Care						
Benton	39	40	2.6%	40	38	-5.0%
Lincoln	42	49	16.7%	49	48	-2.0%
Linn	185	184	-0.5%	184	183	-0.5%
District 4 Total	**266**	**273**	**2.6%**	**273**	**269**	**-1.5%**

District 4 Regional Forecast, Oregon Health Authority (clients)

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Benton	869	929	6.9%	929	925	-0.4%
Lincoln	906	947	4.5%	947	920	-2.9%
Linn	2,385	2,595	8.8%	2,595	2,596	0.0%
District 4 Total	**4,160**	**4,471**	**7.5%**	**4,471**	**4,441**	**-0.7%**
Children's Medicaid Program						
Benton	4,490	4,398	-2.0%	4,398	4,513	2.6%
Lincoln	4,568	4,477	-2.0%	4,477	4,414	-1.4%
Linn	12,690	12,113	-4.5%	12,113	11,074	-8.6%
District 4 Total	**21,748**	**20,988**	**-3.5%**	**20,988**	**20,001**	**-4.7%**
Children's Health Insurance Program (CHIP)						
Benton	1,000	1,059	5.9%	1,059	1,137	7.4%
Lincoln	732	767	4.8%	767	711	-7.3%
Linn	2,006	2,121	5.7%	2,121	1,995	-5.9%
District 4 Total	**3,738**	**3,947**	**5.6%**	**3,947**	**3,843**	**-2.6%**
Pregnant Women Program						
Benton	203	202	-0.5%	202	173	-14.4%
Lincoln	208	219	5.3%	219	177	-19.2%
Linn	598	648	8.4%	648	540	-16.7%
District 4 Total	**1,009**	**1,069**	**5.9%**	**1,069**	**890**	**-16.7%**

District 4 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Benton, Lincoln and Linn

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Benton	214	204	-4.7%	204	203	-0.5%
Lincoln	288	292	1.4%	292	300	2.7%
Linn	721	692	-4.0%	692	706	2.0%
District 4 Total	**1,223**	**1,188**	**-2.9%**	**1,188**	**1,209**	**1.8%**
Aid to the Blind/Disabled						
Benton	1,126	1,148	2.0%	1,148	1,183	3.0%
Lincoln	1,309	1,316	0.5%	1,316	1,345	2.2%
Linn	3,350	3,271	-2.4%	3,271	3,198	-2.2%
District 4 Total	**5,785**	**5,735**	**-0.9%**	**5,735**	**5,726**	**-0.2%**
Old Age Assistance						
Benton	407	407	0.0%	407	425	4.4%
Lincoln	634	655	3.3%	655	778	18.8%
Linn	1,377	1,365	-0.9%	1,365	1,468	7.5%
District 4 Total	**2,418**	**2,427**	**0.4%**	**2,427**	**2,671**	**10.1%**
ACA Adults						
Benton	6,666	6,568	-1.5%	6,568	5,666	-13.7%
Lincoln	6,421	6,297	-1.9%	6,297	5,551	-11.8%
Linn	13,579	13,239	-2.5%	13,239	11,452	-13.5%
District 4 Total	**26,666**	**26,104**	**-2.1%**	**26,104**	**22,669**	**-13.2%**

South-Central Oregon - Districts 5 and 6 Regional Forecast

Lane County (District 5) and Douglas County (District 6) are being presented together as "South-Central Oregon." Although these two counties share the same region, they are somewhat different in terms of economy and demographics.

Lane County is something of a microcosm of the state as a whole: some costal/tourism employment, some agriculture, some manufacturing, and a large white-collar workforce in Eugene. Historically, unemployment has been about the same in Lane County as the state overall, although recently that is not the case. Unemployment is a bit higher in Lane County, and employment levels have yet to return to pre-recession levels. There has been broad-based improvement in most employment sectors, but construction and manufacturing jobs are still well below pre-recession levels, lowering the total employment level. Manufacturing remains 32 percent below pre-recession levels, and construction is 23 percent below 2007 levels. These two sectors alone represent a drop of 8,200 jobs comparing August 2016 to 2007.

Unemployment in Douglas County is among the highest in the state. Still, things are improving from the six years when Douglas County unemployment was in double-digits, which started in 2008. Historically, Douglas County has had higher unemployment than the state overall.

Employment opportunities are improving in Douglas County with over 1,200 more jobs in August 2016 than the year before, but the county still has a ways to go to reach pre-recession levels. Manufacturing and construction jobs remain low, as they are in many parts of the state. Unfortunately, many employment sectors that have bounced back in other parts of Oregon – like hospitality, retail sales, and government – still remain well below pre-recession levels.

Due to the continuing lag in recovery from the Great Recession, SNAP caseloads are forecast to drop more slowly in these counties than statewide. Long Term Care is expected to rise more quickly in Lane County than the state overall due to the increases in In-Home Care. TANF in Douglas County is expected to fall at the same pace as the state overall as employment picks up.

Southwestern Oregon	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Lane (District 5)	365,639	19.4%	16.2%	$43,685	20.4%	6.4%	5.9%
Douglas (District 6)	112,043	19.8%	22.3%	$40,820	19.7%	8.2%	7.0%

South-Central Oregon Regional Forecast, Oregon Department of Human Services

Counties served: Southwestern Oregon: Lane (District 5); Douglas (District 6)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Lane (District 5)	31,515	31,278	-0.8%	31,278	28,643	-8.4%
Douglas (District 6)	9,369	9,523	1.6%	9,523	8,636	-9.3%
SNAP - Aid to People with Disabilities						
Lane (District 5)	14,657	14,617	-0.3%	14,617	15,563	6.5%
Douglas (District 6)	5,625	5,583	-0.7%	5,583	5,997	7.4%
TANF						
Lane (District 5)	2,057	2,083	1.3%	2,083	2,025	-2.8%
Douglas (District 6)	918	867	-5.6%	867	752	-13.3%
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Lane (District 5)	2,092	2,061	-1.5%	2,061	2,446	18.7%
Douglas (District 6)	636	624	-1.9%	624	648	3.8%
Community-Based Care						
Lane (District 5)	1,049	1,042	-0.7%	1,042	1,060	1.7%
Douglas (District 6)	369	361	-2.2%	361	359	-0.6%
Nursing Care						
Lane (District 5)	457	456	-0.2%	456	462	1.3%
Douglas (District 6)	116	116	0.0%	116	112	-3.4%

South-Central Oregon Regional Forecast, Oregon Health Authority (clients)

Counties served: Southwestern Oregon: Lane (District 5); Douglas (District 6)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Lane (District 5)	6,334	6,638	4.8%	6,638	6,684	0.7%
Douglas (District 6)	2,284	2,588	13.3%	2,588	2,505	-3.2%
Children's Medicaid Program						
Lane (District 5)	28,353	28,614	0.9%	28,614	28,214	-1.4%
Douglas (District 6)	10,826	10,564	-2.4%	10,564	10,495	-0.7%
Children's Health Insurance Program (CHIP)						
Lane (District 5)	5,312	5,531	4.1%	5,531	5,347	-3.3%
Douglas (District 6)	1,394	1,402	0.6%	1,402	1,302	-7.1%
Pregnant Women Program						
Lane (District 5)	1,622	1,699	4.7%	1,699	1,410	-17.0%
Douglas (District 6)	461	505	9.5%	505	394	-22.0%
Foster Care & Adoption Services						
Lane (District 5)	2,572	2,602	1.2%	2,602	2,733	5.0%
Douglas (District 6)	833	855	2.6%	855	898	5.0%

South-Central Oregon Regional Forecast, Oregon Health Authority (continued)

Counties served: Southwestern Oregon: Lane (District 5); Douglas (District 6)

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Lane (District 5)	9,795	9,719	-0.8%	9,719	10,008	3.0%
Douglas (District 6)	3,121	3,104	-0.5%	3,104	3,193	2.9%
Old Age Assistance						
Lane (District 5)	3,934	4,000	1.7%	4,000	4,632	15.8%
Douglas (District 6)	1,210	1,201	-0.7%	1,201	1,251	4.2%
ACA Adults						
Lane (District 5)	43,142	42,404	-1.7%	42,404	37,008	-12.7%
Douglas (District 6)	14,060	13,777	-2.0%	13,777	12,085	-12.3%

District 7 Regional Forecast

Coos and Curry counties have still not recovered from employment losses incurred during the Great Recession. However, both counties are adding jobs – Curry County added 360 jobs and Coos County added 120 comparing August 2016 to the August 2015. Unemployment in both counties is higher than statewide, but is improving.

Both counties had an extreme draw-down in construction employment, logging, and wood products manufacturing during the Great Recession. Local government in Coos County employs significantly fewer people than before the recession; a result of a lower tax base and insecurity about continued funding from federal timber payments.

The economies of Coos and Curry counties are also fighting uphill against a demographic tide. The region is losing its population of young working-age adults. This hampers the region's ability to grow economically. Coos and Curry counties have a high percentage of retirement-age adults and will likely continue to feel the strain of a population in need of age-related services, while at the same time the district has a smaller base of employment-age adults to provide those services.

SNAP caseloads are expected to fall in Coos and Curry counties in line with statewide expectations. TANF caseloads have reached pre-recession levels in both counties, and are therefore expected to remain flat at this caseload "floor." Coos County is expected to increase Long Term Care faster than the state overall, due to increases in In-Home Care.

DISTRICT 7	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Coos	63,897	18.7%	22.7%	$39,193	18.0%	7.9%	7.0%
Curry	22,112	15.7%	29.5%	$41,939	15.4%	8.9%	7.5%

District 7 Regional Forecast, Oregon Department of Human Services (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Coos	5,979	6,237	4.3%	6,237	5,477	-12.2%
Curry	1,481	1,534	3.6%	1,534	1,343	-12.5%
District 7 Total	**7,460**	**7,771**	**4.2%**	**7,771**	**6,820**	**-12.2%**
SNAP - Aid to People with Disabilities						
Coos	3,901	3,913	0.3%	3,913	4,068	4.0%
Curry	1,351	1,349	-0.1%	1,349	1,397	3.6%
District 7 Total	**5,252**	**5,262**	**0.2%**	**5,262**	**5,465**	**3.9%**
TANF						
Coos	470	464	-1.3%	464	459	-1.1%
Curry	71	71	0.0%	71	71	0.0%
District 7 Total	**541**	**535**	**-1.1%**	**535**	**530**	**-0.9%**

District 7 Regional Forecast, Oregon Department of Human Services (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Coos	684	689	0.7%	689	795	15.4%
Curry	118	131	11.0%	131	148	13.0%
District 7 Total	**802**	**820**	**2.2%**	**820**	**943**	**15.0%**
Community-Based Care						
Coos	284	283	-0.4%	283	290	2.5%
Curry	133	126	-5.3%	126	129	2.4%
District 7 Total	**417**	**409**	**-1.9%**	**409**	**419**	**2.4%**
Nursing Care						
Coos	93	99	6.5%	99	102	3.0%
Curry	24	26	8.3%	26	26	0.0%
District 7 Total	**117**	**125**	**6.8%**	**125**	**128**	**2.4%**

District 7 Regional Forecast, Oregon Health Authority (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Coos	1,323	1,390	5.1%	1,390	1,347	-3.1%
Curry	387	425	9.8%	425	427	0.5%
District 7 Total	**1,710**	**1,815**	**6.1%**	**1,815**	**1,774**	**-2.3%**
Children's Medicaid Program						
Coos	6,058	5,805	-4.2%	5,805	5,561	-4.2%
Curry	1,850	1,815	-1.9%	1,815	1,865	2.8%
District 7 Total	**7,908**	**7,620**	**-3.6%**	**7,620**	**7,426**	**-2.5%**
Children's Health Insurance Program (CHIP)						
Coos	905	907	0.2%	907	836	-7.8%
Curry	280	288	2.9%	288	272	-5.6%
District 7 Total	**1,185**	**1,195**	**0.8%**	**1,195**	**1,108**	**-7.3%**
Pregnant Women Program						
Coos	272	279	2.6%	279	230	-17.6%
Curry	84	87	3.6%	87	75	-13.8%
District 7 Total	**356**	**366**	**2.8%**	**366**	**305**	**-16.7%**
Foster Care & Adoption Services						
Coos	588	578	-1.7%	578	589	1.9%
Curry	75	81	8.0%	81	81	0.0%
District 7 Total	**663**	**659**	**-0.6%**	**659**	**670**	**1.7%**

District 7 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Coos	2,322	2,316	-0.3%	2,316	2,387	3.1%
Curry	610	607	-0.5%	607	632	4.1%
District 7 Total	**2,932**	**2,923**	**-0.3%**	**2,923**	**3,019**	**3.3%**
Old Age Assistance						
Coos	1,057	1,060	0.3%	1,060	1,091	2.9%
Curry	365	379	3.8%	379	435	14.8%
District 7 Total	**1,422**	**1,439**	**1.2%**	**1,439**	**1,526**	**6.0%**
ACA Adults						
Coos	8,454	8,315	-1.6%	8,315	7,303	-12.2%
Curry	2,854	2,793	-2.1%	2,793	2,446	-12.4%
District 7 Total	**11,308**	**11,108**	**-1.8%**	**11,108**	**9,749**	**-12.2%**

District 8 Regional Forecast

Recovery from the Great Recession has been slow, but has finally paid off in the Rogue Valley. Employment contraction in the Medford area began in 2006, a year before the recession started for the rest of the state. But things have been improving steadily for the past few years, and the region has finally recovered all the jobs lost since the Great Recession. However, the employment base is restructuring. For example, construction and natural resource jobs (mining and logging) are still lagging, while new growth is coming from the lower-paying health and social assistance sector. Although Medford has recovered manufacturing and transportation jobs, which is a good sign; Grants Pass has not.

The region is expected to see a boost from households moving to the Rogue Valley from other states – especially California – at levels similar to what was seen in the 1990s.

TANF caseloads are expected to drop very slowly across the forecast horizon for both counties. Josephine County is also expected to see SNAP caseloads fall more slowly than the state overall. Long Term Care in Josephine County is expected to remain rather flat, as Nursing Facility Care continues to fall.

DISTRICT 8	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Jackson	223,464	21.4%	18.8%	$44,086	17.8%	7.3%	6.7%
Josephine	89,211	19.9%	23.4%	$37,447	19.7%	8.5%	7.5%

District 8 Regional Forecast, Oregon Department of Human Services

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Jackson	18,524	18,695	0.9%	18,695	16,753	-10.4%
Josephine	9,299	9,426	1.4%	9,426	8,804	-6.6%
District 8 Total	**27,823**	**28,121**	**1.1%**	**28,121**	**25,557**	**-9.1%**
SNAP - Aid to People with Disabilities						
Jackson	8,102	8,138	0.4%	8,138	8,394	3.1%
Josephine	4,402	4,370	-0.7%	4,370	4,486	2.7%
District 8 Total	**12,504**	**12,508**	**0.0%**	**12,508**	**12,880**	**3.0%**
TANF						
Jackson	1,511	1,669	10.5%	1,669	1,576	-5.6%
Josephine	984	965	-1.9%	965	919	-4.8%
District 8 Total	**2,495**	**2,634**	**5.6%**	**2,634**	**2,495**	**-5.3%**
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Jackson	961	962	0.1%	962	1,052	9.4%
Josephine	500	474	-5.2%	474	483	1.9%
District 8 Total	**1,461**	**1,436**	**-1.7%**	**1,436**	**1,535**	**6.9%**
Community-Based Care						
Jackson	742	728	-1.9%	728	751	3.2%
Josephine	361	351	-2.8%	351	372	6.0%
District 8 Total	**1,103**	**1,079**	**-2.2%**	**1,079**	**1,123**	**4.1%**
Nursing Care						
Jackson	159	156	-1.9%	156	161	3.2%
Josephine	122	128	4.9%	128	105	-18.0%
District 8 Total	**281**	**284**	**1.1%**	**284**	**266**	**-6.3%**

District 8 Regional Forecast, Oregon Health Authority (clients)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Jackson	4,487	4,855	8.2%	4,855	4,968	2.3%
Josephine	2,106	2,239	6.3%	2,239	2,206	-1.5%
District 8 Total	**6,593**	**7,094**	**7.6%**	**7,094**	**7,174**	**1.1%**
Children's Medicaid Program						
Jackson	22,046	21,608	-2.0%	21,608	22,077	2.2%
Josephine	9,383	9,241	-1.5%	9,241	9,161	-0.9%
District 8 Total	**31,429**	**30,849**	**-1.8%**	**30,849**	**31,238**	**1.3%**
Children's Health Insurance Program (CHIP)						
Jackson	3,878	3,968	2.3%	3,968	3,677	-7.3%
Josephine	1,337	1,374	2.8%	1,374	1,302	-5.2%
District 8 Total	**5,215**	**5,342**	**2.4%**	**5,342**	**4,979**	**-6.8%**
Pregnant Women Program						
Jackson	1,076	1,187	10.3%	1,187	978	-17.6%
Josephine	495	539	8.9%	539	444	-17.6%
District 8 Total	**1,571**	**1,726**	**9.9%**	**1,726**	**1,422**	**-17.6%**
Foster Care & Adoption Services						
Jackson	1,280	1,313	2.6%	1,313	1,354	3.1%
Josephine	562	571	1.6%	571	580	1.6%
District 8 Total	**1,842**	**1,884**	**2.3%**	**1,884**	**1,934**	**2.7%**

District 8 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Coos and Curry

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Jackson	4,485	4,524	0.9%	4,524	4,573	1.1%
Josephine	2,552	2,542	-0.4%	2,542	2,530	-0.5%
District 8 Total	**7,037**	**7,066**	**0.4%**	**7,066**	**7,103**	**0.5%**
Old Age Assistance						
Jackson	2,225	2,233	0.4%	2,233	2,452	9.8%
Josephine	1,168	1,173	0.4%	1,173	1,229	4.8%
District 8 Total	**3,393**	**3,406**	**0.4%**	**3,406**	**3,681**	**8.1%**
ACA Adults						
Jackson	27,768	27,150	-2.2%	27,150	23,637	-12.9%
Josephine	13,053	12,855	-1.5%	12,855	11,335	-11.8%
District 8 Total	**40,821**	**40,005**	**-2.0%**	**40,005**	**34,972**	**-12.6%**

District 9 Regional Forecast

District 9 is the largest service district in the state in terms of number of counties, but is the least populated. It contains three counties (Gilliam, Sherman, and Wheeler) that have a very limited, farm-based economy and two (Hood River and Wasco) that are relatively more populated and serve as the economic drivers for the region.

Unemployment in the region is a mixed bag: Gilliam County's unemployment, at 7.3 percent, is among the highest in the state, while Hood River (at 4.4 percent) has the lowest. Most counties in the district have lower unemployment than the state overall and have recovered the jobs lost due to the Great Recession, but Gilliam County employs almost 17 percent fewer people now than in 2007.

Hood River County has been one of the fastest growing counties in the state, and the state demographer expects that growth to continue, bringing with it economic stimulus and a chance to further diversify the county's economy.

DISTRICT 9	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Gilliam	2,016	20.4%	23.3%	$46,490	7.8%	7.4%	7.3%
Hood River	23,485	25.4%	13.7%	$56,417	15.7%	4.7%	4.4%
Sherman	1,986	19.2%	23.7%	$39,960	19.4%	6.8%	4.7%
Wasco	24,297	22.5%	18.7%	$43,226	16.9%	5.6%	5.2%
Wheeler	1,591	15.3%	30.7%	$34,808	18.3%	5.7%	4.9%

District 9 Regional Forecast, Oregon Department of Human Services

Counties served: Gilliam, Hood River, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Gilliam	92	90	-2.2%	90	80	-11.1%
Hood River	1,154	1,109	-3.9%	1,109	897	-19.1%
Sherman	83	91	9.6%	91	95	4.4%
Wasco	1,876	1,939	3.4%	1,939	1,622	-16.3%
Wheeler	81	86	6.2%	86	77	-10.5%
District 9 Total	**3,286**	**3,315**	**0.9%**	**3,315**	**2,771**	**-16.4%**
SNAP - Aid to People with Disabilities						
Gilliam	52	58	11.5%	58	65	12.1%
Hood River	421	419	-0.5%	419	477	13.8%
Sherman	57	59	3.5%	59	59	0.0%
Wasco	1,051	1,060	0.9%	1,060	1,105	4.2%
Wheeler	62	67	8.1%	67	73	9.0%
District 9 Total	**1,643**	**1,663**	**1.2%**	**1,663**	**1,779**	**7.0%**
TANF						
Gilliam	7	7	0.0%	7	7	0.0%
Hood River	51	51	0.0%	51	47	-7.8%
Sherman	3	4	33.3%	4	4	0.0%
Wasco	102	99	-2.9%	99	99	0.0%
Wheeler	1	2	100.0%	2	2	0.0%
District 9 Total	**164**	**163**	**-0.6%**	**163**	**159**	**-2.5%**

District 9 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Gilliam, Hood River, Sherman, Wasco, and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Gilliam	5	6	20.0%	6	7	16.7%
Hood River	30	32	6.7%	32	30	-6.3%
Sherman	4	5	25.0%	5	5	0.0%
Wasco	96	101	5.2%	101	107	5.9%
Wheeler	2	4	100.0%	4	7	75.0%
District 9 Total	**137**	**148**	**8.0%**	**148**	**156**	**5.4%**
Community-Based Care						
Gilliam	8	8	0.0%	8	8	0.0%
Hood River	30	31	3.3%	31	32	3.2%
Sherman	3	3	0.0%	3	3	0.0%
Wasco	76	79	3.9%	79	79	0.0%
Wheeler	9	8	-11.1%	8	9	12.5%
District 9 Total	**126**	**129**	**2.4%**	**129**	**131**	**1.6%**
Nursing Care						
Gilliam	0	0	0.0%	0	0	0.0%
Hood River	32	34	6.3%	34	35	2.9%
Sherman	1	1	0.0%	1	1	0.0%
Wasco	97	104	7.2%	104	106	1.9%
Wheeler	1	0	-100.0%	0	0	0.0%
District 9 Total	**131**	**139**	**6.1%**	**139**	**142**	**2.2%**

District 9 Regional Forecast, Oregon Health Authority (clients)

Counties served: Gilliam, Hood River, Sherman, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Gilliam	24	29	20.8%	29	31	6.9%
Hood River	316	307	-2.8%	307	308	0.3%
Sherman	31	28	-9.7%	28	27	-3.6%
Wasco	465	493	6.0%	493	492	-0.2%
Wheeler	33	29	-12.1%	29	30	3.4%
District 9 Total	**869**	**886**	**2.0%**	**886**	**888**	**0.2%**
Children's Medicaid Program						
Gilliam	166	157	-5.4%	157	170	8.3%
Hood River	2,757	2,594	-5.9%	2,594	2,624	1.2%
Sherman	119	113	-5.0%	113	119	5.3%
Wasco	2,950	2,855	-3.2%	2,855	2,913	2.0%
Wheeler	107	99	-7.5%	99	113	14.1%
District 9 Total	**6,099**	**5,818**	**-4.6%**	**5,818**	**5,939**	**2.1%**
Children's Health Insurance Program (CHIP)						
Gilliam	25	31	24.0%	31	35	12.9%
Hood River	631	646	2.4%	646	597	-7.6%
Sherman	11	16	45.5%	16	18	12.5%
Wasco	540	551	2.0%	551	516	-6.4%
Wheeler	10	12	20.0%	12	17	41.7%
District 9 Total	**1,217**	**1,256**	**3.2%**	**1,256**	**1,183**	**-5.8%**

District 9 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Gilliam, Hood River, Sherman, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Pregnant Women Program						
Gilliam	4	3	-25.0%	3	3	0.0%
Hood River	111	116	4.5%	116	98	-15.5%
Sherman	6	7	16.7%	7	8	14.3%
Wasco	150	158	5.3%	158	139	-12.0%
Wheeler	5	5	0.0%	5	5	0.0%
District 9 Total	**276**	**289**	**4.7%**	**289**	**253**	**-12.5%**
Foster Care & Adoption Services						
Gilliam	13	10	-23.1%	10	9	-10.0%
Hood River	73	89	21.9%	89	100	12.4%
Sherman	14	14	0.0%	14	14	0.0%
Wasco	184	175	-4.9%	175	175	0.0%
Wheeler	8	11	37.5%	11	10	-9.1%
District 9 Total	**292**	**299**	**2.4%**	**299**	**308**	**3.0%**
Aid to the Blind/Disabled						
Gilliam	30	30	0.0%	30	30	0.0%
Hood River	238	236	-0.8%	236	241	2.1%
Sherman	28	27	-3.6%	27	27	0.0%
Wasco	640	628	-1.9%	628	629	0.2%
Wheeler	18	20	11.1%	20	21	5.0%
District 9 Total	**954**	**941**	**-1.4%**	**941**	**948**	**0.7%**

District 9 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Gilliam, Hood River, Sherman, Wasco and Wheeler

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Old Age Assistance						
Gilliam	18	18	0.0%	18	18	0.0%
Hood River	161	160	-0.6%	160	170	6.3%
Sherman	7	9	28.6%	9	9	0.0%
Wasco	324	340	4.9%	340	349	2.6%
Wheeler	18	20	11.1%	20	22	10.0%
District 9 Total	**528**	**547**	**3.6%**	**547**	**568**	**3.8%**
ACA Adults						
Gilliam	151	156	3.3%	156	142	-9.0%
Hood River	2,519	2,473	-1.8%	2,473	2,203	-10.9%
Sherman	150	157	4.7%	157	159	1.3%
Wasco	3,043	2,995	-1.6%	2,995	2,646	-11.7%
Wheeler	175	164	-6.3%	164	144	-12.2%
District 9 Total	**6,038**	**5,945**	**-1.5%**	**5,945**	**5,294**	**-11.0%**

District 10 Regional Forecast

The Central Oregon economy has been growing fast – there has been a 5.7 percent increase in employment comparing August 2016 to the previous year. That's the biggest increase in the state. In Deschutes County, the total number of persons working exceeds pre-recession levels. The economy has been re-structured in Bend, though, with more jobs in lower-paying health-services and food services, and fewer in manufacturing and construction.

Crook County was among the worst hit during the Great Recession, receiving the one-two punch of losing both construction and wood-products jobs when the housing boom went bust. Unemployment remains higher than most counties in the state, but is still an improvement from the double-digit rates experienced for six years prior to 2014. Total non-farm employment is still almost 17 percent below pre-recession levels. Wood products manufacturing has not yet recovered, nor has manufacturing-dependent transportation jobs.

Jefferson is one of the least populated counties in the state, but unlike many other sparsely populated areas, it has mostly recovered from the Great Recession. However, unemployment is relatively high. Jobs in wood products manufacturing and wholesale trade are still below pre-recession levels, but jobs in health services are on the rise.

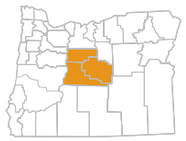
The TANF caseload are expected to continue to fall at a fast pace in Deschutes County, fueled by an excellent jobs market. SNAP is expected to fall in Deschutes and Crook counties faster than the rest of the state, while Jefferson County caseloads are expected to drop much more slowly.

DISTRICT 10	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Crook	25,249	20.3%	22.7%	$36,158	20.8%	8.8%	7.5%
Deschutes	178,418	22.2%	16.6%	$49,584	15.0%	6.5%	5.4%
Jefferson	24,079	24.7%	16.5%	$46,588	20.9%	7.5%	7.1%

District 10 Regional Forecast, Oregon Department of Human Services

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Crook	1,538	1,597	3.8%	1,597	1,282	-19.7%
Deschutes	10,298	10,434	1.3%	10,434	8,042	-22.9%
Jefferson	2,714	2,742	1.0%	2,742	2,652	-3.3%
District 10 Total	**14,550**	**14,773**	**1.5%**	**14,773**	**11,976**	**-18.9%**
SNAP - Aid to People with Disabilities						
Crook	954	940	-1.5%	940	940	0.0%
Deschutes	4,277	4,300	0.5%	4,300	4,438	3.2%
Jefferson	973	963	-1.0%	963	1,018	5.7%
District 10 Total	**6,204**	**6,203**	**0.0%**	**6,203**	**6,396**	**3.1%**
TANF						
Crook	117	117	0.0%	117	103	-12.0%
Deschutes	512	452	-11.7%	452	272	-39.8%
Jefferson	346	313	-9.5%	313	266	-15.0%
District 10 Total	**975**	**882**	**-9.5%**	**882**	**641**	**-27.3%**



District 10 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Crook	144	137	-4.9%	137	153	11.7%
Deschutes	483	435	-9.9%	435	471	8.3%
Jefferson	106	102	-3.8%	102	105	2.9%
District 10 Total	**733**	**674**	**-8.0%**	**674**	**729**	**8.2%**
Community-Based Care						
Crook	58	60	3.4%	60	61	1.7%
Deschutes	428	430	0.5%	430	455	5.8%
Jefferson	68	71	4.4%	71	72	1.4%
District 10 Total	**554**	**561**	**1.3%**	**561**	**588**	**4.8%**
Nursing Care						
Crook	23	23	0.0%	23	23	0.0%
Deschutes	57	62	8.8%	62	64	3.2%
Jefferson	11	12	9.1%	12	13	8.3%
District 10 Total	**91**	**97**	**6.6%**	**97**	**100**	**3.1%**

District 10 Regional Forecast, Oregon Health Authority (clients)

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Crook	488	493	1.0%	493	460	-6.7%
Deschutes	2,748	2,925	6.4%	2,925	2,953	1.0%
Jefferson	741	770	3.9%	770	774	0.5%
District 10 Total	**3,977**	**4,188**	**5.3%**	**4,188**	**4,187**	**0.0%**
Children's Medicaid Program						
Crook	2,321	2,263	-2.5%	2,263	2,395	5.8%
Deschutes	14,206	14,151	-0.4%	14,151	14,428	2.0%
Jefferson	3,720	3,729	0.2%	3,729	4,102	10.0%
District 10 Total	**20,247**	**20,143**	**-0.5%**	**20,143**	**20,925**	**3.9%**
Children's Health Insurance Program (CHIP)						
Crook	415	414	-0.2%	414	382	-7.7%
Deschutes	3,910	3,844	-1.7%	3,844	3,627	-5.6%
Jefferson	375	379	1.1%	379	343	-9.5%
District 10 Total	**4,700**	**4,637**	**-1.3%**	**4,637**	**4,352**	**-6.1%**
Pregnant Women Program						
Crook	95	106	11.6%	106	88	-17.0%
Deschutes	660	734	11.2%	734	616	-16.1%
Jefferson	135	144	6.7%	144	118	-18.1%
District 10 Total	**890**	**984**	**10.6%**	**984**	**822**	**-16.5%**

District 10 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Crook, Deschutes and Jefferson

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Crook	101	109	7.9%	109	119	9.2%
Deschutes	603	611	1.3%	611	637	4.3%
Jefferson	242	257	6.2%	257	268	4.3%
District 10 Total	**946**	**977**	**3.3%**	**977**	**1,024**	**4.8%**
Aid to the Blind/Disabled						
Crook	499	488	-2.2%	488	534	9.4%
Deschutes	2,520	2,547	1.1%	2,547	2,702	6.1%
Jefferson	643	638	-0.8%	638	696	9.1%
District 10 Total	**3,662**	**3,673**	**0.3%**	**3,673**	**3,932**	**7.1%**
Old Age Assistance						
Crook	222	225	1.4%	225	241	7.1%
Deschutes	1,045	1,059	1.3%	1,059	1,195	12.8%
Jefferson	254	261	2.8%	261	287	10.0%
District 10 Total	**1,521**	**1,545**	**1.6%**	**1,545**	**1,723**	**11.5%**
ACA Adults						
Crook	2,659	2,601	-2.2%	2,601	2,225	-14.5%
Deschutes	18,971	18,681	-1.5%	18,681	16,326	-12.6%
Jefferson	3,291	3,301	0.3%	3,301	2,915	-11.7%
District 10 Total	**24,921**	**24,583**	**-1.4%**	**24,583**	**21,466**	**-12.7%**

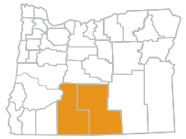
District 11 Regional Forecast

Klamath and Lake counties have higher unemployment than the rest of the state – but that's been historically true since before the Great Recession. Added to the historical weakness in the labor market, the Klamath Basin has suffered an extreme drought. Drought conditions resulted in negative direct effects on farmers and ranchers as well as negative indirect effects to businesses that provide goods and services to those farmers and ranchers. The snowpack in the winter of 2015-16 was 113 percent of average, which is good news for irrigators, but may take multiple years of good precipitation for the land to recover completely.

Employment has been growing in both Klamath and Lake counties, but still remains below pre-recession levels.

SNAP and TANF caseloads are expected to fall at the same rate as the state overall in Klamath County. The TANF counts in Lake County fell sharply starting in 2011, and are now below pre-recession levels. It is expected to remain at this unprecedented "floor" through the forecast horizon.

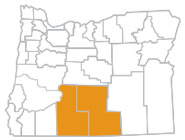
DISTRICT 11	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Klamath	68,851	21.8%	18.2%	$39,534	18.6%	8.3%	7.4%
Lake	7,468	18.4%	21.3%	$34,535	17.8%	7.9%	6.6%



District 11 Regional Forecast, Oregon Department of Human Services

Counties served: Klamath and Lake

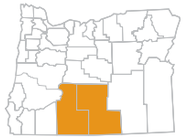
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Klamath	6,871	6,771	-1.5%	6,771	6,249	-7.7%
Lake	465	481	3.4%	481	420	-12.7%
District 11 Total	**7,336**	**7,252**	**-1.1%**	**7,252**	**6,669**	**-8.0%**
SNAP - Aid to People with Disabilities						
Klamath	3,090	3,096	0.2%	3,096	3,273	5.7%
Lake	366	360	-1.6%	360	362	0.6%
District 11 Total	**3,456**	**3,456**	**0.0%**	**3,456**	**3,635**	**5.2%**
TANF						
Klamath	470	473	0.6%	473	448	-5.3%
Lake	19	18	-5.3%	18	19	5.6%
District 11 Total	**489**	**491**	**0.4%**	**491**	**467**	**-4.9%**
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Klamath	388	351	-9.5%	351	391	11.4%
Lake	30	32	6.7%	32	35	9.4%
District 11 Total	**418**	**383**	**-8.4%**	**383**	**426**	**11.2%**
Community-Based Care						
Klamath	186	188	1.1%	188	191	1.6%
Lake	3	4	33.3%	4	5	25.0%
District 11 Total	**189**	**192**	**1.6%**	**192**	**196**	**2.1%**
Nursing Care						
Klamath	38	43	13.2%	43	44	2.3%
Lake	13	16	23.1%	16	17	6.3%
District 11 Total	**51**	**59**	**15.7%**	**59**	**61**	**3.4%**



District 11 Regional Forecast, Oregon Health Authority (clients)

Counties served: Klamath and Lake

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Klamath	1,593	1,679	5.4%	1,679	1,672	-0.4%
Lake	111	138	24.3%	138	141	2.2%
District 11 Total	**1,704**	**1,817**	**6.6%**	**1,817**	**1,813**	**-0.2%**
Children's Medicaid Program						
Klamath	7,471	7,330	-1.9%	7,330	7,195	-1.8%
Lake	697	680	-2.4%	680	701	3.1%
District 11 Total	**8,168**	**8,010**	**-1.9%**	**8,010**	**7,896**	**-1.4%**
Children's Health Insurance Program (CHIP)						
Klamath	861	855	-0.7%	855	765	-10.5%
Lake	78	80	2.6%	80	77	-3.8%
District 11 Total	**939**	**935**	**-0.4%**	**935**	**842**	**-9.9%**
Pregnant Women Program						
Klamath	350	382	9.1%	382	317	-17.0%
Lake	32	33	3.1%	33	35	6.1%
District 11 Total	**382**	**415**	**8.6%**	**415**	**352**	**-15.2%**
Foster Care & Adoption Services						
Klamath	584	588	0.7%	588	603	2.6%
Lake	55	54	-1.8%	54	49	-9.3%
District 11 Total	**639**	**642**	**0.5%**	**642**	**652**	**1.6%**



District 11 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Klamath and Lake

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Klamath	2,013	2,006	-0.3%	2,006	2,066	3.0%
Lake	181	184	1.7%	184	186	1.1%
District 11 Total	**2,194**	**2,190**	**-0.2%**	**2,190**	**2,252**	**2.8%**
Old Age Assistance						
Klamath	726	746	2.8%	746	849	13.8%
Lake	73	77	5.5%	77	82	6.5%
District 11 Total	**799**	**823**	**3.0%**	**823**	**931**	**13.1%**
ACA Adults						
Klamath	8,892	8,766	-1.4%	8,766	7,703	-12.1%
Lake	812	799	-1.6%	799	707	-11.5%
District 11 Total	**9,704**	**9,565**	**-1.4%**	**9,565**	**8,410**	**-12.1%**

District 12 Regional Forecast

Information systems jobs have Morrow County booming, with employment now over 33 percent higher than in 2007. Many of the new jobs have attracted people with specialized skills, growing the population. With booms come busts, however, and the construction boost related to new industries moving into the area has ended. The result is a modest contraction in overall employment, and an unemployment rate higher than the state overall.

Umatilla County has almost recovered all jobs lost during the Great Recession. Manufacturing, transportation, and health services are expanding.

District 12 will likely see a drop in SNAP caseload equivalent to the state overall. Umatilla County experienced a sharp drop in TANF from 2013 to 2015, but the caseload has now flattened out at a rate well above pre-recession levels. TANF is expected to fall very slowly in Umatilla County.

DISTRICT 12	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Morrow	15,011	28.2%	13.2%	$50,443	19.3%	6.2%	5.9%
Umatilla	79,701	26.2%	13.3%	$47,185	17.1%	6.7%	5.9%

District 12 Regional Forecast, Oregon Department of Human Services

Counties served: Morrow and Umatilla

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Morrow	734	770	4.9%	770	665	-13.6%
Umatilla	5,610	5,640	0.5%	5,640	4,886	-13.4%
District 12 Total	**6,344**	**6,410**	**1.0%**	**6,410**	**5,551**	**-13.4%**
SNAP - Aid to People with Disabilities						
Morrow	317	311	-1.9%	311	332	6.8%
Umatilla	2,310	2,310	0.0%	2,310	2,378	2.9%
District 12 Total	**2,627**	**2,621**	**-0.2%**	**2,621**	**2,710**	**3.4%**
TANF						
Morrow	90	85	-5.6%	85	80	-5.9%
Umatilla	565	568	0.5%	568	551	-3.0%
District 12 Total	**655**	**653**	**-0.3%**	**653**	**631**	**-3.4%**
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Morrow	43	46	7.0%	46	54	17.4%
Umatilla	392	381	-2.8%	381	399	4.7%
District 12 Total	**435**	**427**	**-1.8%**	**427**	**453**	**6.1%**
Community-Based Care						
Morrow	12	16	33.3%	16	18	12.5%
Umatilla	226	223	-1.3%	223	222	-0.4%
District 12 Total	**238**	**239**	**0.4%**	**239**	**240**	**0.4%**
Nursing Care						
Morrow	9	6	-33.3%	6	6	0.0%
Umatilla	85	84	-1.2%	84	84	0.0%
District 12 Total	**94**	**90**	**-4.3%**	**90**	**90**	**0.0%**

District 12 Regional Forecast, Oregon Health Authority (clients)

Counties served: Morrow and Umatilla

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Morrow	223	229	2.7%	229	227	-0.9%
Umatilla	1,451	1,532	5.6%	1,532	1,450	-5.4%
District 12 Total	**1,674**	**1,761**	**5.2%**	**1,761**	**1,677**	**-4.8%**
Children's Medicaid Program						
Morrow	1,681	1,610	-4.2%	1,610	1,635	1.6%
Umatilla	9,438	9,221	-2.3%	9,221	9,038	-2.0%
District 12 Total	**11,119**	**10,831**	**-2.6%**	**10,831**	**10,673**	**-1.5%**
Children's Health Insurance Program (CHIP)						
Morrow	200	211	5.5%	211	183	-13.3%
Umatilla	1,344	1,347	0.2%	1,347	1,203	-10.7%
District 12 Total	**1,544**	**1,558**	**0.9%**	**1,558**	**1,386**	**-11.0%**
Pregnant Women Program						
Morrow	43	49	14.0%	49	39	-20.4%
Umatilla	415	367	-11.6%	367	288	-21.5%
District 12 Total	**458**	**416**	**-9.2%**	**416**	**327**	**-21.4%**
Foster Care & Adoption Services						
Morrow	43	49	14.0%	49	54	10.2%
Umatilla	393	390	-0.8%	390	410	5.1%
District 12 Total	**436**	**439**	**0.7%**	**439**	**464**	**5.7%**

District 12 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Klamath and Lake

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Aid to the Blind/Disabled						
Morrow	201	209	4.0%	209	224	7.2%
Umatilla	1,584	1,560	-1.5%	1,560	1,591	2.0%
District 12 Total	**1,785**	**1,769**	**-0.9%**	**1,769**	**1,815**	**2.6%**
Old Age Assistance						
Morrow	89	90	1.1%	90	97	7.8%
Umatilla	814	836	2.7%	836	858	2.6%
District 12 Total	**903**	**926**	**2.5%**	**926**	**955**	**3.1%**
ACA Adults						
Morrow	993	957	-3.6%	957	811	-15.3%
Umatilla	7,123	6,969	-2.2%	6,969	5,988	-14.1%
District 12 Total	**8,116**	**7,926**	**-2.3%**	**7,926**	**6,799**	**-14.2%**

District 13 Regional Forecast

Northeastern Oregon is sparsely populated, and like a lot of rural areas has struggled to climb out of the hole created by the Great Recession. Unemployment remains higher in the area than the state overall, especially in Baker County.

Wallowa and Baker County are adding jobs, while Union is holding steady to recent gains, but all three still have a ways to go to reach pre-recession levels.

Unemployment has been historically higher in Baker County than the state overall, but the county is creating new jobs in most employment sectors. Weakness in the tourism-driven leisure and hospitality sector is cause for some concern.

The employment picture in Northeast Oregon is hampered by demographics. Prime working age is generally defined as ages 25 to 54, and there are fewer workers in Eastern Oregon that fall into that category than anywhere else in the state.

SNAP and TANF caseloads are expected to fall at the same pace as the state overall in Baker County, and slower in the other counties of District 13.

DISTRICT 13	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Baker	16,717	19.8%	23.6%	$40,576	18.3%	7.6%	7.0%
Union	26,545	22.2%	17.6%	$43,265	18.8%	6.6%	6.4%
Wallowa	7,611	18.6%	25.1%	$41,522	13.9%	7.9%	6.8%

District 13 Regional Forecast, Oregon Department of Human Services

Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Baker	1,211	1,249	3.1%	1,249	1,130	-9.5%
Union	1,767	1,811	2.5%	1,811	1,753	-3.2%
Wallowa	327	332	1.5%	332	305	-8.1%
District 13 Total	**3,305**	**3,392**	**2.6%**	**3,392**	**3,188**	**-6.0%**
SNAP - Aid to People with Disabilities						
Baker	736	716	-2.7%	716	713	-0.4%
Union	877	870	-0.8%	870	901	3.6%
Wallowa	268	264	-1.5%	264	284	7.6%
District 13 Total	**1,881**	**1,850**	**-1.6%**	**1,850**	**1,898**	**2.6%**
TANF						
Baker	120	121	0.8%	121	113	-6.6%
Union	217	226	4.1%	226	217	-4.0%
Wallowa	34	39	14.7%	39	40	2.6%
District 13 Total	**371**	**386**	**4.0%**	**386**	**370**	**-4.1%**

District 13 Regional Forecast, Oregon Department of Human Services (continued)

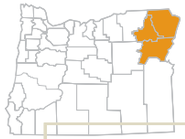
Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Baker	52	51	-1.9%	51	51	0.0%
Union	101	105	4.0%	105	118	12.4%
Wallowa	53	53	0.0%	53	64	20.8%
District 13 Total	**206**	**209**	**1.5%**	**209**	**233**	**11.5%**
Community-Based Care						
Baker	70	73	4.3%	73	80	9.6%
Union	102	107	4.9%	107	113	5.6%
Wallowa	29	31	6.9%	31	32	3.2%
District 13 Total	**201**	**211**	**5.0%**	**211**	**225**	**6.6%**
Nursing Care						
Baker	2	3	50.0%	3	0	-100.0%
Union	26	19	-26.9%	19	11	-42.1%
Wallowa	3	3	0.0%	3	3	0.0%
District 13 Total	**31**	**25**	**-19.4%**	**25**	**14**	**-44.0%**

District 13 Regional Forecast, Oregon Health Authority (clients)

Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Baker	321	349	8.7%	349	351	0.6%
Union	472	515	9.1%	515	495	-3.9%
Wallowa	129	133	3.1%	133	137	3.0%
District 13 Total	**922**	**997**	**8.1%**	**997**	**983**	**-1.4%**
Children's Medicaid Program						
Baker	1,550	1,562	0.8%	1,562	1,645	5.3%
Union	2,427	2,483	2.3%	2,483	2,466	-0.7%
Wallowa	581	563	-3.1%	563	575	2.1%
District 13 Total	**4,558**	**4,608**	**1.1%**	**4,608**	**4,686**	**1.7%**
Children's Health Insurance Program (CHIP)						
Baker	193	198	2.6%	198	177	-10.6%
Union	431	443	2.8%	443	416	-6.1%
Wallowa	200	204	2.0%	204	238	16.7%
District 13 Total	**824**	**845**	**2.5%**	**845**	**831**	**-1.7%**
Pregnant Women Program						
Baker	55	63	14.5%	63	54	-14.3%
Union	128	138	7.8%	138	122	-11.6%
Wallowa	16	18	12.5%	18	16	-11.1%
District 13 Total	**199**	**219**	**10.1%**	**219**	**192**	**-12.3%**



District 13 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Baker, Union and Wallowa

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Baker	134	130	-3.0%	130	136	4.6%
Union	151	155	2.6%	155	160	3.2%
Wallowa	22	19	-13.6%	19	20	5.3%
District 13 Total	**307**	**304**	**-1.0%**	**304**	**316**	**3.9%**
Aid to the Blind/Disabled						
Baker	423	412	-2.6%	412	420	1.9%
Union	628	613	-2.4%	613	616	0.5%
Wallowa	161	161	0.0%	161	168	4.3%
District 13 Total	**1,212**	**1,186**	**-2.1%**	**1,186**	**1,204**	**1.5%**
Old Age Assistance						
Baker	169	175	3.6%	175	177	1.1%
Union	229	232	1.3%	232	235	1.3%
Wallowa	86	94	9.3%	94	113	20.2%
District 13 Total	**484**	**501**	**3.5%**	**501**	**525**	**4.8%**
ACA Adults						
Baker	1,850	1,830	-1.1%	1,830	1,588	-13.2%
Union	2,638	2,543	-3.6%	2,543	2,085	-18.0%
Wallowa	761	748	-1.7%	748	647	-13.5%
District 13 Total	**5,249**	**5,121**	**-2.4%**	**5,121**	**4,320**	**-15.6%**

District 14 Regional Forecast

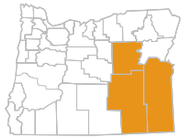
District 14 continues to struggle with high unemployment. Grant County has had the highest unemployment in the state for the past 11 months (October 2015 to August 2016). Although all three counties in the district have been adding jobs over the last 12 months, it has not been fast enough to keep pace with demand.

Employment in Malheur County is approaching pre-recession levels, and is growing in the traditionally higher-paying manufacturing, natural resource extraction, and construction areas. This is good news given that Malheur County has the highest percentage of residents in poverty in the state.

Employment in the area is hampered by demographics. Prime working age is generally defined as ages 25 to 54, and there are fewer workers in Eastern Oregon that fall into that category than elsewhere in the state.

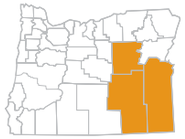
SNAP is projected to remain virtually unchanged in Harney County through the forecast horizon. Malheur County SNAP and TANF caseloads will fall in line with the expected statewide rate of decline. TANF in Grant County has returned to historical levels last seen before the Great Recession and is not expected to fall much lower than its current low level.

DISTRICT 14	Population			Income		Unemployment	
Region	Total population	Percent under age 18	Percent age 65 and over	Median Household Income	Percent in poverty	August 2015	August 2016
Oregon	4,095,708	22.1%	14.9%	$50,521	16.7%	5.8%	5.4%
Grant	7,562	18.7%	25.1%	$37,258	15.4%	8.8%	8.0%
Harney	7,779	21.3%	20.4%	$35,828	21.1%	7.4%	6.7%
Malheur	35,552	25.0%	15.4%	$34,380	28.4%	6.9%	6.2%



District 14 Regional Forecast, Oregon Department of Human Services
Counties served: Grant, Harney and Malheur

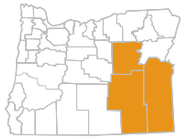
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Self Sufficiency (households)						
SNAP - Self Sufficiency						
Grant	347	365	5.2%	365	322	-11.8%
Harney	452	469	3.8%	469	424	-9.6%
Malheur	2,754	2,850	3.5%	2,850	2,410	-15.4%
District 14 Total	**3,553**	**3,684**	**3.7%**	**3,684**	**3,156**	**-14.3%**
SNAP - Aid to People with Disabilities						
Grant	285	277	-2.8%	277	273	-1.4%
Harney	361	349	-3.3%	349	379	8.6%
Malheur	1,335	1,351	1.2%	1,351	1,430	5.8%
District 14 Total	**1,981**	**1,977**	**-0.2%**	**1,977**	**2,082**	**5.3%**
TANF						
Grant	17	17	0.0%	17	16	-5.9%
Harney	32	29	-9.4%	29	23	-20.7%
Malheur	336	315	-6.3%	315	295	-6.3%
District 14 Total	**385**	**361**	**-6.2%**	**361**	**334**	**-7.5%**



District 14 Regional Forecast, Oregon Department of Human Services (continued)

Counties served: Grant, Harney and Malheur

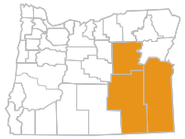
	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Aging and People with Disabilities, Long Term Care (clients)						
In-Home Care						
Grant	28	26	-7.1%	26	27	3.8%
Harney	30	31	3.3%	31	32	3.2%
Malheur	162	167	3.1%	167	174	4.2%
District 14 Total	**220**	**224**	**1.8%**	**224**	**233**	**4.0%**
Community-Based Care						
Grant	25	28	12.0%	28	31	10.7%
Harney	32	28	-12.5%	28	27	-3.6%
Malheur	143	144	0.7%	144	157	9.0%
District 14 Total	**200**	**200**	**0.0%**	**200**	**215**	**7.5%**
Nursing Care						
Grant	10	10	0.0%	10	9	-10.0%
Harney	1	1	0.0%	1	1	0.0%
Malheur	21	16	-23.8%	16	13	-18.8%
District 14 Total	**32**	**27**	**-15.6%**	**27**	**23**	**-14.8%**



District 14 Regional Forecast, Oregon Health Authority (clients)

Counties served: Grant, Harney and Malheur

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Parents/Caretaker Relative						
Grant	101	111	9.9%	111	113	1.8%
Harney	105	120	14.3%	120	124	3.3%
Malheur	796	866	8.8%	866	877	1.3%
District 14 Total	**1,002**	**1,097**	**9.5%**	**1,097**	**1,114**	**1.5%**
Children's Medicaid Program						
Grant	483	499	3.3%	499	519	4.0%
Harney	668	653	-2.2%	653	671	2.8%
Malheur	4,796	4,765	-0.6%	4,765	4,905	2.9%
District 14 Total	**5,947**	**5,917**	**-0.5%**	**5,917**	**6,095**	**3.0%**
Children's Health Insurance Program (CHIP)						
Grant	98	105	7.1%	105	101	-3.8%
Harney	115	116	0.9%	116	109	-6.0%
Malheur	379	383	1.1%	383	198	-48.3%
District 14 Total	**592**	**604**	**2.0%**	**604**	**408**	**-32.5%**
Pregnant Women Program						
Grant	21	21	0.0%	21	18	-14.3%
Harney	33	36	9.1%	36	27	-25.0%
Malheur	174	182	4.6%	182	157	-13.7%
District 14 Total	**228**	**239**	**4.8%**	**239**	**202**	**-15.5%**



District 14 Regional Forecast, Oregon Health Authority (clients) (continued)

Counties served: Grant, Harney and Malheur

	Current Biennium			Fall 16 Forecast		
	Spring 16 Forecast	Fall 16 Forecast	% Change between Forecasts	2015-17	2017-19	% Change between Biennia
Health Systems Medicaid (clients)						
Foster Care & Adoption Services						
Grant	39	40	2.6%	40	40	0.0%
Harney	44	44	0.0%	44	43	-2.3%
Malheur	201	206	2.5%	206	213	3.4%
District 14 Total	**284**	**290**	**2.1%**	**290**	**296**	**2.1%**
Aid to the Blind/Disabled						
Grant	138	142	2.9%	142	144	1.4%
Harney	196	197	0.5%	197	209	6.1%
Malheur	940	932	-0.9%	932	973	4.4%
District 14 Total	**1,274**	**1,271**	**-0.2%**	**1,271**	**1,326**	**4.3%**
Old Age Assistance						
Grant	81	80	-1.2%	80	80	0.0%
Harney	79	77	-2.5%	77	78	1.3%
Malheur	447	448	0.2%	448	475	6.0%
District 14 Total	**607**	**605**	**-0.3%**	**605**	**633**	**4.6%**
ACA Adults						
Grant	644	642	-0.3%	642	562	-12.5%
Harney	833	806	-3.2%	806	705	-12.5%
Malheur	3,277	3,250	-0.8%	3,250	2,805	-13.7%
District 14 Total	**4,754**	**4,698**	**-1.2%**	**4,698**	**4,072**	**-13.3%**

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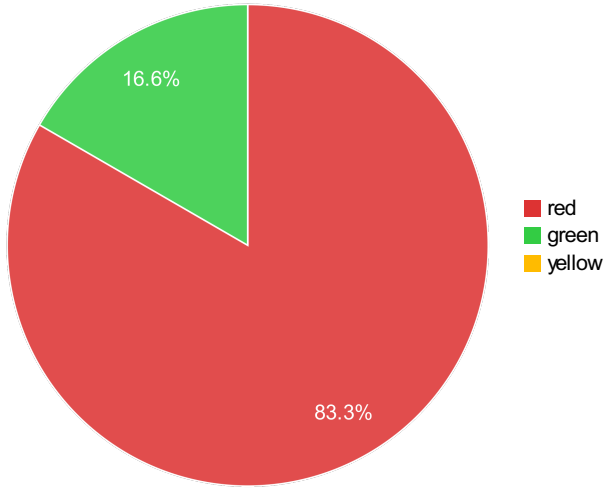
Oregon Health Authority

Annual Performance Progress Report

Reporting Year 2016

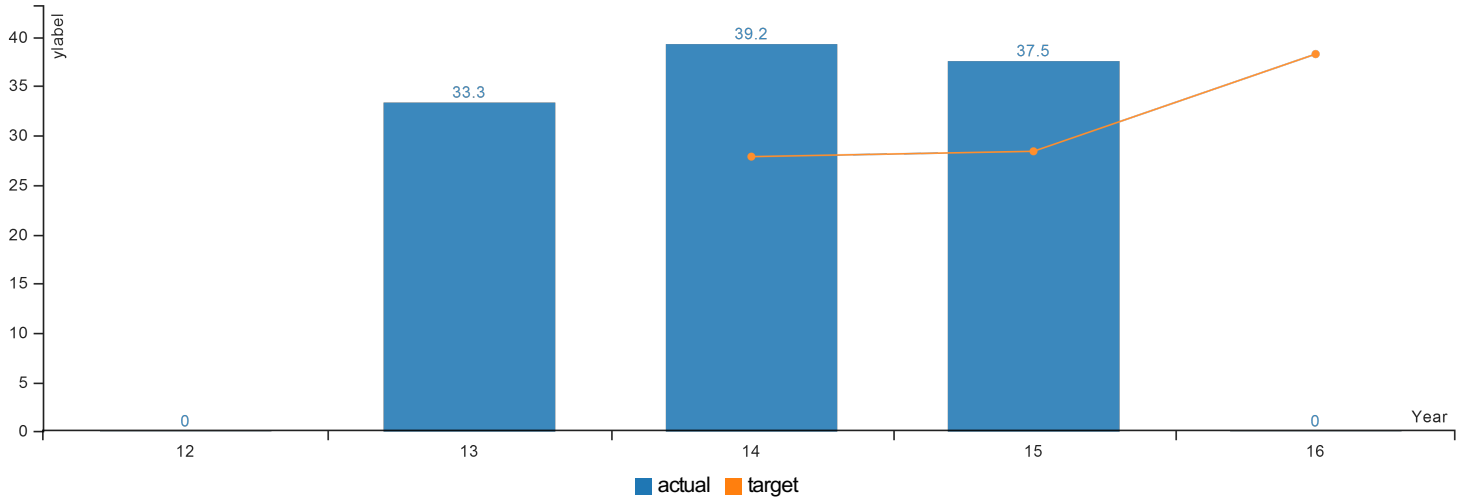
Published: 10/6/2016 9:31:56 AM

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 AND PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody.
5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
7	30 DAY ILLICIT DRUG USE AMONG 6TH GRADERS - Percentage of 6th graders who have used illicit drugs in the past 30 days.
8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
9	30 DAY ILLICIT DRUG USE AMONG 8TH GRADERS - Percentage of 8th graders who have used illicit drugs in the past 30 days.
10	30 DAY ALCOHOL USE AMONG 8TH GRADERS - Percentage of 8th graders who have used alcohol in the past 30 days.
11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
15	PRIMARY CARE SENSITIVE HOSPITAL ADMISSIONS/INPATIENT STAYS - Rate per 100,000 client years of admissions (for 12 diagnoses) that are more appropriately treated in an outpatient setting.
15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
16	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).
17	MEMBER EXPERIENCE OF CARE - Composite measurement: how well doctors communicate; health plan information and customer service (Medicaid population).
19	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good).
19	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
20	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
21	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
22	RATE OF OBESITY (MEDICAID) - Percentage of Medicaid population who are obese.
23	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
24	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
25	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
26	FLU SHOTS (MEDICAID) - Percentage of adults ages 50-64 who receive a flu vaccine.
27	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
28	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
29	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
36	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.



	Green	Yellow	Red
	= Target to -5%	= Target -6% to -15%	= Target > -15%
Summary Stats:	16.67%	0%	83.33%

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



Report Year	2012	2013	2014	2015	2016
Initiation of alcohol and other drug dependence treatment					
Actual	No Data	33.30%	39.20%	37.50%	No Data
Target	TBD	TBD	27.81%	28.35%	38.20%

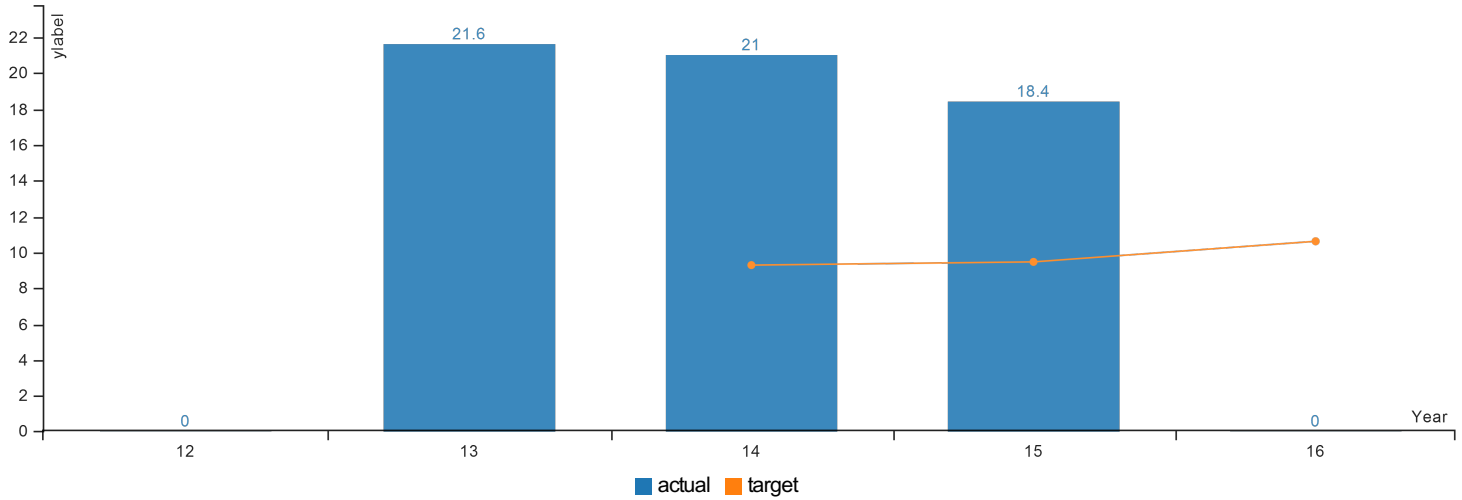
How Are We Doing

The percentage of Medicaid members ages 13 and older who were newly diagnosed with alcohol or other drug dependencies and who began treatment within 14 days of initial diagnosis has increased since 2013 and remains above the KPM target.

Factors Affecting Results

It is possible that the increased statewide emphasis on alcohol and drug use screening (SBIRT) due to the CCO incentive measure has 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



Report Year	2012	2013	2014	2015	2016
Engagement of alcohol and other drug dependence treatment					
Actual	No Data	21.60%	21%	18.40%	No Data
Target	TBD	TBD	9.27%	9.45%	10.60%

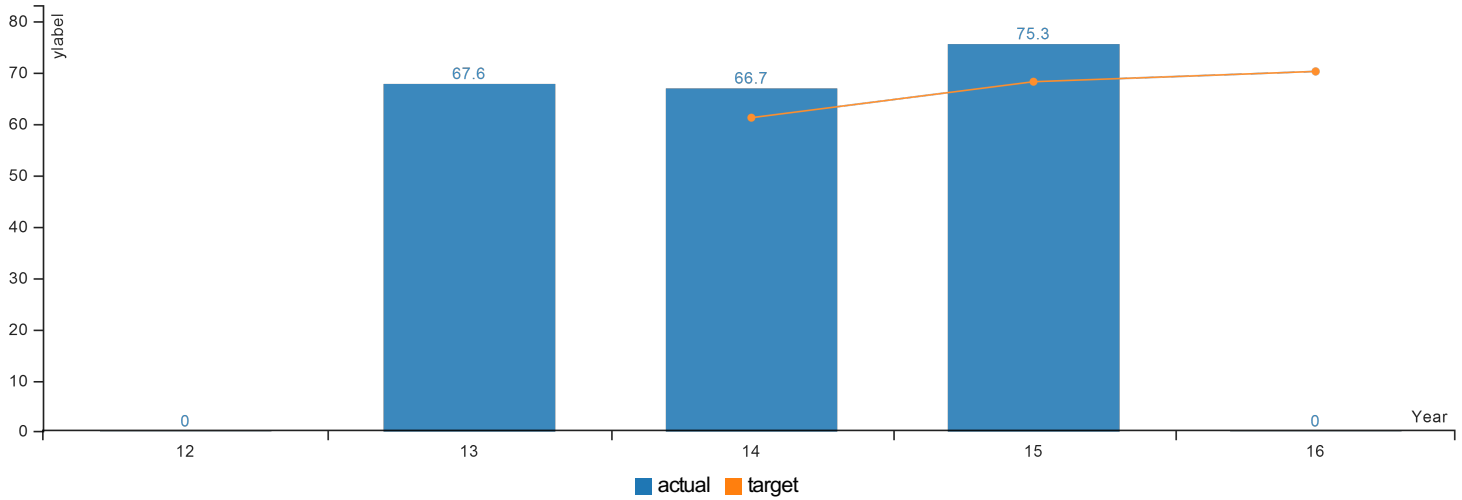
How Are We Doing

While initiation of treatment for Medicaid members ages 13 and older diagnosed with alcohol or other drug dependency (i.e. KPM #1) has increased since 2013, continued engagement -- defined as receiving two or additional services within 30 days of initial treatment -- declined in 2015. However, performance remains above the KPM target.

Factors Affecting Results

Nationally, performance on this metric is low, with a 2013 national Medicaid median of only 10.6%.

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



Report Year	2012	2013	2014	2015	2016
Follow-up after hospitalization for mental illness					
Actual	No Data	67.60%	66.70%	75.30%	No Data
Target	TBD	TBD	61%	68%	70%

How Are We Doing

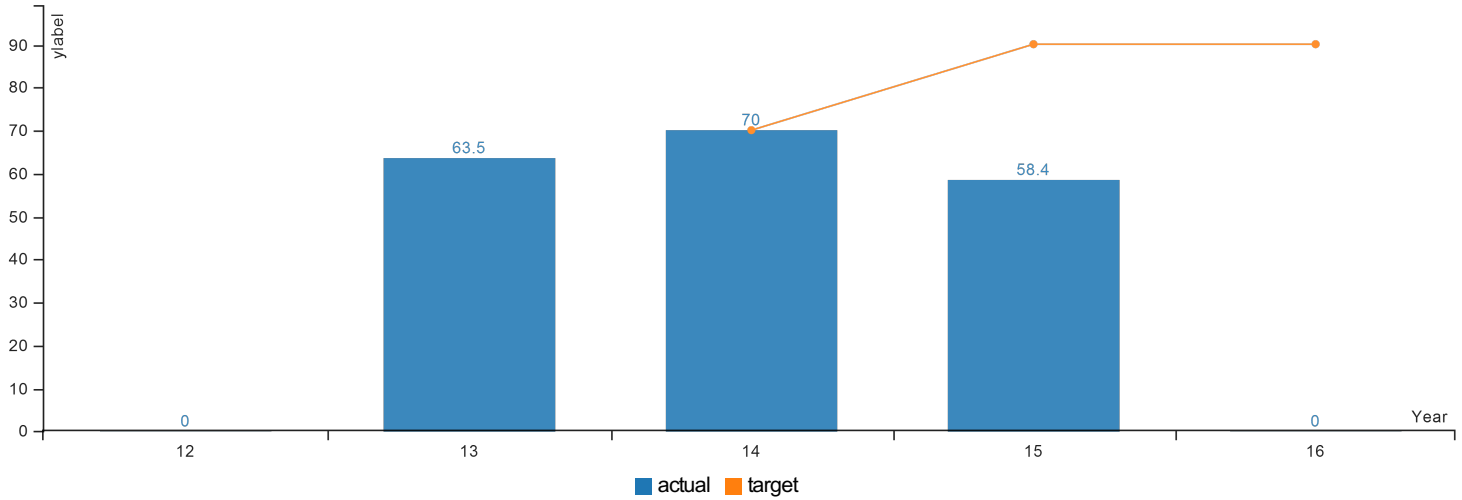
In 2015, three quarters of Medicaid members (ages 6 and older) who were admitted to the hospital for mental illness received follow-up with a health care provider within seven days of discharge. Oregon is achieving the KPM target and in 2015 surpassed the 2014 national Medicaid 90th percentile.

Beginning in 2015, follow-up visits on the same day of discharge were included in the measure. 2014 performance re-calculated using these updated measure specifications is 71.8%.

Factors Affecting Results

Oregon is using a modified version of the measure which includes follow up care provided in community health settings, resulting in our higher rate. This is also a CCO incentive measure and hospital incentive measure, so CCOs and hospitals across the state are making concerted efforts to improve performance.

KPM #4	MENTAL AND PHYSICAL HEALTH ASSESSMENTS FOR CHILDREN IN DHS CUSTODY - Percentage of children in DHS custody who receive a mental and physical health assessment within 60 days of initial custody.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Mental health assessment for children in DHS custody					
Actual	No Data	63.50%	70%	58.40%	No Data
Target	TBD	TBD	70%	90%	90%

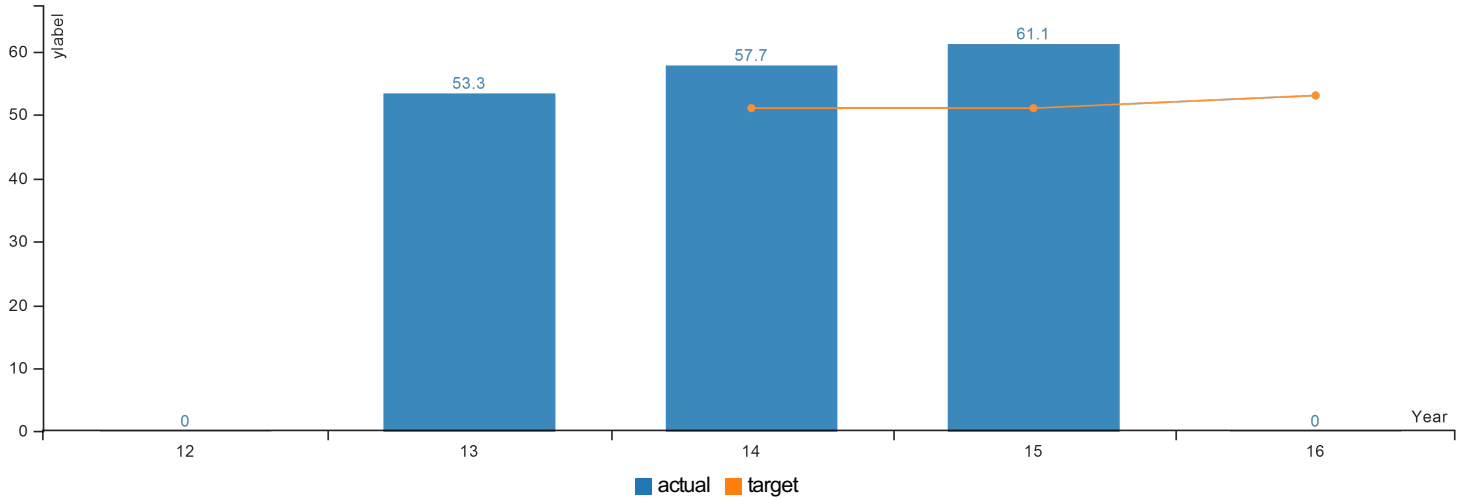
How Are We Doing

In 2015, dental health assessments were added to this CCO incentive measure, resulting in a notable decrease from earlier years when only mental and physical health assessments were included in the measure calculations (63.5% and 70.0% in 2013 and 2014, respectively). However when 2014 data are recalculated using these updated specifications, we find that only 27.9% of members received all three components of care. Thus, while there is plenty of room for continued improvement, progress was notable in this first year of using the updated specifications.

Factors Affecting Results

Because this is a CCO incentive measure, CCOs across the state are making concerted efforts to improve performance. One factor driving improvement has been increased coordination between CCOs and local DHS branch offices.

KPM #5	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (INITIATION) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Follow-up care for children prescribed with ADHD medication (initiation)					
Actual	No Data	53.30%	57.70%	61.10%	No Data
Target	TBD	TBD	51%	51%	53%

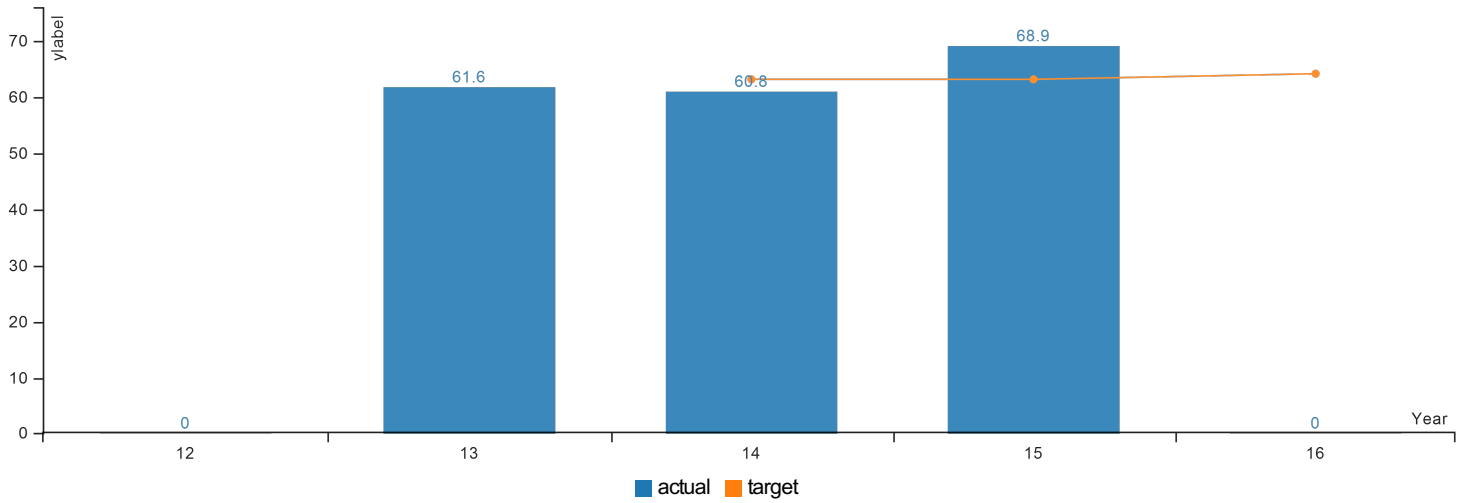
How Are We Doing

In 2011, 52.3% of children ages 6-12 had at least one follow up visit with a health care provider during the 30 days after receiving a new prescription for Attention Deficit Hyperactivity Disorder (ADHD) medication. In 2013, the rate had increased just slightly to 53.3%, above the KPM target, and above the 90th percentile nationally. The rate has continued to improve since then, with 61.1% of patients newly prescribed ADHD medication receiving follow up in 2015. Due in part to these successes, this measure had been retired as a CCO incentive measure beginning in 2015. Oregon is above the national 90th percentile for both Medicaid and Commercial.

Factors Affecting Results

We have heard from providers that limiting the follow up visit to within the first 30 days is not well aligned with some of the current ADHD medications, which may require a 45 day initial prescription. Children with these longer initial prescriptions would fall outside of the 30 day window for this measure.

KPM #6	FOLLOW-UP CARE FOR CHILDREN PRESCRIBED WITH ADHD MEDICATION (CONTINUATION AND MAINTENANCE) - Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Follow-up care for children prescribed with ADHD medication (continuation and maintenance)					
Actual	No Data	61.60%	60.80%	68.90%	No Data
Target	TBD	TBD	63%	63%	64%

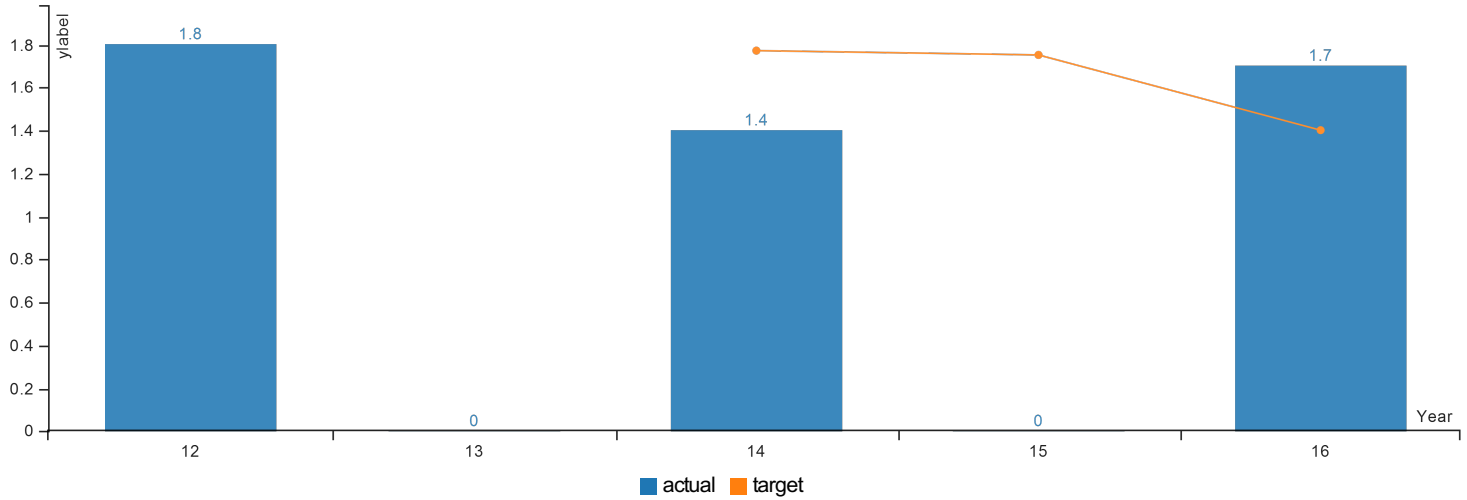
How Are We Doing

Calendar year 2011 is the baseline for this measure. In 2011, 61.0% of children who remained on ADHD medication for 210 days after receiving a new prescription also had at least two follow up visits with a provider. This rate remained fairly steady in 2013 and 2014, and increased notably in 2015, with 68.9% of children receiving continued follow-up with a provider.

Factors Affecting Results

A number of other CCO incentive measures as well as initiatives including the patient-centered primary care home model put greater emphasis on preventive care and well child visits. These efforts may result in children being more likely to engage with their primary care providers, leading to greater follow-up care for children prescribed medications for their ADHD. This measure is also notable for small denominators across the CCOs (with some having fewer than 30 children that meet these criteria); data shifts are more likely given these small numbers.

KPM #7	30 DAY ILLICIT DRUG USE AMONG 6TH GRADERS - Percentage of 6th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
30 day illicit drug use among 6th graders					
Actual	1.80%	No Data	1.40%	No Data	1.70%
Target	TBD	TBD	1.77%	1.75%	1.40%

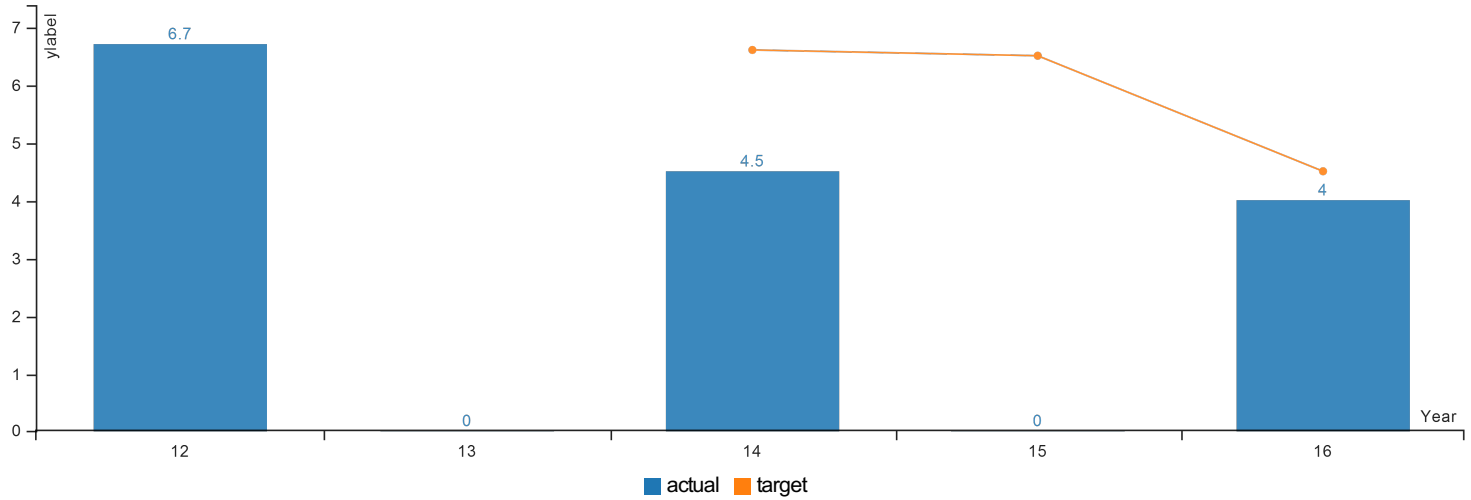
How Are We Doing

In 2012, the percentage of 6th graders who used any illicit drug in the past 30 days was 1.8%; in 2014 this decreased slightly to 1.4%; and in 2016 this increased again 1.7%.

Factors Affecting Results

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes toward drugs use have a tremendous effect on youth use. Youth whose parents feel that drug use is a “rite of passage” or that “kids will be kids” have much higher rates of illicit drug use than those whose parents are clear that youth should not do drugs.

KPM #8	30 DAY ALCOHOL USE AMONG 6TH GRADERS - Percentage of 6th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
30 day alcohol use among 6th graders					
Actual	6.70%	No Data	4.50%	No Data	4%
Target	TBD	TBD	6.60%	6.50%	4.50%

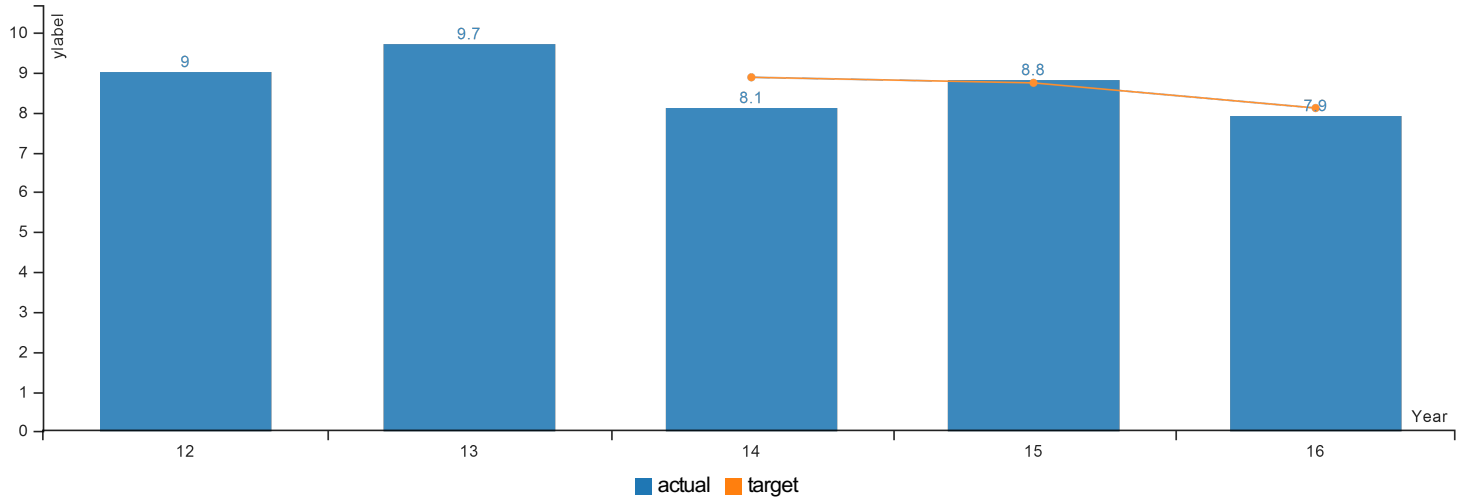
How Are We Doing

In 2012, 6.7% of 6th graders had at least one drink of alcohol within the past 30 days; in 2016, this decreased to 4.0%, meeting the target for 2016.

Factors Affecting Results

Underage drinking is considered a form of excessive alcohol use because it is both illegal and often involves consumption in quantities and settings that can lead to serious immediate and long-term consequences. The availability (price and retailer density), promotion and marketing of alcohol influence youth use rates.

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



Report Year	2012	2013	2014	2015	2016
30 day illicit drug use among 8th graders					
Actual	9%	9.70%	8.10%	8.80%	7.90%
Target	TBD	TBD	8.87%	8.73%	8.10%

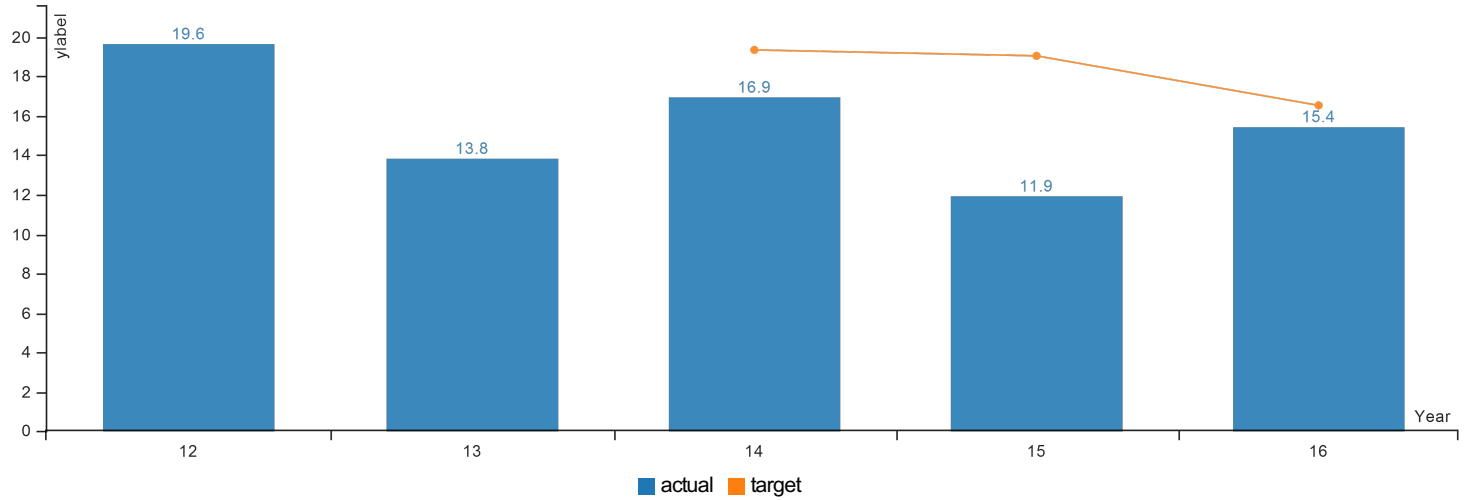
How Are We Doing

In 2012, the percentage of 8th graders who used any illicit drug in the past 30 days was 9.0%. After a slight increase in 2013 (9.7%), the rate has decreased each year with 7.9% of 8th graders using illicit drugs in the past 30 days in 2016.

Factors Affecting Results

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes toward drugs use have a tremendous effect on youth use. Youth whose parents feel that drug use is a “rite of passage” or that “kids will be kids” have much higher rates of illicit drug use than those whose parents are clear that youth should not do drugs.

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



Report Year	2012	2013	2014	2015	2016
30 day alcohol use among 8th graders					
Actual	19.60%	13.80%	16.90%	11.90%	15.40%
Target	TBD	TBD	19.31%	19.01%	16.50%

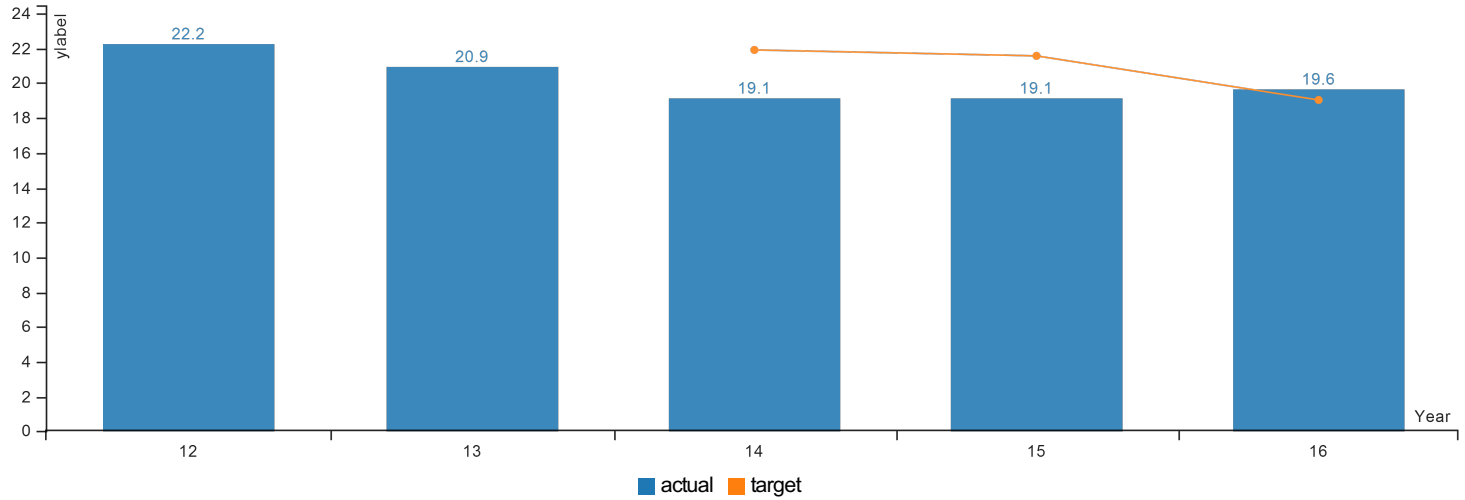
How Are We Doing

In 2012, 19.6% of 8th graders had at least one drink of alcohol in the past 30 days; in 2016, the rate decreased to 15.4%, meeting the 2016 target.

Factors Affecting Results

Underage drinking is considered a form of excessive alcohol use because it is both illegal and often involves consumption in quantities and settings that can lead to serious immediate and long-term consequences. The availability (price and retailer density), promotion and marketing of alcohol influence youth use rates.

KPM #11	30 DAY ILLICIT DRUG USE AMONG 11TH GRADERS - Percentage of 11th graders who have used illicit drugs in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
30 day illicit drug use among 11th graders					
Actual	22.20%	20.90%	19.10%	19.10%	19.60%
Target	TBD	TBD	21.87%	21.53%	19%

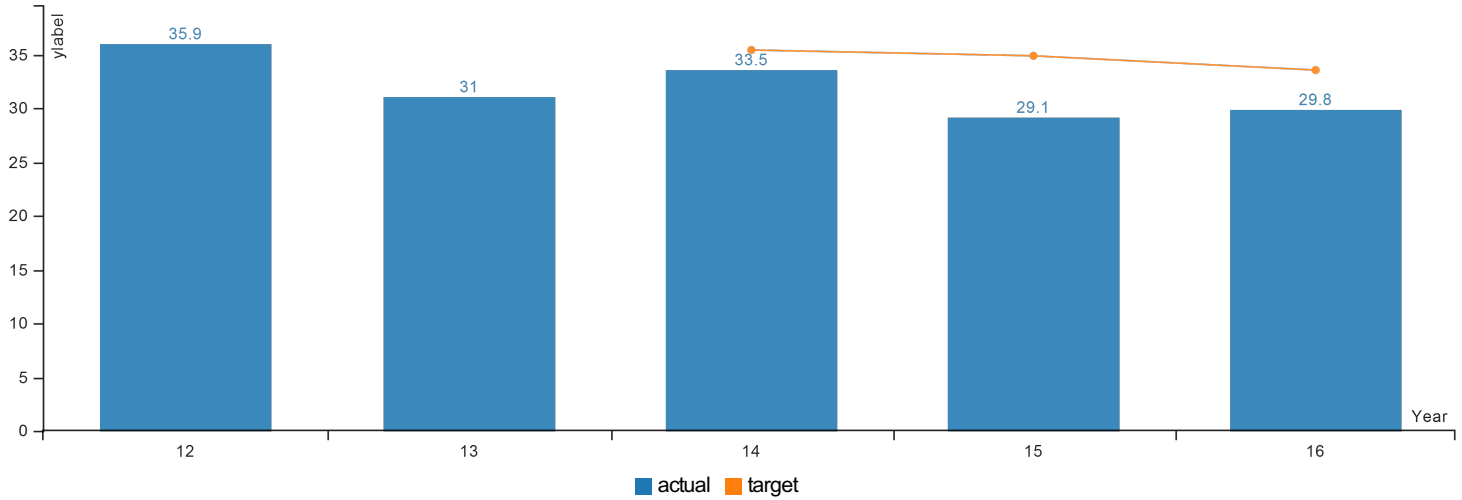
How Are We Doing

In 2012, the percentage of 11th graders who used any illicit drug in the past 30 days was 22.2%. By 2016, this decrased somewhat to 19.6%.

Factors Affecting Results

Favorable attitudes on the part of youth about using alcohol and other drugs can be a major predictor of their use. Parental attitudes toward drugs use have a tremendous effect on youth use. Youth whose parents feel that drug use is a “rite of passage” or that “kids will be kids” have much higher rates of illicit drug use than those whose parents are clear that youth should not do drugs.

KPM #12	30 DAY ALCOHOL USE AMONG 11TH GRADERS - Percentage of 11th graders who have used alcohol in the past 30 days.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
30 day alcohol use among 11th graders					
Actual	35.90%	31%	33.50%	29.10%	29.80%
Target	TBD	TBD	35.36%	34.82%	33.50%

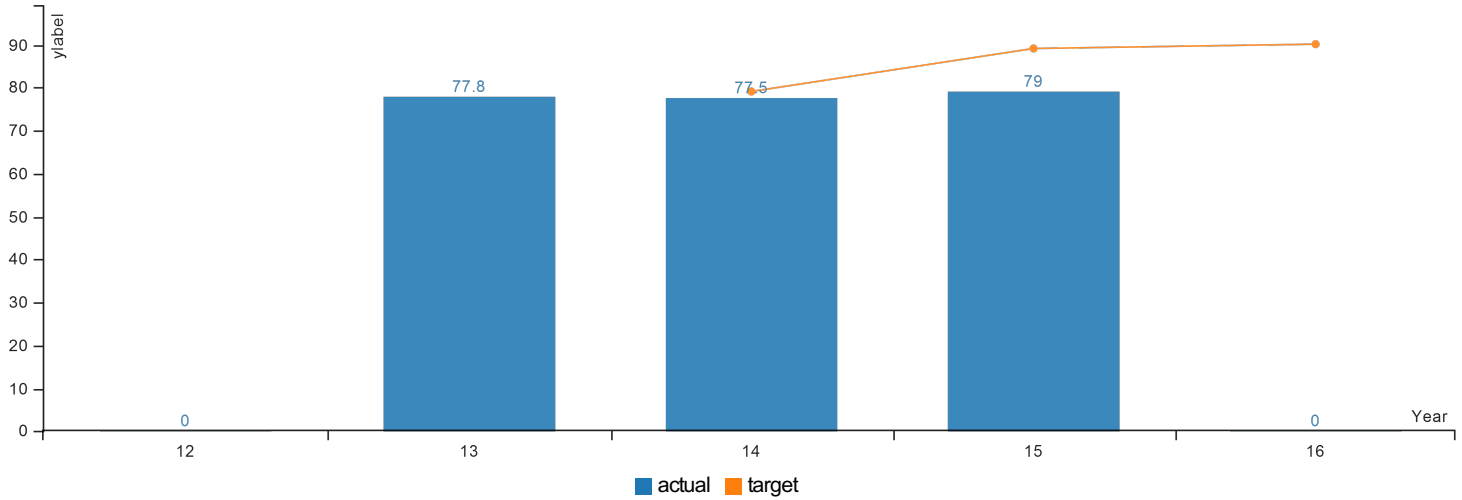
How Are We Doing

In 2012, 35.9% of Oregon 11th graders had at least one drink of alcohol in the past 30 days; in 2016 this decreased to 29.8%, meeting the 2016 target.

Factors Affecting Results

Underage drinking is considered a form of excessive alcohol use because it is both illegal and often involves consumption in quantities and settings that can lead to serious immediate and long-term consequences. The availability (price and retailer density), promotion and marketing of alcohol influence youth use rates.

KPM #13	PRENATAL CARE (POPULATION) - Percentage of women who initiated prenatal care in the first 3 months of pregnancy.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Prenatal care - population					
Actual	No Data	77.80%	77.50%	79%	No Data
Target	TBD	TBD	79%	89%	90%

How Are We Doing

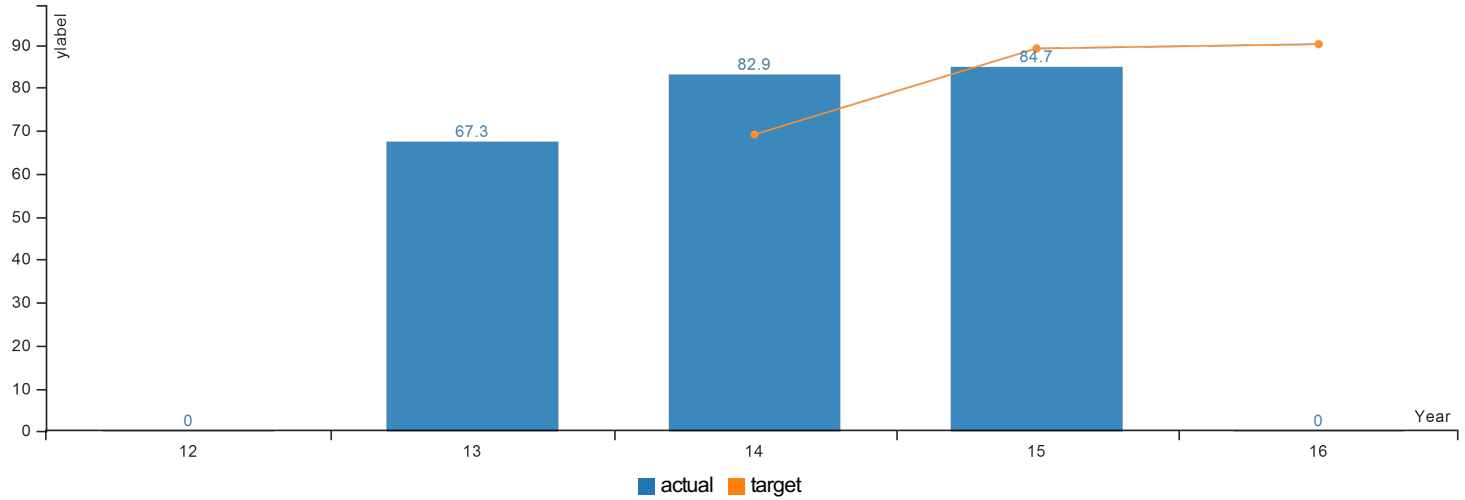
The rate of first trimester prenatal care has risen from 77.8% in 2012 to 79% in 2015.

In 2015, the overall rate in Oregon surpassed the HP 2020 objective of 77.9%; however, rates vary by race/ethnicity and maternal age. According to the March of Dimes PeriStats, in 2013 Washington's rate was 74.1% and California's 82.8%, compared to 77.8% in Oregon.

Factors Affecting Results

Women give a variety of reasons for not accessing early prenatal care.Women may not feel that early care is important, may not know they are pregnant or may be experiencing barriers such as lack of insurance coverage, inability to get a prenatal care appointment or unreliable transportation.

KPM #14	PRENATAL CARE (MEDICAID) - Percentage of women who initiated prenatal care within 42 days of enrollment.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Prenatal care - Medicaid					
Actual	No Data	67.30%	82.90%	84.70%	No Data
Target	TBD	TBD	69%	89%	90%

How Are We Doing

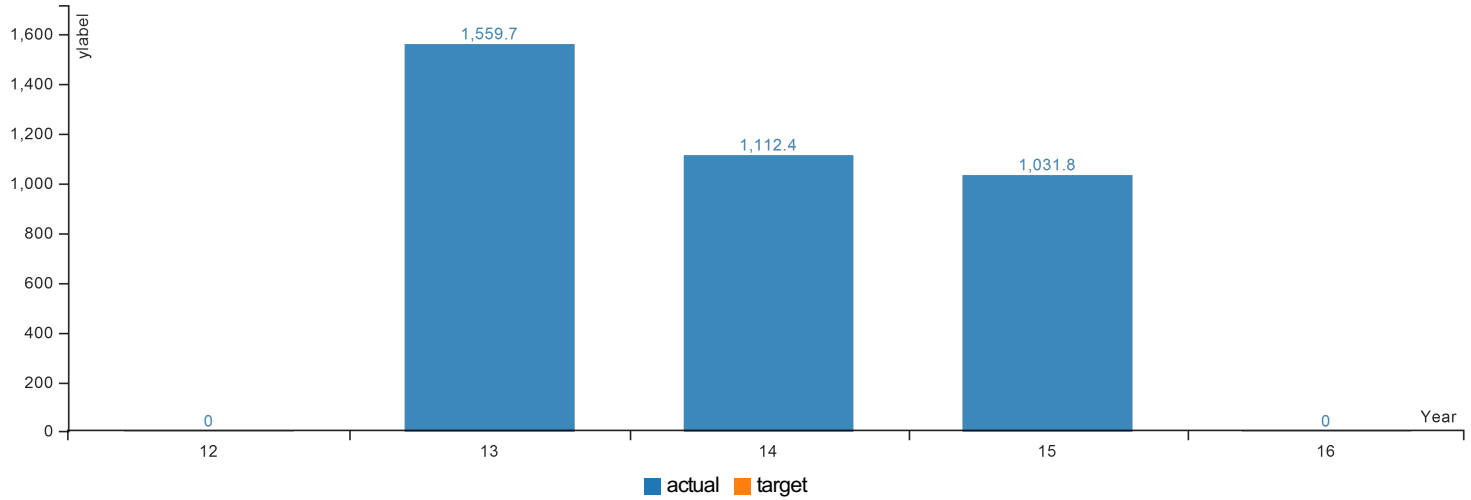
The rate of first trimester prenatal care for Medicaid increased slightly from 65.3% in 2011 to 67.3% in 2013 (administrative data only). In 2014, the percentage of women who received timely prenatal care was 75.0%* (measured using administrative data and medical record review). Much of the increase in the rate is due to the incorporation of information from the medical record review. In 2015, the rate increased again to 84.7%.

*Note: 2014 data have been revised since originally submitted in this KPM report.

Factors Affecting Results

Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation. Because this is a CCO incentive measure, CCOs across the state are making concerted efforts to improve performance.

KPM #15	PRIMARY CARE SENSITIVE HOSPITAL ADMISSIONS/INPATIENT STAYS - Rate per 100,000 client years of admissions (for 12 diagnoses) that are more appropriately treated in an outpatient setting.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Primary care sensitive hospital admissions/inpatient stays					
Actual	No Data	1,559.70	1,112.40	1,031.80	No Data
Target	TBD	TBD	TBD	TBD	TBD

How Are We Doing

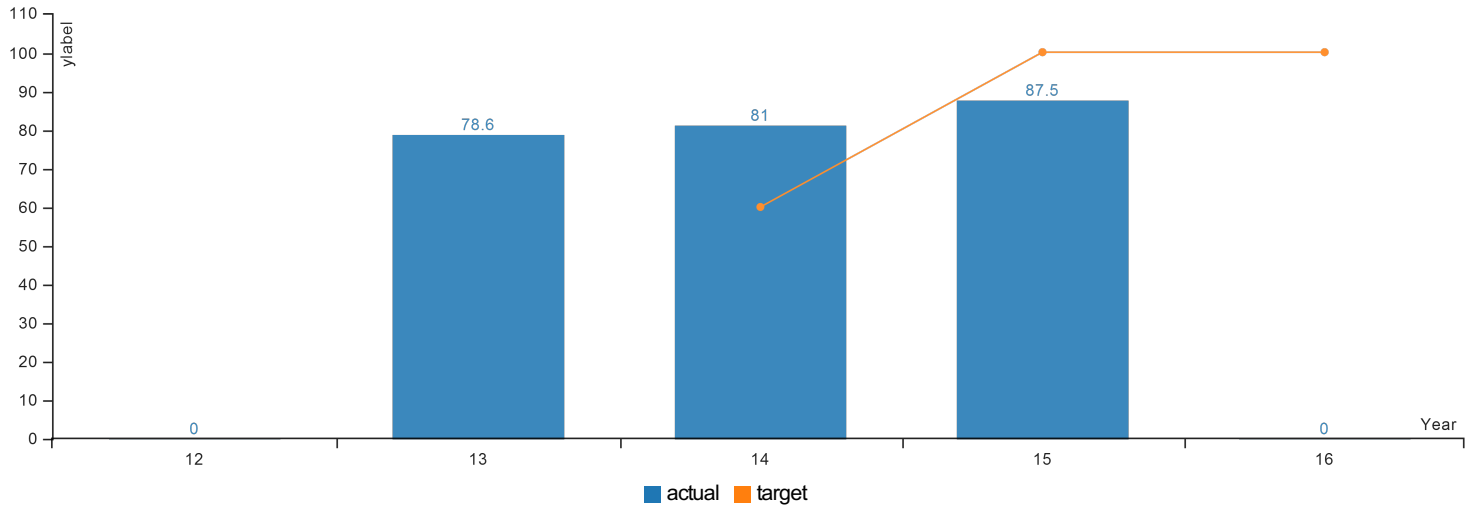
The composite rate of adult Medicaid members who were admitted to a hospital for preventable conditions continues to decrease (a lower rate is better).

This measure, as well as four of the condition-specific admission rates, are also reported twice per year online here: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx.

Factors Affecting Results

As CCOs continue to focus on ensuring their members receive the appropriate care at the appropriate time in the appropriate place, many performance indicators are affected. As enrollment in patient-centered primary care homes continues to increase (see KPM #15), and CCOs and providers continue to emphasize the importance of preventive care, chronic and acute conditions are more likely to be addressed outside of hospital settings, resulting in improvements to this composite rate.

KPM #15	PATIENT CENTERED PRIMARY CARE HOME (PCPCH) ENROLLMENT - Number of members enrolled in patient-centered primary care homes by tier.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Patient centered primary care home (PCPCH) enrollment					
Actual	No Data	78.60%	81%	87.50%	No Data
Target	TBD	TBD	60%	100%	100%

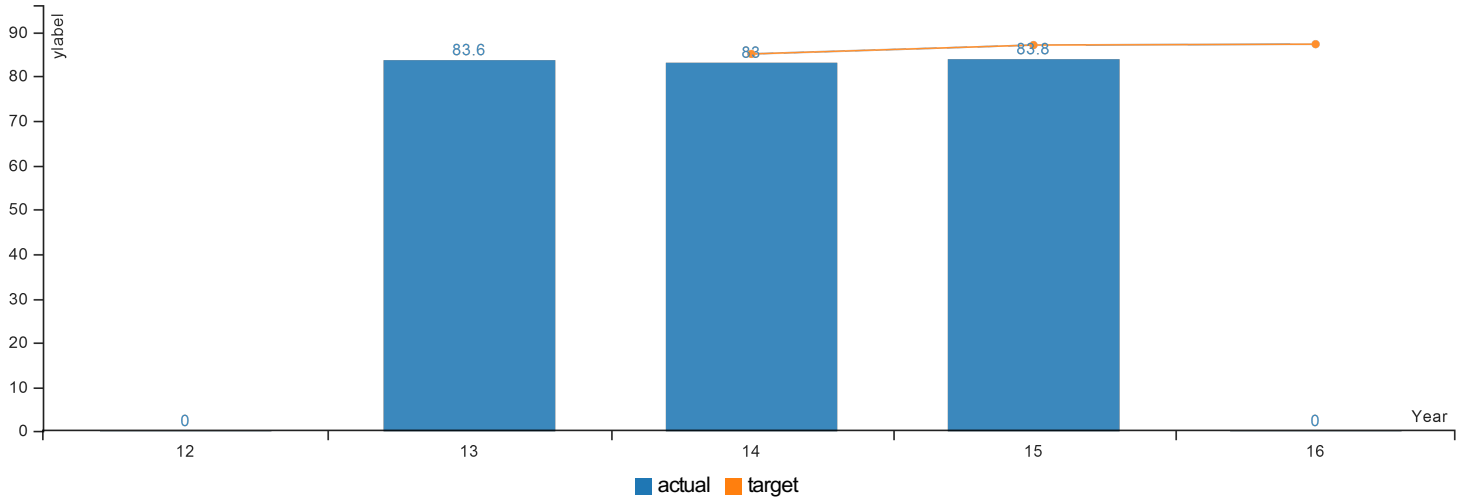
How Are We Doing

Calendar year 2012 is the baseline for this measure. In 2012, 51.8 percent of Medicaid members were enrolled in a certified patient centered primary care home. This increased to 78.6 percent by the end of 2013, well above the 2014 target of 60 percent. All but one CCO saw increased PCPCH enrollment between 2011 and 2013. In 2014 and 2015, the percentage of members enrolled in a patient-centered primary care home continued to increase, to 81.0% in 2014 and 87.5% in 2015. This improvement is impressive considering that CCO enrollment increased more than 60 percent in 2014 due to the ACA Medicaid expansion.

Factors Affecting Results

Coordinated care organizations are driving improvement on this measure through two main efforts: (1) working with contracted providers to go through the PCPCH recognition process, and (2) preferentially assigning members to certified PCPCHs. PCPCH enrollment is also a CCO incentive measure,

KPM #16	ACCESS TO CARE - Percentage of members who responded "always" or "usually" too getting care quickly (composite for adult and child).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Access to care					
Actual	No Data	83.60%	83%	83.80%	No Data
Target	TBD	TBD	85%	87%	87.20%

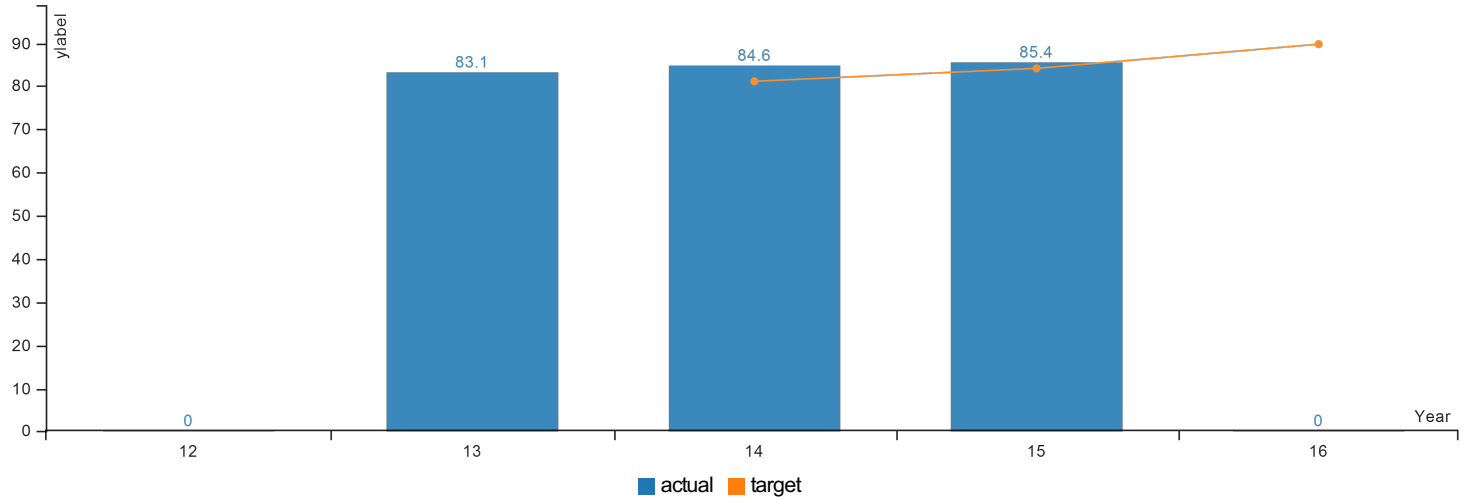
How Are We Doing

The percent of Medicaid members reporting they were able to receive appointments and care when they needed them has remained steady since 2011, with the percentage of members reporting that they "always or usually" received appointments and care when they needed them hovering near 83%.

Factors Affecting Results

The number of Oregonians enrolled in Medicaid increased by more than 60 percent in 2014, predictably increasing demand for care. Access also declined slightly at the national level from 2013 to 2014 (the 75th percentile declined from 88.0% in 2013 to 87.2%).

KPM #17	MEMBER EXPERIENCE 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	2012	2013	2014	2015	2016
Member experience of care					
Actual	No Data	83.10%	84.60%	85.40%	No Data
Target	TBD	TBD	81%	84%	89.60%

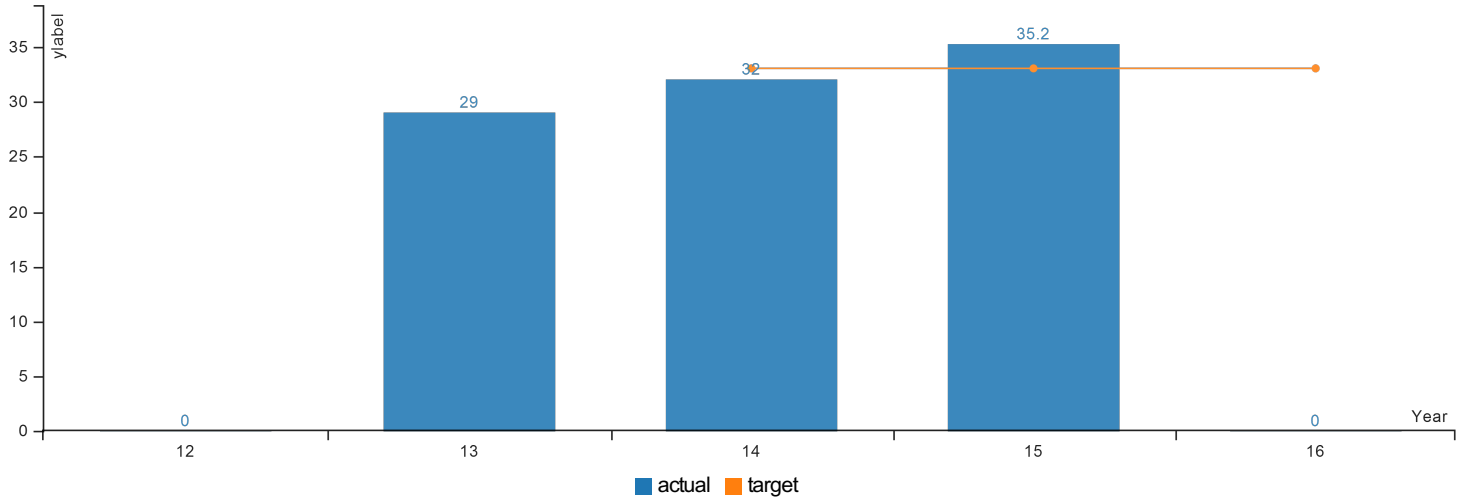
How Are We Doing

Calendar year 2011 is the baseline for this measure. In 2011, 78 percent of adults and children reported they received needed information or help and thought they were treated with courtesy and respect by their health plan's customer service staff. In 2013, the rate increased to 83.1 percent, just shy of the benchmark of 84.0 percent, but still notable considering this increase occurred as CCOs were newly established. This increase from 2011 to 2013 was seen across 13 of the 15 CCOs. In 2014 and 2015, the statewide rate continued to increase to 84.6% (2014) and 85.4% (2015), surpassing the KPM target in both years.

Factors Affecting Results

Inclusion in the CCO incentive program helps ensure that CCOs focus on improving member satisfaction and experiences with their health plan. It is important that Oregon continue to monitor and report on this measure.

KPM #19	MEMBER HEALTH STATUS - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Member health status					
Actual	No Data	29%	32%	35.20%	No Data
Target	TBD	TBD	33%	33%	33%

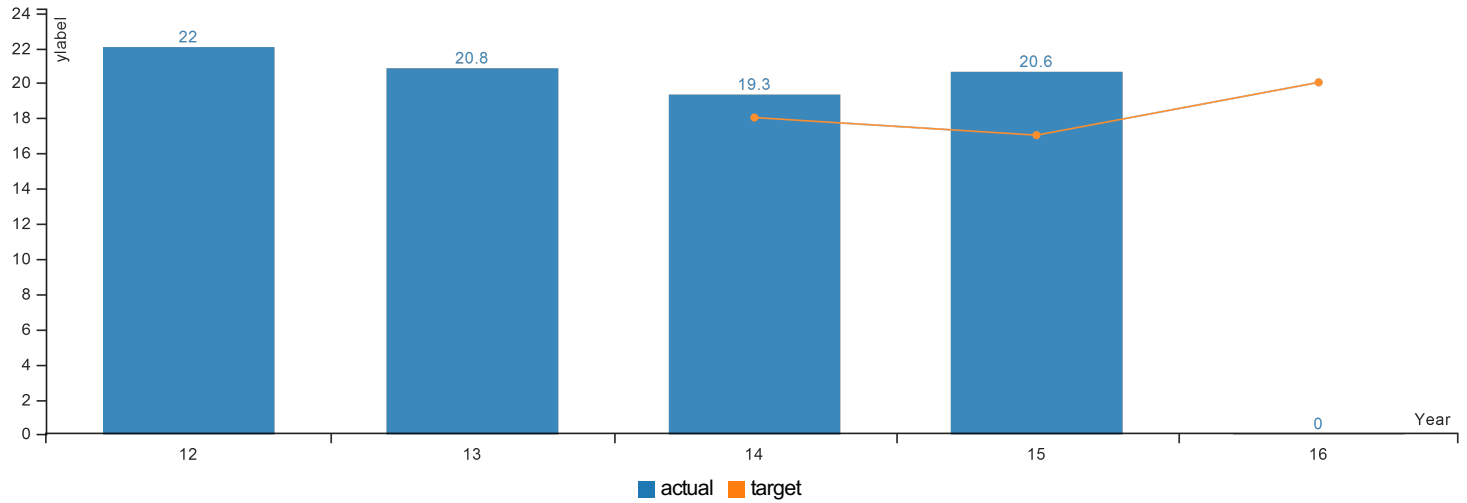
How Are We Doing

Calendar year 2011 is the baseline for this measure. In 2011, 23% of CCO enrollees responding to the CAHPS survey had a positive self-reported rating of overall health (excellent or very good). This rate has increased steadily each year since then, and in 2015, 35.2% of adults reported excellent or very good health status.

Factors Affecting Results

This improvement may be due in part to the influx of new Medicaid members after the ACA expansion took effect in 2014. Prior to 2014, a higher percentage of adult members were eligible for Medicaid due to disability. With the influx of new, previously ineligible members in 2014, the proportion of members who feel healthier may have increased.

KPM #19	RATE OF TOBACCO USE (POPULATION) - Rate of tobacco use among adults.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Rate of tobacco use - adult population					
Actual	22%	20.80%	19.30%	20.60%	No Data
Target	TBD	TBD	18%	17%	20%

How Are We Doing

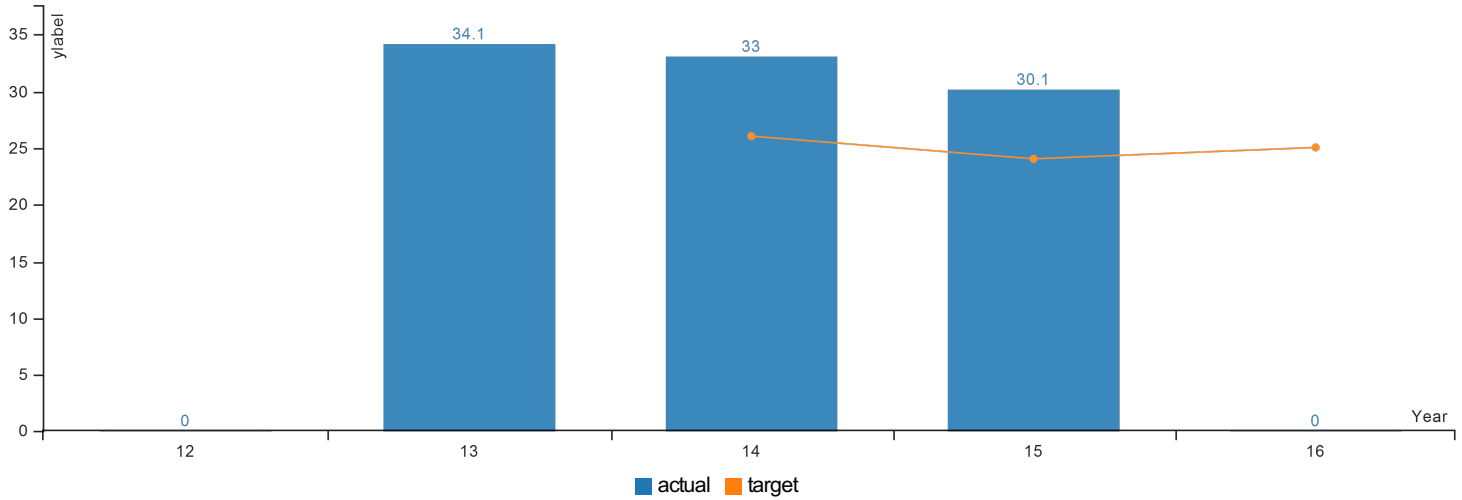
In 2014, Oregon's adult current tobacco use was slightly lower than all other states in the United States (19% versus 21%). Since the beginning of Oregon's Tobacco Prevention and Education Program (TPEP) in 1997, adult cigarette smoking has declined by 25 percent. However, much work needs to be done. Tobacco use remains the number one preventable cause of death and disease in Oregon, killing over 7,000 people each year, and costing Oregonians $2.5 billion a year in medical expenditures and lost productivity due to premature death. Results from the Behavioral Risk Factors Surveillance System (BRFSS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveyS show that the adult Medicaid population used tobacco at a much higher rate than the non-Medicaid adult population in 2015 (30% versus 21%).

Factors Affecting Results

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidencelbased funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, to eliminate exposure to secondhand smoke, and to identify and eliminate tobaccolrelated disparities. For Oregon, the recommended funding is $10.09 per capita, which equates to $39.3 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.5 billion lost to medical care and lost productivity annually in Oregon.

During the 2015 - 2017 biennium Oregon received about $2.77 per capita for tobacco prevention from all funding sources, which is 27% of CDC's recommended funding for tobacco prevention. This is comparable with what was allotted to Oregon tobacco prevention a dozen years ago; however, funding levels have been much lower in the years in between. TPEP received approximately $2.87 per capita during the 2001l2003 biennium, but was temporarily shuttered when the Legislature directed the allocated revenues elsewhere. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented. Since funding was reinstated to TPEP, per capita cigarette consumption has steadily declined.

KPM #20	RATE OF TOBACCO USE (MEDICAID) - Percentage of CCO enrollees who currently smoke cigarettes or use tobacco every day or some days.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Rate of tobacco use - Medicaid population					
Actual	No Data	34.10%	33%	30.10%	No Data
Target	TBD	TBD	26%	24%	25%

How Are We Doing

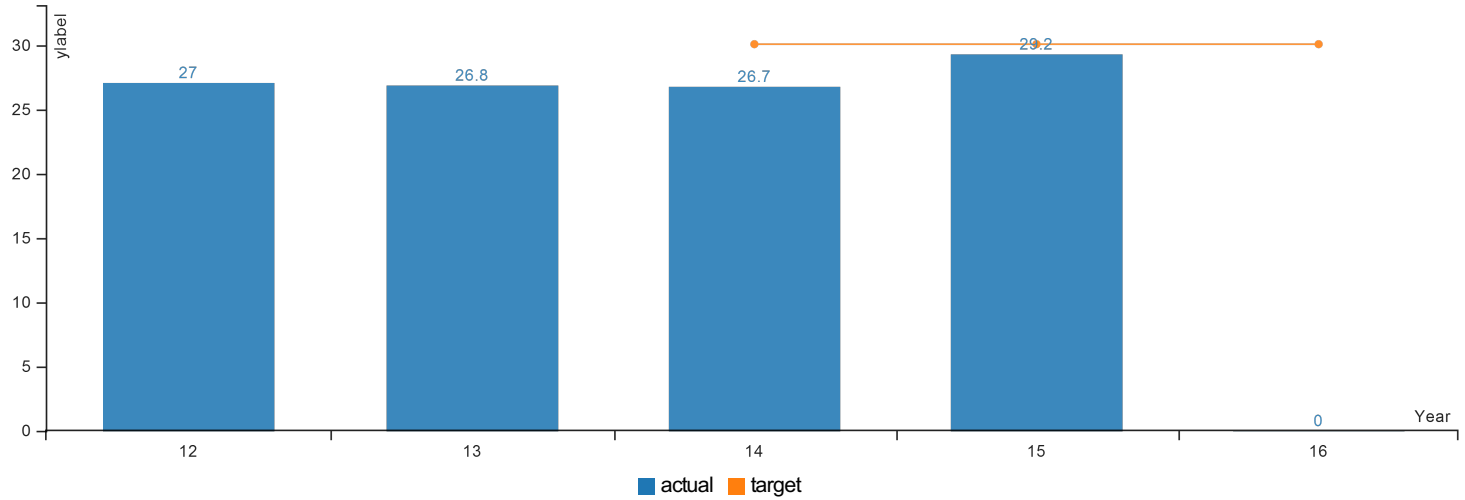
In 2014, Oregon's adult current tobacco use was slightly lower than all other states in the United States (19% versus 21%). Since the beginning of Oregon's Tobacco Prevention and Education Program (TPEP) in 1996, adult cigarette smoking has declined by 25 percent. However, much work needs to be done. Tobacco use remains the number one preventable cause of death and disease in Oregon, killing over 7,000 people each year, and costing Oregonians $2.5 billion a year in medical expenditures and lost productivity due to premature death. From the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, tobacco use prevalence increased slightly from 31% in 2011 to 33% in 2014 among the adult Medicaid population, and declined again between 2014 and 2015 to 30.1%. Compared to the non-Medicaid adult population (see KPM #19), adults on Medicaid are more likely to use tobacco.

Factors Affecting Results

The Centers for Disease Control and Prevention Office of Smoking and Health has developed an evidence‐based funding model for countering the health and economic destruction of tobacco use. The recommended model funds programs to prevent initiation of tobacco use among young people, to promote quitting among adults and young people, to eliminate exposure to secondhand smoke, and to identify and eliminate tobacco‐related disparities. For Oregon, the recommended funding is $10.09 per capita, which equates to $39.3 million annually. This recommendation represents just a fraction of the cost of tobacco use, with more than $2.5 billion lost to medical care and lost productivity annually in Oregon.

During the 2015 - 2017 biennium Oregon received about $2.77 per capita for tobacco prevention from all funding sources, which is 27% of CDC's recommended funding for tobacco prevention. This is comparable with what was allotted to Oregon tobacco prevention a dozen years ago; however, funding levels have been much lower in the years in between. TPEP received approximately $2.87 per capita during the 2001‐2003 biennium, but was temporarily shuttered when the Legislature directed the allocated revenues elsewhere. After this interruption, smoking among pregnant women and adolescents stopped decreasing, and per capita consumption of cigarettes increased for the first time since the program was first implemented. Since funding was reinstated to TPEP, per capita cigarette consumption has steadily declined.

KPM #21	RATE OF OBESITY (POPULATION) - Percentage of adults who are obese among Oregonians.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Rate of obesity - adult population					
Actual	27%	26.80%	26.70%	29.20%	No Data
Target	TBD	TBD	30%	30%	30%

How Are We Doing

In 2015, 29.2% of adults in Oregon were obese. Oregon's adult obesity has increased by 145 percent since 1990. More need to be done to slow down obesity rate. In Oregon, obesity contributes to the deaths about 1,400 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. From the Behavioral Risk Factors Surveillance System, the adult Medicaid population who are obese were 40% higher than the level of the non-Medicaid adult population (35% versus 25%).

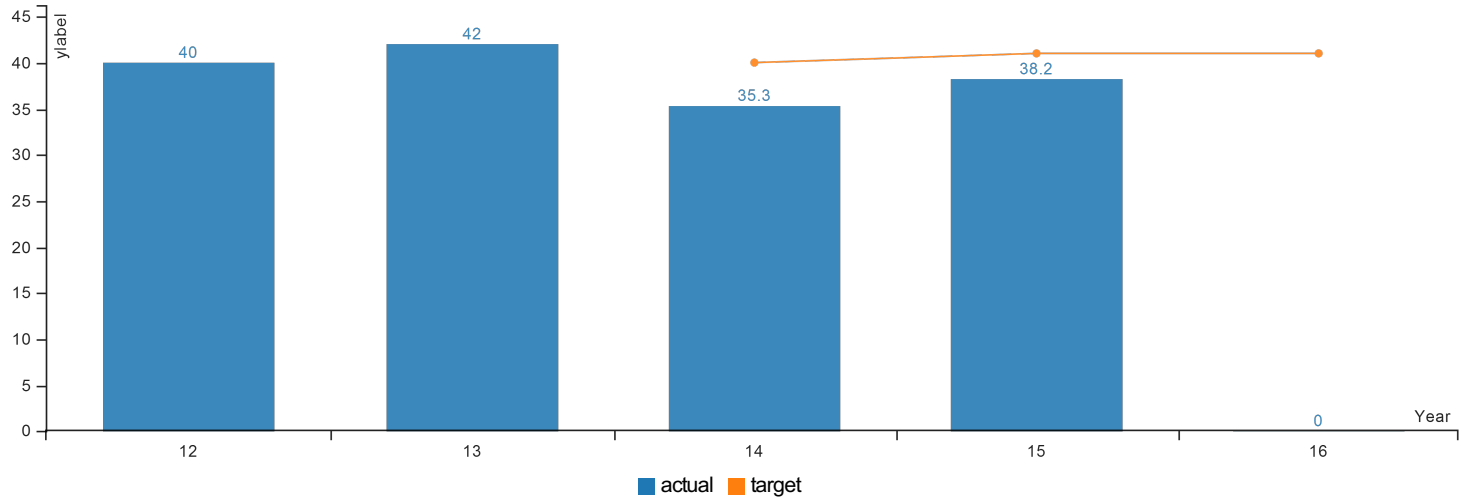
Factors Affecting Results

Poor nutrition and lack of physical activity are the main factors driving obesity in Oregon. Obesity results from calorie consumption that exceeds the number of calories expended. Since calorie consumption is difficult and costly to assess accurately, eating ≥5 servings of fruits and vegetables a day is used as marker of a healthy diet. Regular physical activity is also a critical component of weight control.

During 2013, fewer than one in four Oregon adults consumed ≥5 servings of fruits and vegetables per day, which has been relatively unchanged since 1996. Among youth the situation is similar: about one in four Oregon eighth graders consumed five or more servings a day of fruits and vegetables in 2015. Young people also drink a lot of sugary beverages: about 10 percent of eighth graders report drinking an average of one or more soft drinks a day. This means that about one in ten eighth graders consume enough soda to add more than 1,000 extra calories to their diets each week.

In 2013, 25% of adult Oregonians met aerobic and muscle strengthening recommendations for physical activity. In 2015, 58% of Oregon eighth graders met physical activity recommendations of getting one or more hours of activity on most days of the week.

KPM #22	RATE OF OBESITY (MEDICAID) - Percentage of Medicaid population who are obese.
	Data Collection Period: Jan 01 - Jan 01



Report Year	2012	2013	2014	2015	2016
Rate of obesity - Medicaid population					
Actual	40%	42%	35.30%	38.20%	No Data
Target	TBD	TBD	40%	41%	41%

How Are We Doing

In 2015, 38.2% of the adult Medicaid population in Oregon was obese. This is almost 30 percent higher than the non-Medicaid population. Since 1990, Oregon's adult obesity has increased by 145 percent. More need to be done to slow down obesity rate. In Oregon, obesity contributes to the deaths about 1,400 Oregonians each year, making it second only to tobacco as the state's leading cause of preventable death. From the Behavioral Risk Factors Surveillance System, the adult Medicaid population who are obese were .0% higher than the level of the non-Medicaid adult population (38.2% versus 29.2%).

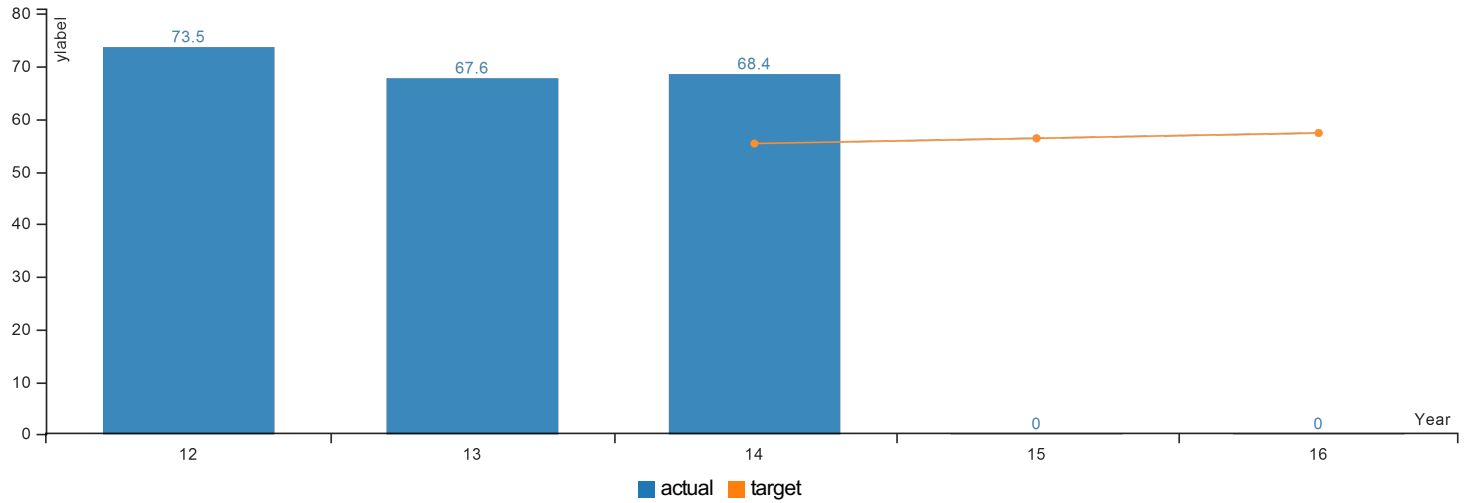
Factors Affecting Results

Poor nutrition and lack of physical activity are the main factors driving obesity in Oregon. Obesity results from calorie consumption that exceeds the number of calories expended. Since calorie consumption is difficult and costly to assess accurately, eating ≥5 servings of fruits and vegetables a day is used as marker of a healthy diet. Regular physical activity is also a critical component of weight control.

During 2013, fewer than one in four Oregon adults consumed ≥5 servings of fruits and vegetables per day, which has been relatively unchanged since 1996. Among youth the situation is similar: about one in four Oregon eighth graders consumed five or more servings a day of fruits and vegetables in 2015. Young people also drink a lot of sugary beverages: about 10 percent of eighth graders report drinking an average of one or more soft drinks a day. This means that about one in ten eighth graders consume enough soda to add more than 1,000 extra calories to their diets each week.

In 2013, 25% of adult Oregonians met aerobic and muscle strengthening recommendations for physical activity. In 2015, 58% of Oregon eight graders met physical activity recommendations of getting one or more hours of activity on most days of the week.

KPM #23	EFFECTIVE CONTRACEPTIVE USE (POPULATION) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Effective contraceptive use - population					
Actual	73.50%	67.60%	68.40%	0%	0%
Target	TBD	TBD	55.20%	56.20%	57.20%

How Are We Doing

From 2011 to 2014, there have been small fluctuations in use of effective contraceptive methods among reproductive-age women who are at risk of unintended pregnancy. When margins of error are considered, these fluctuations cannot be considered to be a significant trend.

Factors Affecting Results

One important obstacle to effective contraceptive use is the limited funding available for family planning programs. Oregon's Title X program, the federal grant program devoted to family planning and reproductive health care, has received funding cuts over the last decade while the number of women aged 13-44 in need of publicly-funded contraceptive services increased by 8% between 2010 and 2014[1]. Access to effective contraceptive use is further limited by a myriad of barriers at the health system-, provider-, and individual-levels[2]. It should also be noted that provisions of the Affordable Care Act (ACA), including coverage of women's preventive services, including contraception, without cost sharing, and the expansion of Medicaid, should increase access to family planning services and thereby help to reduce unintended pregnancy rates.

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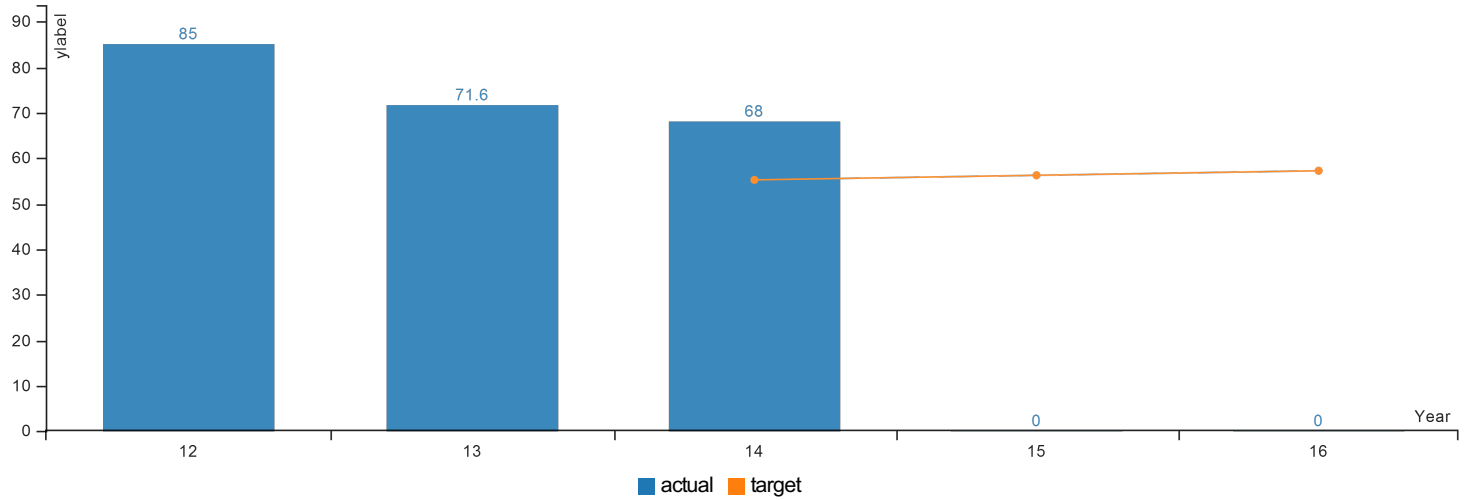
[1] Frost JJ et al., *Contraceptive Needs and Services, 2014 Update,* New York: Guttmacher Institute, 2016.

[2] Oregon Health Authority, Effective Contraceptive Use Guidance Document, December 2014.

KPM #24	EFFECTIVE CONTRACEPTIVE USE (MEDICAID) - Percentage of reproductive age women who are at risk of unintended pregnancy using an effective method of contraception.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Effective contraceptive use - Medicaid population					
Actual	85%	71.60%	68%	0%	0%
Target	TBD	TBD	55.20%	56.20%	57.20%

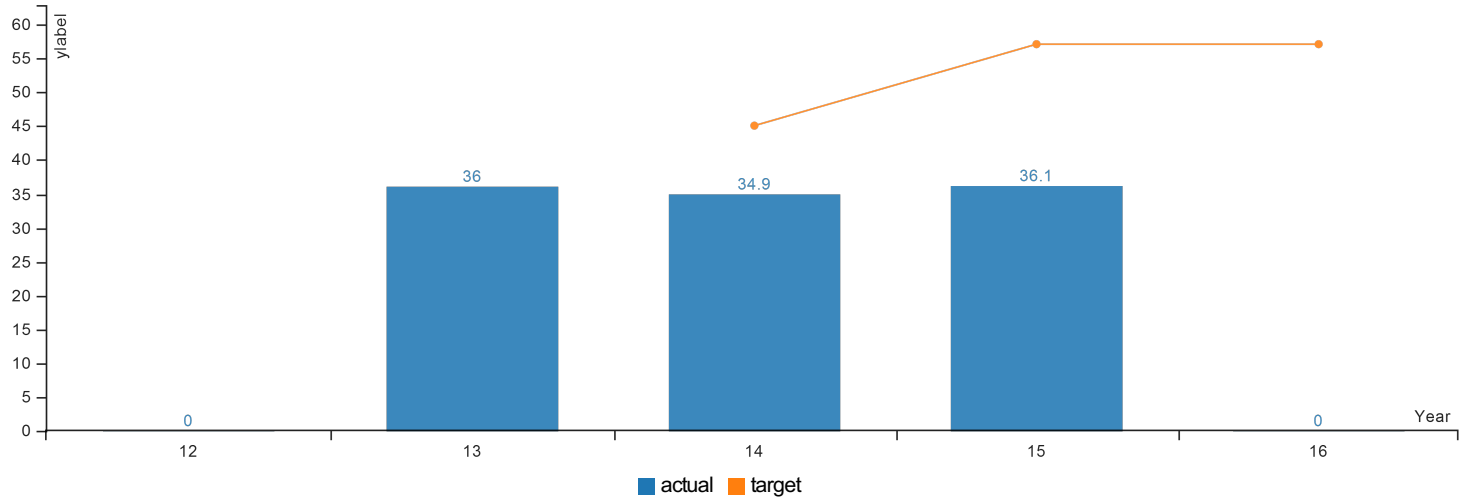
How Are We Doing

Calendar year 2011 is the baseline for this measure. From 2011 to 2014, there have been fluctuations in use of effective contraceptive methods among reproductive-age women enrolled in the Oregon Health Plan (OHP) who are at risk of unintended pregnancy. Estimated use of effective contraceptive methods in this population increased from 74.7% in 2011 to 85.0% in 2012, then decreased to 68.0% in 2014. When small sample sizes and margins of error are considered, these fluctuations cannot be considered to be a significant trend.

Factors Affecting Results

Because of limited access to OHP in the past, few women of reproductive age, aside from those deemed eligible due to pregnancy, have been enrolled in full-benefit Medicaid coverage. Medicaid expansion in January of 2014 has increased enrollment among the target population, resulting an increase in the number of women with access to contraceptive and other preventive health services.

KPM #25	FLU SHOTS (POPULATION) - Percentage of adults ages 50-64 who receive a flu vaccine.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Flu shots - population					
Actual	No Data	36%	34.90%	36.10%	No Data
Target	TBD	TBD	45%	57%	57%

How Are We Doing

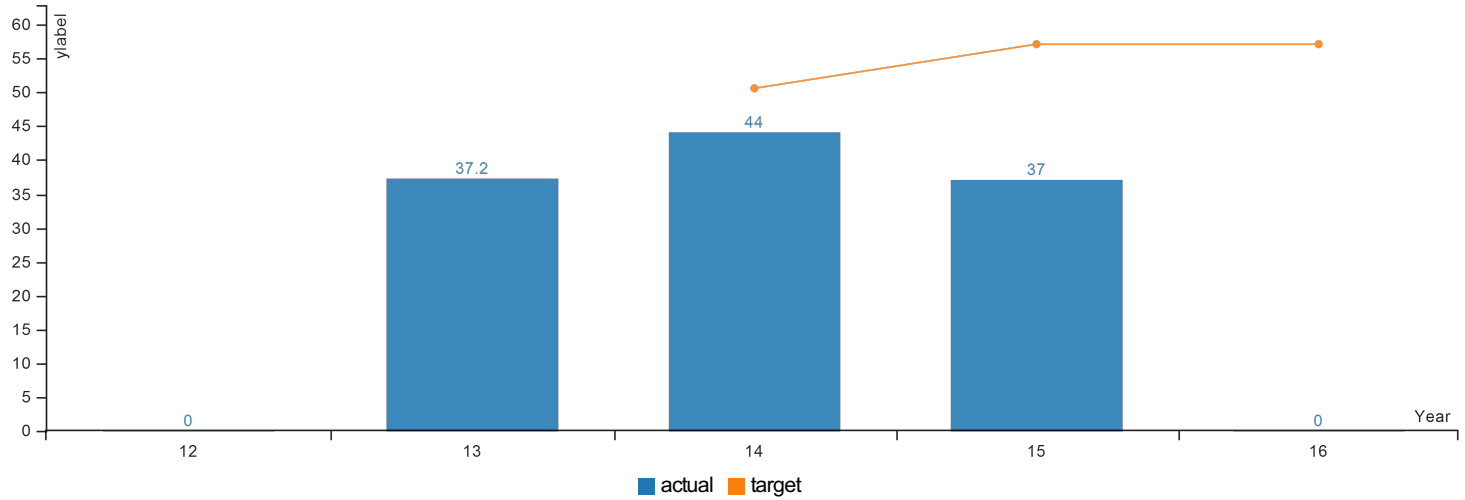
In 2015, 36% of 50‐64 year olds in Oregon had received an influenza vaccination in the past 12 months as compared to 35% in 2014 and 36% in 2013. This measure has shown little fluctuation over the past four years.

In comparison, 44.3% of people in this age range, nationwide, received an influenza vaccination. State‐specific vaccination rate estimates range from 36.0% to 60.6% for the 2014-2015 flu season.

Factors Affecting Results

Immunization rates are influenced by public perception of the need for and efficacy of vaccinations. Factors that negatively influence rates include: the absence of policies that motivate health systems to routinely vaccinate all clients and employees (although improvement has been seen on this point in recent years), limited funding for adult immunizations, and challenges around increasing provider use of the ALERT IIS – the statewide immunization registry – that could provide immunization information for providers about their adult populations. During the 2007 legislative session, HB 2188 passed expanding ALERT IIS to a lifespan registry, and during the 2011 legislative session, HB 2371 passed stating that VFC and 317 providers need to report all administered doses to ALERT IIS. Pharmacies are now also required to report all administered vaccines to the ALERT IIS and can presently vaccinate down to age seven. Over the next few years as the IIS collects and processes data, the IIS will contain more comprehensive immunization histories across the lifespan, which will help healthcare providers identify candidates for vaccine and potentially send out reminders to clients to seek out an influenza immunization every year.

KPM #26	FLU SHOTS (MEDICAID) - Percentage of adults ages 50-64 who receive a flu vaccine.
	Data Collection Period: Jan 01 - Dec 31



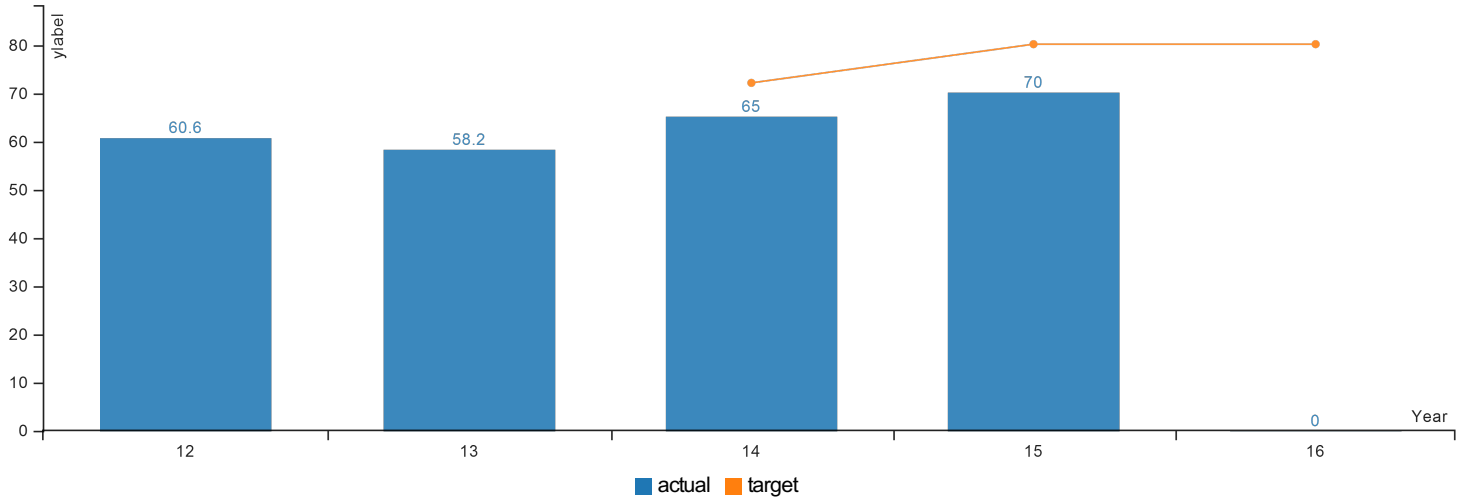
Report Year	2012	2013	2014	2015	2016
Flu shots - Medicaid population					
Actual	No Data	37.20%	44%	37%	No Data
Target	TBD	TBD	50.50%	57%	57%

How Are We Doing

In 2015, 37% of all Medicaid recipients in Oregon 50l64 year of age had received an influenza vaccination in the past 12 months. This measure has shown little improvement over the years.

Factors Affecting Results

KPM #27	CHILD IMMUNIZATION RATES (POPULATION) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Child immunization rates - population					
Actual	60.60%	58.20%	65%	70%	No Data
Target	TBD	TBD	72%	80%	80%

How Are We Doing

The 4:3:1:3:3:1:4 rate for children 24–35 months of age in 2015 is 70%. This is an increase from 65% in 2014 and 58% in 2013.

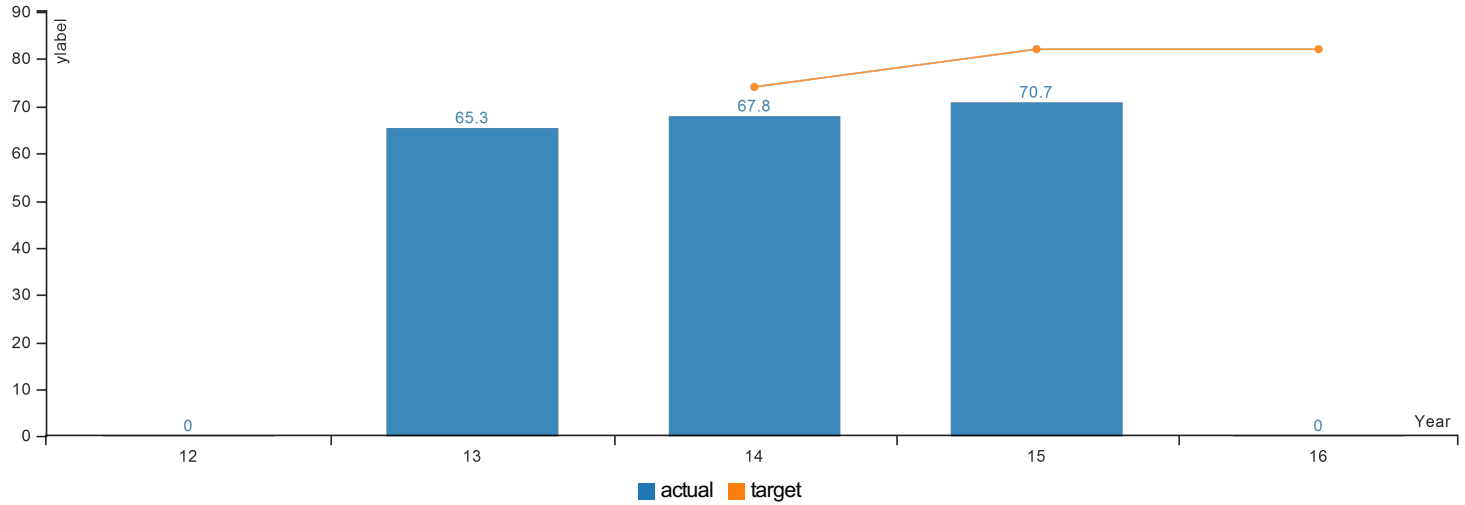
This KPM reflects children 24–35 months olds with vaccines reported to the statewide immunization information system (IIS). A national comparison is difficult because national data is based on the National Immunization Survey (NIS), which is a telephone survey that samples a limited number of Oregon residents 19–35 months of age. However, the national NIS rate for the 4:3:1:3:3:1:4 series in 2015 was 71.6% (+/– 1.5%), with 65.3% (+/– 7.9%) for Oregon, 67.4% (+/– 8.1%) for Washington, and 65.9% (+/– 8.0%) for Idaho.

Beginning in 2016, childhood immunizations (KPM #28) is a CCO incentive metric. This may help drive outreach and improve workflows for this immunization series for all children.

Factors Affecting Results

Completion of the four–dose PCV series has increased from 73.7% in 2013 to 77.4% in 2015. Other vaccines in the 4:3:1:3:3:1:4 series have stayed generally stable during that time. The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon partnership between the Oregon Immunization Program and public and private providers. Ninety–five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children. Other influences include parent and provider knowledge, attitudes, and practices.

KPM #28	CHILD IMMUNIZATION RATES (MEDICAID) - Percentage of children who are adequately immunized (immunization series 4:3:1:3:3:1:4).
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Child immunization rates - Medicaid population					
Actual	No Data	65.30%	67.80%	70.70%	No Data
Target	TBD	TBD	74%	82%	82%

How Are We Doing

In 2011, the Medicaid baseline rate used for CCO incentive measure calculation was 66.0%; this decreased slightly in 2013 to 65.3% and since then has increased to 67.8% in 2014 and to 70.7% in 2015.

The national 75th percentile has held steady at 82% since 2013. This is also the CCO incentive measure benchmark.

The National Immunization Survey (NIS) involves a telephone survey that samples Oregon residents 19–35 months of age. The national rate for the 4:3:1:3:3:1:4 series in - 2015 was 71.6% (+/- 1.5%), with 65.3% (+/- 7.9%) for Oregon, 67.4% (+/- 8.1%) for Washington, and 65.9% (+/- 8.0%) for Idaho.

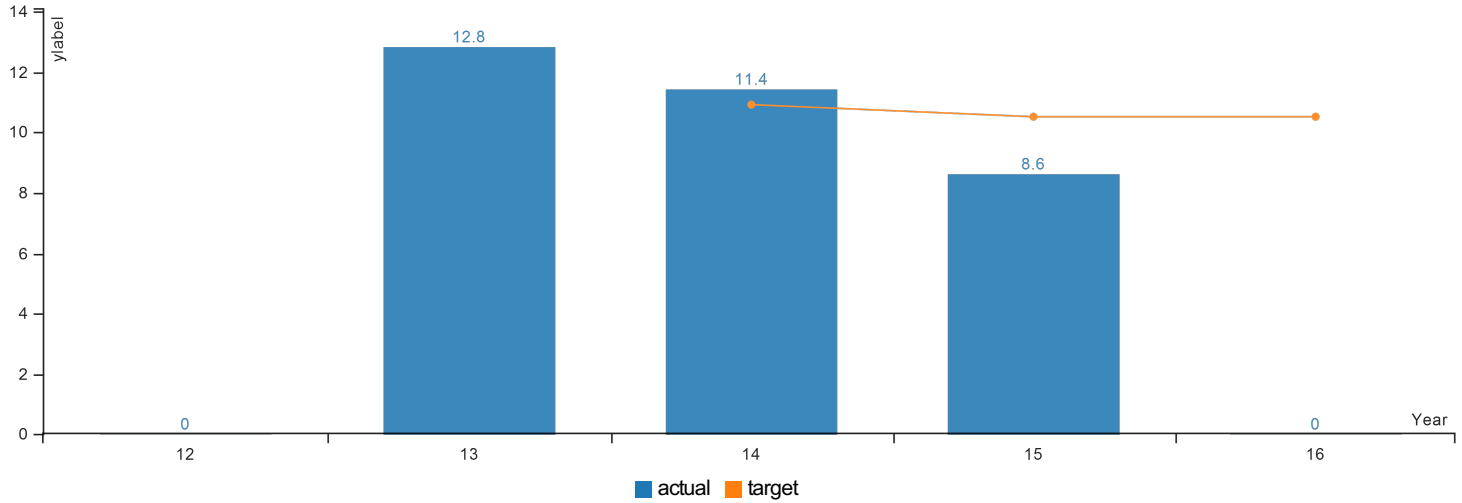
Factors Affecting Results

The Immunization Program oversees the Vaccines for Children (VFC) program, a federally funded entitlement that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. The success of VFC is based upon partnership between the Oregon Immunization Program and public and private providers. Ninety-five percent of Oregon's childhood immunizations are captured in the ALERT IIS, which is used to estimate immunization rates, while also providing a clinical record for providers to accurately assess the vaccine needs of individual children. Other influences include parent and provider knowledge, attitudes, and practices.

Beginning 2016, childhood immunization status is a CCO incentive metric which will likely drive improved outreach and workflows.

This measure is also available online here: http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx. Data are available statewide and stratified by race/ethnicity and by CCO. Results are published twice per year (January and June).

KPM #29	PLAN ALL CAUSE READMISSIONS - Percentage of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years and older.
	Data Collection Period: Jan 01 - Dec 31



Report Year	2012	2013	2014	2015	2016
Plan all cause readmissions					
Actual	No Data	12.80%	11.40%	8.60%	No Data
Target	TBD	TBD	10.90%	10.50%	10.50%

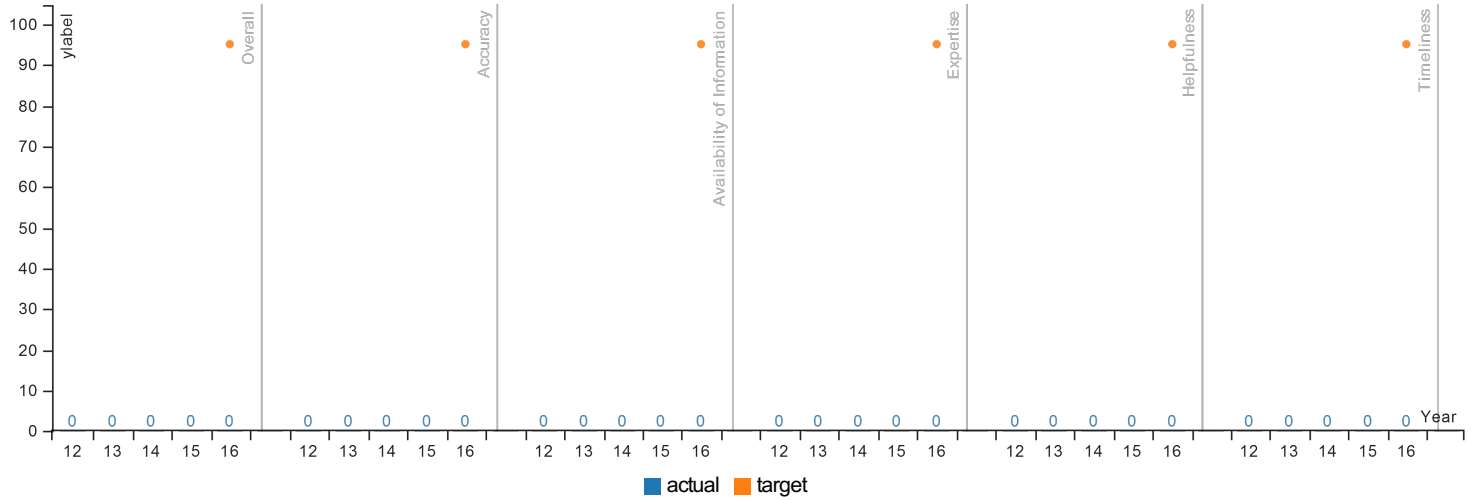
How Are We Doing

Hospital readmissions continue to decline in Oregon (lower is better) and in 2015 achieved the KPM target.

Factors Affecting Results

As CCOs continue to focus on ensuring their members receive the appropriate care at the appropriate time in the appropriate place, many performance indicators are affected. As enrollment in patient-centered primary care homes continues to increase (see KPM #15), and CCOs and providers continue to emphasize the importance of coordinated, preventive care, post-discharge care is likely to be more appropriately addrsesed, resulting in a reduction in this readmission rate.

KPM #36	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	2012	2013	2014	2015	2016
Overall					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	95%
Accuracy					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	95%
Availability of Information					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	95%
Expertise					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	95%
Helpfulness					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	95%
Timeliness					
Actual	No Data	No Data	No Data	No Data	No Data
Target	TBD	TBD	TBD	TBD	95%

How Are We Doing

OREGON HEALTH AUTHORITY: PROPOSED KPMS

Mechanical adjustments

KPM #25	Effective contraceptive use (Medicaid)
Proposed change	Change data source from survey to medical claims
Rationale	A claims-based measure was developed for use as a CCO incentive measure beginning in 2015.

Proposed replacements

KPM #4	Mental and physical health assessments for children in DHS custody
Replace with	Mental, physical, and dental health assessments for children in DHS custody
Rationale	This is a CCO incentive measure. In 2015, dental health assessments were added to the measure.

KPM #15	Primary care sensitive hospital admissions / inpatient stays
Replace with	1. PQI 1: Diabetes short-term complications admission rate 2. PQI 5: COPD or asthma admission rate 3. PQI 8: Congestive heart failure admission rate 4. PQI 15: Adult asthma admission rate
Rationale	The current KPM is a Prevention Quality Indicator (PQI) composite of 15 chronic and acute condition specific admission rates, which we don't report on regularly. We are proposing replacing this composite with four of the individual PQIs within the composite that are part of our required performance reporting under the Medicaid Demonstration Waiver.

KPM #19	Member health status - Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good)
Replace with	Member health status: Percentage of CAHPS survey respondents with a positive self-reported rating of overall health (excellent, very good, good)
Rationale	The proposed replacement is a state core measure, which OHA regularly reports to CMS. Including "good" is also a better indicator of positive health status.

Proposed additions

KPM #	TBD
Title	Clostridium difficile (C. difficile) incidence
Description	Annual cases of hospital-onset, laboratory identified *C. difficile* infections, reported as rate per 10,000 patient days
Data collection period	Jan 1 – Dec 31
Upward trend good? (y/n)	No
Rationale	Clostridium difficile is a toxin-producing bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. C. difficile infections are often linked to medical care and individuals taking antibiotics and are the most common source of healthcare-associated infections.

KPM #	TBD
Title	Opioid-related overdose deaths
Description	Annual rates of opioid-related mortality in Oregon
Data collection period	Jan 1 – Dec 31
Upward trend good? (y/n)	No
Rationale	Opioid overdose, misuse and abuse is recognized as a national epidemic, and is one of the leading causes of injury death in Oregon. Tracking opioid overdose deaths helps OHA determine whether prevention efforts aimed at reducing overdose deaths are having an impact that improves the health of communities throughout Oregon.

Proposed deletions

KPM #31	Customer service - Percentage of OHA customers rating their satisfaction with the agency's customer service as "good" or "excellent" overall on timeliness, accuracy, helpfulness, expertise, availability of information.
Rationale for deleting	There is no existing measure or methodology to report on this. OHA has not been reporting on this KPM.

IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 17-19 Costs	All biennia total project cost	Base or POP	Project Phase: I=Initiation P=Planning E=Execution C=Close-out	If Continuing project - has it been rebaselined for either cost, scope or schedule? Y/N - If Y, how many times	Purpose L=Lifecycle Replacement; U=Upgrade existing system; N=New System	What Program or line of business does the project support	Comments
Health Systems Division	OHA	MMIS Modularization	This POP requests state funds to secure 90% federal financial participation funds to: align to CMS mandates for states to modularize their medicaid portfolio. These funds will be used to define Oregon's Medicaid Service Delivery strategic plan, assess other states modularization approaches, identify options for modular solutions, define certification requirements as required by CMS, and begin procurement activities to secure modular solution components.	Jan-17	Jun-19	$ -	$ 3,854,917	TBD	POP	P	N	L	HSD	this is a planning POP with an expectation of a follow up for additional funding that will come forward for implementation in AY19-21 or AY21-23
Health Systems Division	OHA	ONE Enhancement and Support Services (ESS) - (MAGI Medicaid Systems Transfer Project Phase II -)	The Centers for Medicare and Medicaid Services (CMS) offers additional enhanced funding for system work for eligibility systems. This policy option package is to request the authority for to fund enhancements to the Modified Adjusted Gross Income (MAGI) Medicaid eligibility determination system (called ONE) that have been identified as necessary to better serve Oregonians. Currently, OHA has a contract with the Systems Integrator that built the ONE system, Deloitte Consulting, to continue to enhance it while maintaining & operating it. The plan is for several builds a year of new functionality, prioritized by Member Services Staff as well as Medicaid policy staff, to be made available inside of ONE. Additionally, this POP will support necessary changes when CMS issues new requirements for MAGI Medicaid eligibility systems such as MARS-E 2.0 Security Compliance.	Apr-16	Jun-18	$ 1,596,629	$ 12,800,000	$ 18,345,775	POP	E	Y,1	U	HSD	IRR
Public Health	OHA	Public Health Modernization	The goal is to ensure basic public health protections for everyone in Oregon. This POP will: • Equip the workforce to respond to emerging health needs: develop an effective and efficient state and local public health workforce; • Fill the 55% health equity service gap: improve health equity by engaging with communities in public health planning; • Provide data needed to monitor public health problems: upgrade outdated information systems needed to collect data on population health and inform decision-making; • Fill the 55% service gap in preventing environmental health hazards, the 37% service gap in communicable disease investigation and the 38% service gap in responding to emergencies: mount timely responses to emerging public health issues.	TBD	TBD	$ -	$ 3,000,000	TBD	POP	I	N	U	Public Health	The project has an IT component, the POP is for the overall project including the IT component.

IT Related Projects/Initiatives

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Aging and People with Disabilities - Oregon Adult Abuse Prevention and Investigations	DHS	Implementing Centralized Abuse Management (CAM) System	The purpose of this project is to develop and implement a comprehensive multi-program centralized abuse management system to capture abuse allegations and investigations from intake and screening through investigation, case closure and referrals, documentation, and to support abuse management oversight and inquiries. House Bill 4151 requires the state of Oregon and DHS as its agent, to standardize its processes and technology related to abuse of vulnerable adults. Oregon's current environment for tracking, reporting, analyzing and investigating incidents of adult abuse relies on accessing information from nine (9) distinct systems or data sources. Additionally, local offices have created their own one-off mechanisms for supporting the abuse investigation processes, further complicating and decentralizing information. Existing systems limitations include the inability to search across program populations, inhibiting the ability to track perpetrators and/or victims over time and between populations. This heightens the risk of not capturing all abuse allegations.	Jul-15	Dec-17	$ 550,142	$ 4,010,290	$ 5,237,494	POP	P	Y, 2	U	APD/OAAPI	
Aging and People with Disabilities/ Self Sufficiency	DHS	Integrated Eligibility Determination Project (IE)	Quick, correct and efficient eligibility determinations for Non-MAGI Medicaid, SNAP, TANF, and Child Care	1-Jul-15	30-Jun-19	$ 10,203,716	$ 113,630,759	$ 163,704,603	POP	E	N	N	APD	
Aging and People with Disabilities/ Developmental Disabilities	DHS	Provider Time Capture (PTC)	Implement a shared time capture solution for the APD, ODDS and AMH programs for their Home Care Workers (HCW) and Personal Support Workers (PSW) to include time, attendance and travel. Bring DHS/OHA in compliance with the Department of Labor's FSLA regarding employee record keeping and overtime.	1-Sep-14	31-Mar-18	$ 1,655,792	$ 4,273,077	$ 9,691,664	Base	E	Y, 1	N	APD/DD	New Estimated End Date is tentative, and has not been approved at ESC.
PHD	OHA	HIV-Electronic (HIV-E)	Replace the current CAREAssist and HIVCAT application with the best fit commercial off the shelf solution.	4-Feb-16	1-Dec-18	$ 27,351	3.2 million	TBD	Base	I	N	L	PHD - HIV	

IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 17-19 Costs	All biennia total project cost	Base or POP	Project Phase: I=Initiation P=Planning E=Execution C=Close-out	If Continuing project - has it been rebaselined for either cost, scope or schedule? Y/N - If Y, how many times	Purpose L=Lifecycle Replacement; U=Upgrade existing system; N=New System	What Program or line of business does the project support	Comments
WIC	OHA	TWIST to Web	The purpose of this project is to upgrade from a client server based system to a FNS web based WIC management information system.	3-Jan-17	1-Jul-20	TBD	TBD	TBD	Base	I	N	L	WIC	Prioritized by PH ISMC to move forward
Immunization	OHA	SMILER (School Module Integrating Law and Electronic Reporting)	Oregon Immunization Program (OIP) seeks a technology that will standardize collection and assessment of student immunization records, produce appropriate exclusion orders, and generate timely reports. The solution will also interface with internal and external stakeholder systems, eliminating the need for repeated, manual data entry across the various systems.	1-Jul-17	1-Jun-19	TBD	$ 500,000	$ 950,000	Base	I	N	N	Immunization	Prioritized by PH ISMC to move forward
Maternal and Child Health	OHA	Tracking Home visiting Effectiveness in Oregon (THEO)	Deliver a maternal and child health home visiting data collection, case management and reporting system.	1-Jun-16	31-Dec-17	$ 284,000	$ 1,516,000	$ 1,800,000	Base	I	N	N	MCH	Estimates are high level at this point until solution vendor contract finalized.
Health Systems Division	OHA	MMIS - Social Security Number Removal Initiative	The Medicare Access and CHIP Reauthorization Act (MACRA) went into law April 16, 2015. This legislation requires CMS to remove Social Security Numbers (SSNs) from Medicare cards and replace with a Medicare Beneficiary Identifier (MBI). MACRA's primary goal is to decrease Medicare beneficiaries' identity theft vulnerability by removing SSNs from Medicare cards. Compliance must occur by April 16, 2019 - within four years from enactment of the MACRA legislation.	1-Jul-17	31-Mar-20	$ -	$ 1,500,000	$ 1,500,000	Base	E	N	N	HSD	This effort is eligible for 90% CMS enhanced funds upon approval of an Advanced Planning Document (APD). The level of effort for this initiative is estimated to be significant as impacted systems require remediation to accept and use the MIB number to support business operations. Comparable recent projects include MMIS ICD-10 and Real+D. Business processes will require modifications to support use of the MIB. Business functional changes include those associated with Medicare Buy-in and Medicaid and Medicare Dual Eligible's. Proposed 15-17 Budget 97,102 - having meetings now to figure out the budget for 17-19

IT Related Projects/Initiatives

Program Area	Agency	Project Name	Project Description	Estimated Start Date	Estimated End Date	Project cost to date	Estimated 17-19 Costs	All biennia total project cost	Base or POP	Project Phase: I=Initiation P=Planning E=Execution C=Close-out	If Continuing project - has it been rebaselined for either cost, scope or schedule? Y/N - If Y, how many times	Purpose L=Lifecycle Replacement; U=Upgrade existing system; N=New System	What Program or line of business does the project support	Comments
The Office of Heatlh Information Technology	OHA	HIT Portfolio	The Office of Health Information Technology (OHIT) Phase 2.0 includes 3 projects with technology components. The name and description of each are: Oregon Common Credentialing Program (OCCP): SB604 requires OHA to implement a credentialing solution mandated for use by practitioners and credentialing organizations. Credentialing organizations currently credential health care practitioners independently, resulting in a duplication of efforts. This comprehensive solution will significatly reduce redundancy, supporting OHA's goal to reduce waste in our health care system. Provider Directory (PD): This will allow healthcare entities access to a state-level directory of healthcare practitioner and practice setting information. It will leverage authoritative data existing in current provider databases and add critical new information and functions. The provider directory can be used across the healthcare continuum to support operations, analytics, and the exchange of health information to deliver key benefits. Clinical Quality Metrics Registry (CQMR): this will enable Coordinated Care Organization (CCO) and Meaningful Use clinical quality metrics to be gathered for quality measurement and incentive payment. It will support the Medicaid Electronic Health Record (EHR) incentive program, which provides federal dollars to Oregon Medicaid providers who achieve meaningful use of EHRs. The CQMR assists OHA meeting its obligations under the Medicaid waiver to lower growth in cost.	TBD	TBD	TBD	TBD	TBD	Base	P	N	N	OHIT	
Health Systems Division	OHA	MMIS Transformed Medicaid Statistical Information System (T-MSIS) Phase 2	CMS recently identified additional Data Elements (DEs) that will be needed for states' files to comply with T-MSIS Phase 2 requirements, as well as deadlines for their inclusion. These DEs cover data fixes, MMIS systems changes, or data fields not currently captured, and may require policy and/or business process changes. Following submission of all previously held files to CMS, OHA will need to initiate T-MSIS Phase 2 efforts, and begin planning for inclusion of the three new DE types. Deadlines for these data are based on DE type (Type 1 – 6 months, Type 2 – 12 months, Type 3 – 18 months).	1-Feb-17	TBD	$ -	TBD	TBD	BAS	P	N	U	HSD	Proposed 15-17 Budget 155,992 - having meetings now to figure out the dubget for 17-19

Oregon Health Authority

AUDIT RESPONSE REPORT

1. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2013, audit # 2014-09, (dated April 2014)

- We recommend department management improve controls in the Receipting Unit to ensure all checks are safeguarded, properly tracked and accounted for in the financial records.

  The agency appropriately segregates the duties of handling checks in its Salem facility. Under the current system, checks received by mail are sorted by category, recorded by count and delivered to the staff member that is responsible for that category. The item count can be reconciled from the online deposit system reports to an excel spreadsheet created by the unit.

  The count and amount of checks received through this process is a small portion of the total revenue recorded by the Receipting unit.

  We have strengthened internal controls on the handoff of checks by including, in addition to a count of checks, the dollar amount, reconciliation, and a check redistribution log.

  As of June 2015, the OFS Receipting unit has overhauled the check scanning process and now images checks into OED (On-Line Electronic Deposit) immediately. There is no longer a reconciliation of a manual process. This finding is complete.

- We recommend department management align policies and procedures with governmental accounting standards to record expenditures in the proper period and we recommend management provide training to staff to ensure that prior period adjustments are utilized when appropriate.

We disagree with the materiality of the finding, although we agree that the operational controls can be improved. Each year the agency records regular, routine transactions to refinance revenue and expenditures related to lagged receipt of various revenue sources. As mentioned in the audit finding, these are normal transactions that occur as part of our regular business process.

In 2009, due to the large dollar amount of these transactions, the agency asked for advice from the Department of Administrative Services, Statewide Accounting and Reporting Services (SARS) on the proper use of prior period adjustments for these transactions. In response, SARS stated, "it's not appropriate to incorporate a prior period adjustment into a routine practice. Prior period adjustments should be reserved for (those infrequent) corrections of errors." This advice was consistent with both the Oregon Accounting Manual (OAM) 15.85.00.PO. and related governmental accounting standards outlined in Governmental Accounting Standards Board (GASB) circulars.

During the 2013 statewide financial audit, auditors again recommended prior period adjustments for routine transactions. On December 3, 2013, the agency, Secretary of State Auditors and SARS met again to discuss the issue. At the meeting, SARS leadership agreed with the auditors that these transactions could, most likely, require prior period adjustments. The agency stated their belief that use of prior period adjustments for routine transactions was contrary to the OAM and GASB.

To ensure that the agency was not in violation of OAM, the agency stated that it would change the practice of recording prior period adjustments (to include material routine transactions) if the OAM were updated to reflect the change.

On December 5, 2013, SARS updated OAM 15.85.00 PO to include new language on when to record a prior period adjustment for these types of transactions.

Since the change in language in the OAM, the unit has started reviewing all adjustments that occurred during fiscal year 2014 to see if prior period adjustments needed to be done. Clarification to staff of the change in the

OAM occurred through the use of Office of Financial Services newsletter, training information shared with Grant Accounting unit, and a process update to improve ability to capture data that would need prior period adjustments.

- We recommend department management review and revise accrual methodologies for revenues and expenditures, as necessary, and perform periodic retrospective comparisons of accruals to actual amounts to ensure the accrual methodologies are reasonable.

  Due to an error during year-end reporting the healthcare provider tax (HPT) revenue, drug rebate revenue and Medicaid Management Information Systems, expenditure accrual estimates were based on a 60-day rather than a 90-day availability period. This accounted for three of the four audit comments in this finding.

  As a corrective action, beginning in fiscal year 2014, the Statewide Financial Reporting unit modified its processes to ensure all governmental fund accrual calculations were based on the 90-day availability period. If actual HPT revenues were not known during month 13 financial adjustment periods, the agency used estimates such as trends and projections based on Generally Accepted Accounting Principles (GAAP). The estimates are compared to actuals for reasonableness.

  Statewide financial reporting timelines require agencies to record accrual estimates within approximately 30 days after the end of the fiscal year even though the accrual period doesn't end until 90 days after the end of the fiscal year. This timeframe produces variances between the estimates and actuals. The fiscal year 2013 variances were partially due to the inherent nature of using estimates. The $17.4 million and the $7.5 million variances seem high, but only make up 6.4% and 2.8% of the total accrual of $270 million.

  Although variances of actuals and estimates are expected, the agency agrees that accrual amounts should be compared to actuals, and future accrual modifications should be implemented as needed. Therefore, as a

corrective action, beginning in 2014 the Statewide Financial Reporting unit implemented a yearly review of its operating statements to document variances and adjust accruals if needed.

Clarification to staff of the change in the OAM occurred through the use of OFS newsletter, training information shared with Grant Accounting unit, and a process update to improve ability to capture data that would need prior period adjustments. The Statewide Financial Reporting unit has reviewed and updated accrual methodologies as appropriate.

- We recommend department management implement internal controls to ensure that all insurance premium revenue due to the department is received, properly classified, and properly recorded.

  The agency reported the correct amount of Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool (FMIP) cash in Fiscal Year 2013. We agree that $5 million of this cash was incorrectly classified as insurance premium revenue, and instead should have been classified as reduction of expenditures. The incorrect classification had no equity impact on the GAAP fund.

  The error occurred primarily because the agency received incomplete revenue reports from Regence in fiscal year 2013. Therefore, beginning in fiscal year 2014, as a corrective action the agency will obtain detailed reports from Regence and adjust its records to correctly classify and report the insurance premiums and reductions of expenditures.

  The FMIP program closed at the end of fiscal year 2013, but the OMIP program was open through the end of December 2013, and the six months of operation will be included in the agency analysis.

  To address audit finding 13-004, in fiscal year 2014 the agency has obtained detailed reports from Regence necessary to determine the source of cash remitted by Regence, and appropriately recorded the cash received based on information available at the time. These reports were received and incorporated in the accounting record on an ongoing basis during fiscal year 2014.

Additionally, to ensure all insurance premiums due to the agency are remitted by Regence, the agency is utilizing the methodology used in the audit analysis, multiplying monthly member contract counts by the relevant premium rates, and reconciling the results with amounts reported and deposited by Regence for the months the programs were open in fiscal year 2014. This analysis was completed for the OMIP program based on information available at accounting close for fiscal year 2014 in September 2014, and the calculated variance was within one percent.

This program has had its closing audit and account has been reconciled for close.

- We recommend department management improve controls to ensure account balances are accurately stated and reconciled to supporting documentation.

  We have inventoried and affirmed the existence of the assets in the building and building improvement account (Oregon State Hospital). We have not identified any other buildings or building improvements that had not been listed. We have reviewed the calculations on the asset spreadsheet and corrected any errors identified. We have implemented controls to ensure accuracy going forward including post-review of recorded entries to documentation and calculations.

  The finding was the result of an addition error that has been corrected and should not be an issue in the future. As this was a correction of an addition error, there is no evidence of the correction.

- We recommend department management gain better understanding of controls already in place and implement the necessary complementary controls to provide assurance that all drug rebate revenue is correctly calculated, invoiced, received, and recorded in the accounting system.

  The CAREAssist program is administered by the Office of Pharmacy Programs. The program requested and received a response from HRSA/Office of Pharmacy Affairs (OPA) which indicates that the federal agency is strengthening its process for oversight of the pharmaceutical manufacturer's compliance with providing rebates to

340B covered entities and the accuracy of the rebates provided. The actual calculations of the rebate amounts will still be privileged information and will be only for internal OPA use. The program received guidance from HRSA and will develop a mechanism by which rebates received by CAREAssist are compared over time to identify a variance of more than an expected percentage. The process will be a report automatically generated from the database and will allow the program to follow up with both the manufacturer and OPA for an explanation for the variance.

The Medicaid Pharmacy program was administered through the Division of Medical Assistance Programs (DMAP). While the program had a number of existing reviews, these reviews lacked a formal process, and lacked formal documentation of the review. Program staff will be developing formal processes to adequately oversee the contractor's invoicing of drug rebate. Program staff worked to develop sound methods of documenting the drug rebate invoicing process. Program staff is also worked with the contractor to develop additional controls around disposition of payments and delinquent payment by developing and using existing MMIS reports for review. Each month for our Rebate meeting, a check off list has been created and after each meeting, the signed check off list is scanned along with reports reviewed.

The agency has contracted with an independent firm to perform annual audits in accordance with the American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting for Controls at a Service Organization, and provide the agency with annual SSAE 16 "type 2 reports" documenting the internal controls and the operating effectiveness of those controls. HP Enterprise Services is required by its contract with OHA to take immediate corrective action to remedy all material weaknesses, deficiencies, or findings identified in a SSAE 16 type 2 audit report. The first annual audit is for state fiscal year 2015, ending in June 2015. The contractor firm is required to submit annual audit reports by the end of September following each state fiscal year.

- We recommend authority management develop a plan that identifies key MMIS edits and implement procedures to periodically test key system edits to ensure they are functioning as intended. We also recommend management

review the claims that should have been rejected by age and gender restriction panel edits to verify those claims are appropriate.

Correct adjudication of Medicaid claims and encounters is a priority for the Oregon Health Authority (OHA). In early 2013, auditors found that the system functionality within the Medicaid Management Information System (MMIS) regarding age and gender restrictions was not as expected. A change request to correct this functionality was discussed. Recognizing the immediate need, a more expedient work-around response to strengthen the rules around age and gender procedures was created. Modifications to these claim rule tables for age and gender restrictions were put in place until the MMIS Restrictions Panel could be corrected. These diagnosis restrictions were inserted into the claim rule tables on February 19, 2013.

In an attempt to confirm that these rules were functioning correctly, a process to randomly pull 35 claims per quarter to be manually checked by staff was initiated using dates of service starting in the first quarter of 2013. The goal of this process was to see if each claim adjudicated properly based on its unique data parameters, including age and gender restrictions. No issues were found processing the claims dataset from the first quarter of 2013. Review of subsequent quarters was delayed due to heavy workloads brought about by Coordinated Care Organization (CCO) evolutions to cover dental and mental health, ICD-10 implementation work and the manual enrollment processes associated with the Patient Protection and Affordable Care Act of 2010 (ACA) Medicaid expansion. Going forward, the random claim pull will be modified to specifically focus on age and gender related procedures and other key edits, such as provider and client eligibility.

With the claim rule table modifications completed, the lack of functionality of the MMIS Restriction Panel was again brought forth in late 2013. Work on the permanent correction to the Restriction Panel began in December 2013, with the creation of a change request. It was anticipated the correct panel functionality would be restored as of January 31, 2015.

Health Systems Division (HSD) tested and implemented (10/2014) a change request which contained six new edits related to age/gender. Those edits, once implemented, were monitored to ensure the expected result was obtained.

Additionally, HSD's plan for ongoing identification and review of key edits is as follows:

- *A group of internal parties (business support, policy, claims, provider services) will be convened to review the MMIS edits to determine what key edits should be tested.*
- *That group will determine how many edits will be tested each quarter and will determine the testing process.*
- *The tester(s) will be identified and informed of the process.*
- *Once claims are tested against the edits, results will be tracked in a central location for review.*
- *If the edits do not function as anticipated, the tester will identify the discrepancy to the Claims and PSU managers for additional action.*

- We recommend authority management maintain evidence of the initial and renewing database checks for enrolled providers.

  It is important to the Division of Medical Assistance Programs (DMAP) that all program integrity requirements to keep excluded persons or entities from participating in the Medicaid programs be followed. Checking the multiple exclusion databases for newly enrolling Medicaid providers has been operational since March, 2011, when the Patient Protection and Affordable Care Act of 2010 (ACA) became effective. The processes necessary to comply with these checks are documented within the provider enrollment policy and procedures manual.

  In addition to newly enrolling providers, all providers within the Medicaid Management Information System (MMIS) are checked against the Medicare Exclusion Database (MED) on a monthly basis. This monthly MED search results in a report being produced that indicates possible matches to excluded individuals or entities. This report is then worked by staff who are tasked to make a determination on the validity of a possible match. If the match is verified, the excluded individual or entity would immediately be terminated from the Medicaid program.

These processes contribute to the high levels of confidence that no excluded individuals or entities are participating in the Oregon Medicaid programs.

A prior audit found that historical documentation of these database checks was not sufficient. To address this, an MMIS change request was written on March 28, 2013. This change request was completed and deployed the week of August 25, 2014 and expanded the provider panel to include a series of check boxes where the enrollment staff can record what databases were checked and when they were checked.

The permanent MMIS solution, which consists of a new panel in the provider subsystem where enrollment staff "checks" a separate box for each required database went into production in the MMIS in August 2014. These checking actions are both date stamped and recorded for audit purposes. All enrollments and revalidations that occurred after the August 2014 date now have the permanent evidence of being reviewed. We have targeted the revalidation process for completion by April 1, 2017.

- We recommend authority management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

We agree the Department of Human Services and Oregon Health Authority have not completed all the elements of a formal ADP risk analysis and security review of the Medicaid systems. However, as we have previously communicated, the agencies have traditionally relied on third-party assessments such as SOC 1, Type 2 reports, audits from Office of Inspector General, Secretary of State, and the Enterprise Security Office's Annual Information Systems Business Risk Assessment report to provide this information. Security control assessment is included in these assessments. Vulnerability assessment scans of the MMIS system software are periodically performed at least every three years or whenever major changes are made to the system. The last vulnerability assessment took place in September 2016.

We use these audits and reports, as well as leveraging reports from the Privacy and Incident Response section, to assist in that determination. While not strictly a formal risk assessment per se, it does provide an analysis of controls from both a system as well as program perspective. In addition, Information Security and Privacy Office (ISPO) staff have conducted physical security walk-throughs of the State Data Center where the MMIS production servers are located.

An information security risk assessment was conducted by the Information Security and Privacy Office (ISPO) on the Provider Services and Provider Enrollment units of Division of Medical Assistance programs (DMAP), which administers the Medicaid program for the State of Oregon. The risk assessment was completed in March 2015. In January 2015, the Oregon Health Authority began an agency-wide restructure. As a result of this major restructure and transitional projects, further ISPO-conducted risk assessments were postponed. We also agree that we need to develop a formal risk assessment and security review program based in industry standards and best practices that assesses risks for programs as a whole and not on a system-by-system basis.

- We recommend management strengthen its review of balance transfers to ensure costs are not charged to a grant outside of its period of availability. We further recommend management consider implementing a process to limit the charging of costs to a closed grant thereby minimizing the need for corrections.

  Currently, the Immunization section follows the Center for Public Health Practice process, which is, as follows:

  1. *Section fiscal analyst prepares documentation of the original transaction from SFMA with an explanation on why the transfer is requested.*
  2. *Request is submitted to the Practice Program Support Manger (PSM) for review and approval.*
  3. *If approved, PSM emails request to the Office of Financial Services (OFS).*
  4. *Request is reviewed by OFS divisional liaison.*
  5. *If approved, adjustment is entered by OFS.*

Step 1 above was expanded to include attaching source documentation from the original transaction. This allows confirmation that the adjustment is appropriate to the period of availability. A new procedure has been developed to establish a more uniform method for making adjustments. The new expense transfer adjustment policy became effective on June 1, 2014.

- We recommend management ensure the appropriate report is submitted at the end of the grant period. We also recommend management strengthen its reconciliations of Federal Financial Reports to ensure accounting records fully support reported amounts.

  Management emphasized the need for staff to properly identify individual grant reporting requirements and stressed the need to communicate effectively between program staff and the Office of Financial Services (OFS). OFS will review adjustment requests for effective dates and invoice descriptions to determine validity of expenditures. OFS staff will review the Notice of Award and determine if the financial report should be an interim, quarterly, annual or final report. OFS staff will monitor grants after federal reporting has occurred to ensure no additional entries are made and make sure accounting structure is shut down to prevent future occurrences. OFS will expand queries of the datamart to measure expenditures by grant component.

  All adjustments are reviewed by either the Grant Accountant or Division Coordinator to ensure adjustments are in accordance with the notice of award. The invoice description and the date of the original are reviewed. All adjustments are entered by the Grant Accountant or Division Coordinator and then released by a manager or other employee. The Grant Accountant runs a query and verifies on the 66 screen in SFMA no activity has occurred on a closed grant.

- We recommend management ensure controls are in place to review and retain reports used to justify payroll funding splits. Management should ensure funding splits entered into OSPA are appropriate, including those with differences noted during the audit.

The Oregon Immunization Program developed a process for centralized tracking of payroll documents and assigned responsibility to specific positions. Immunization staff was trained on the improved workflow for payroll documents. This process was tested from July 2013 through January 2014, and formalized in Unit Guideline OPS001 (dated January 28, 2014).

2. OHA: Safe Drinking Water Revolving Loan Fund for the Fiscal Year Ended June 30, 2013, audit # 2015- 01, (dated January 2015)

- We recommend the agency continue to refine their financial reporting process to accurately adjust the Safe Drinking Water financial statements to comply with GAAP.

  We agree with the finding. Program has incorporated the adjustments and resubmitted the appropriate financial statements. A process has been developed and documented for the creation and review of these financial statements. An appropriate review will be done by the Statewide Financial Reporting Unit going forward.

- We recommend the agency review its process to ensure payroll charged to a program is allowable and unallowable payroll is detected and corrected timely.

  We agree with the finding that an error was made in our payroll coding. The employee's time was coded to the Technical Assistance set-aside when it should have been coded to the other fund fee-based program, Operator Certification. An adjustment to correct this error has been made and will be reflected in the Fiscal Year 2014 expenditure reports. We are now more closely reviewing our time and activity reports to help us avoid similar miscoding in the future.

3. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2014, audit #2015-05 (dated April 2015)

- We recommend department management seek adequate assurance for the accuracy of all financial information they report. Management should have a documented understanding of the controls involved in transactions, whether

automated or manual, to ensure the integrity of the information. When necessary, such as for significant financial systems operated by independent service providers, department management should obtain timely independent assurance over the accuracy and reliability of the information.

Medical Assistance Programs of the Oregon Health Authority released a Request for Proposal (RFP) in late December 2014 to procure an independent contractor to perform annual audits of the internal controls implemented by Hewlett-Packard (HP) Enterprise Services, LLC, for its operation of the MMIS. The selected contractor will be required to perform the annual audits in accordance with the American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting for Controls at a Service Organization, and provide the agency with annual SSAE 16 "type 2 reports" documenting the internal controls and the operating effectiveness of those controls. HP Enterprise Services is required by its contract with OHA to take immediate corrective action to remedy all material weaknesses, deficiencies, or findings identified in a SSAE 16 type 2 audit report. The first annual audit by the selected contractor was for state fiscal year 2015, ending in June 2015. OHA will require the selected contractor to submit annual audit reports by the end of September following each state fiscal year. Received the first Moss-Adams final report September 2015.

In addition to the ongoing effort to better oversee and document the contractor controls within the drug rebate program addressed in last year's audit, staff from Medical Assistance Programs and the Office of Financial Services meet biweekly with Hewlett Packard counterparts from technical and financial areas to discuss MMIS data questions and anomalies, system testing, outstanding MMIS production changes, and upcoming system changes and impacts. The group also reviews and manages an action item list to document the group's work and those responsible for taking action.

- We recommend department and authority management strengthen controls to ensure sufficient documentation is maintained to demonstrate compliance with federal requirements, support for payment amounts and income is retained, and the client liability is calculated accurately.

The department will be working within our programs to ensure these requirements are shared with staff and continued to be followed appropriately. Since the period of time covered by the audit, DHS Self Sufficiency field offices have been in the process of moving toward electronic case files as part of our EDMS Expansion project.

As part of this effort, in November 2014 an all-staff transmittal was issued identifying the standardized data capture elements for offices that have moved to electronic case files. This standardization assists in locating documentation in EDMS. Additionally, DHS Self-Sufficiency field offices were also provided with refresher tools on archiving to help in documenting which case files and time frames are shipped to Archives to be scanned.

APD has completed the roll out of the EDMS Expansion and all files are in the process of being converted to electronic format. Training was completed in every field office and AAA throughout the state. It is believed that having files in electronic format will ensure that eligibility documentation is not lost and will be easier to locate when needed.

APD offices have completed training and roll out of the EDMS system for client eligibility documentation. The program continues to remind staff and managers of the importance of maintaining client documentation through staff meetings and "In the Loop" newsletter articles.

- We recommend management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

We agree the Department of Human Services and Oregon Health Authority have not completed all the elements of a formal ADP risk analysis and security review of the Medicaid systems. However, as we have previously communicated, the agencies have traditionally relied on third-party assessments such as SOC 1, Type 2 reports, audits from Office of Inspector General, Secretary of State, and the Enterprise Security Office's Annual Information Systems Business Risk Assessment report to provide this information. Security control assessment is included in these assessments. Vulnerability assessment scans of the MMIS system software are periodically

performed at least every three years or whenever major changes are made to the system. The last vulnerability assessment took place in September 2016.

We use these audits and reports, as well as leveraging reports from the Privacy and Incident Response section, to assist in that determination. While not strictly a formal risk assessment per se, it does provide an analysis of controls from both a system as well as program perspective. In addition, Information Security and Privacy Office (ISPO) staff have conducted physical security walk-throughs of the State Data Center where the MMIS production servers are located.

An information security risk assessment was conducted by the Information Security and Privacy Office (ISPO) on the Provider Services and Provider Enrollment units of Division of Medical Assistance programs (DMAP), which administers the Medicaid program for the State of Oregon. The risk assessment was completed in March 2015. In January 2015, the Oregon Health Authority began an agency-wide restructure. As a result of this major restructure and transitional projects, further ISPO-conducted risk assessments were postponed. We also agree that we need to develop a formal risk assessment and security review program based in industry standards and best practices that assesses risks for programs as a whole and not on a system-by-system basis.

We recommend management develop a plan that identifies key MMIS edits and implement procedures to periodically test key system edits to ensure they are functioning as intended.

Health Systems Division (HSD) tested and implemented (10/2014) a change request which contained six new edits related to age/gender. Those edits, once implemented, were monitored to ensure the expected result was obtained.

Additionally, HSD's plan for ongoing identification and review of key edits is as follows:

- *A group of internal parties (business support, policy, claims, provider services) will be convened to review the MMIS edits to determine what key edits should be tested.*
- *That group will determine how many edits will be tested each quarter and will determine the testing process.*
- *The tester(s) will be identified and informed of the process.*

- *Once claims are tested against the edits, results will be tracked in a central location for review.*
- *If the edits do not function as anticipated, the tester will identify the discrepancy to the Claims and PSU managers for additional action.*

- We recommend that authority management maintain evidence of the initial and renewing database checks for enrolled providers.

  It is important to the authority that all program integrity requirements to keep excluded persons or entities from participating in the various Medicaid programs be followed. Medical Assistance Programs (MAP) enrollment staff has been checking these required exclusion databases per the updated enrollment policies and procedures manual since March, 2011. As the enrollment effort is largely a paperless process, producing paper screen prints for each database result and matching these prints to the electronic application was deemed impractical. By using the procedures developed for the ACA requirements in combination with the added security of the required automated monthly Medicaid Exclusion Database (MED) checks, management was confident the intent of compliance to these checks was not compromised from March 2011 to the point where a permanent Medicaid Management Information System (MMIS) solution could be implemented into the production MMIS environment.

  The permanent MMIS solution, which consists of a new panel in the provider subsystem where enrollment staff "checks" a separate box for each required database went into production in the MMIS in August 2014. These checking actions are both date stamped and recorded for audit purposes. All enrollments and revalidations that occurred after the August 2014 date now have the permanent evidence of being reviewed. We have targeted the revalidation process for completion by April 1, 2017.

  To address future documentation requirements, a change request has been submitted to create two additional labels for the Provider Validation panel. The result of this change will be better documentation for which databases where checked and why, based on whether the provider was revalidated, reactivated or renewed.

- We recommend management ensure compliance site visits are performed timely for all enrolled and active providers.

The Centers for Disease Control and Prevention (CDC) have added new requirements to the Vaccines for Children (VFC) program over the past two years that create additional work related to provider site visits. These additional requirements, in addition to Oregon vaccine stewardship laws, have increased the length of time spent preparing for, completing, and following up on VFC site visits.

To address the additional resource expense that the new site visit requirements necessitate, the Oregon Immunization Program is in the process of reviewing, and when needed, reprioritizing work in order to allow for timely site visits, while still complying with other grant-required activities. Tablets will be activated to allow entry of site visit data directly into the CDC database during the visit. New follow-up templates are being developed to increase the efficiency of provider follow up.

The Oregon Immunization Program set aside time for an on-site review by the CDC April 7-9, 2015 to discuss this compliance issue with our project officer to see if CDC could assist us in finding additional efficiencies or the necessary resources to meet the requirement.

We did not meet the CDC 50% target in 2015. . To address this audit finding in 2015, the Oregon Immunization Program took a variety of steps aimed at impacting the program's ability to meet their federally determined site visit goal. These actions included:

- *Reviewing, and when needed, reprioritizing work in order to allow for timely site visits, while still complying with other grant-required activities.*
- *The use of technology to make the site visits more efficient for staff namely tablets have been implemented to streamline site visits and cut down on double data entry.*
- *Removal of appropriate tasks from staff who complete site visits and assignment of these tasks to lower level staff*
- *Development and use of new templates to increase the efficiency of provider follow-up.*

- *The use of process improvement activities to create additional efficiencies.*

In addition to continuing the steps described above, the Oregon Immunization Program has set in motion the following steps in order to impact the program's ability to meet their federally determined site visit goal in 2016.

- *Two positions on the Provider Services Team (which conducts the site visits) have been reclassified from a Health Educator 2 to a Compliance Specialist 2. This change in position classification will have significant impact on our program's ability to complete our site visit requirements, by creating two positions whose sole pan pose is to complete site visits and site visit follow-up, will complete the bulk of our required site visits, and will be freed from the other duties previously assigned to Health Educators thus allowing more focused attention on meeting this audit requirement.*

- *We have developed a VFC provider waitlist which will provide additional control over the number of providers requiring site visits. This will help slow the continued growth in the program, especially considering our staffing and resource limitations which have not kept pace with our addition of provider sites.*

Continued data analysis is planned to evaluate the number of staff needed to complete the new are able to maintain in the program, develop justification for potential addition of resources, and support planful growth targeting areas where access to vaccination is of concern, such as rural or frontier areas of our state.

In addition to the two Compliance Specialists positions referenced above, the program has transitioned a third position into a Compliance Specialist. These three positions are wholly focused on completing site visits and addressing this target area. At the mid-year point, the program is well positioned to meet this federal and state target.

- We recommend management consider implementing a payroll process that is sufficiently detailed to allow for an efficient and effective review of employee time and coding. We also recommend management ensure controls are fully implemented to document the review used to justify payroll funding splits.

In April and May of 2014, the Public Health Division completed a large-scale project to address and clarify Time and Activity reporting requirements that come with federal grant funding. This project included development of policies, tools to assist both staff and managers in meeting this requirement, and a mandatory training event for every Public Health Division employee. This training has a component for all employees and then an additional component for managers who review and approve time. Registration for the event was required, and attendance was tracked to ensure all employees received the information. All of the procedures and tools created and presented in training are available on PHD's Intranet for use by staff at any time.

While the policy clearly states the process and tools to use in reviewing time, we recognize room for improvement in the area of documentation. The only documentation of managers' review and approval of timesheets and work activity coding is currently through the locking of the timesheets. Each manager receives information from the staff assigned to review timesheet coding in comparison with where staff have been assigned to work. If coding does not appear accurate or complete, both the individual employee and manager are notified. The employee is expected to fix errors and respond. After a final review, another email is sent to the managers notifying them that errors are resolved and timesheets are ready to lock. At this point, if the timesheets are not locked, we do not have a way to demonstrate the review and approval of time by management.

PHD will conduct a rigorous review and make necessary changes to ensure documentation of the manager's approval of the time recorded. This would be in addition to their locking of the employee timesheet. In the interim, the program began creating a more thorough record of the coding reviews that occur, in accordance with the Division procedure, to keep a monthly file of the reports used to verify time (Timesheet Audit and Control report), as well as the communications between staff and with managers that demonstrate the review was completed. Additionally, we assigned staff to review the locking status of the timesheets prior to the period close and followed up with an additional reminder to managers as necessary. We also incorporated a review of the lock reports when received after the monthly close. If there are any unlocked timesheets on the report, the approving manager was required to explain, in writing, why this occurred and what will be done to prevent a recurrence in the future. This explanation will be filed with other review documentation for the month. This will be an accountability and performance measure for the approving manager.

The agency worked with the Department of Administrative Services on a recommendation to enhance the new e-time system to allow both the manager and staff to see the descriptive name of the activity charged at time entry and time locking. This enhancement allows the agency to more efficiently and effectively manage payroll costs charged to grants.

Program has finalized the payroll review procedures. Files have been created, and the initial review of the files was completed in May, 2015.

- We recommend management determine the amount of interest owed to the federal government for Medicaid and CHIP and ensure clearance patterns in the draw calculation spreadsheet are updated annually to reflect any changes in the CMIA agreement.

  We determined the amount of interest owed and included it with our interest spreadsheet which was sent to the Oregon Department of Administrative Services on December 1, 2015. The accountant has put on the calendar a reminder to update the check clearance pattern percent and has also put a note in the spreadsheet to update.

- We recommend the department update the cost allocation plans to reflect current practices and ensure future changes are communicated timely.

  Historically, the agency submitted biennial updates to the cost allocation plan and submitted changes to the plan annually when significant changes were made. There were no significant modifications to the plan during the last year so an update was not submitted to the Division of Cost Allocation.

  The agency agrees that updates to the plan should be submitted annually, even if no changes are made. Further, the agency is currently communicating with the Division of Cost Allocation for guidance on their process for the submission of amendments to the public assistance cost allocation plans regarding mid-year modifications.

Due to changes in the organizational structure of OHA, our update of the OHA PACAP was delayed until July 2016. The current biennium cost allocation plan was submitted for review in July 2016 and is awaiting a response from DCA.

4. OHA: SOS Safe Drinking Water Revolving Loan Fund SFY 2014-Applying Agreed-Upon Procedures, audit #2015-17 (dated July 2015)

- We recommend the agency continue to refine their financial reporting process by having a person with experience and knowledge of financial reporting conduct a review of the adjustments prepared for financial reporting purposes.

  To ensure reporting consistency/process improvements, detailed processes for preparing yearly Drinking Water financial statements have been documented in the SFR unit procedures. Audit notes and recommended improvements are included in this process document. Yearly preparers will first review the processes, audit notes, and recommended improvements. They also will consult/train with the prior year's preparer to ensure transfer of information, and to ensure understanding of the processes. Before final report submission, a peer review with another professional level team member will be completed.

  SFR has also made several changes to our review process that should further reduce errors in the report. Last year, our experienced reviewer took a new job immediately prior to completion of the report. We have since hired a person who has experience in financial reporting, and she conducted a formal, detailed review of this years' report prepared by our lead accountant. This included a check of the formulas in the spreadsheet and of the queries used to produce the data. This formal review is now incorporated into our standard operating manual. In addition, we are working with the grant accountants more closely to determine if there are adjustments that did not have cash draws associated with them, or any other activity that may affect the financial statements. The process will conclude with a final review by the unit manager.

- We recommend agency management ensure proper coding of revenues and expenditures to the correct grant phase and set aside fund. Additionally, agency management should ensure that ASAP and SFMA are reconciled on a regular basis to ensure proper accounting of funds.

  To ensure the agency receives the accrual transaction information timely, the Statewide Financial Reporting unit has updated its accrual procedures to include instructions to request the accrual information before July 1 with the year-end task list , and then to check back for this information no later than August 1. To ensure the accrual review will include an analysis of the financial impact, a section has been added to accrual procedures to include review at the comptroller and rollup GAAP object level.

5. Oregon State Hospital: significant Actions Taken to Improve Safety and Promote Patient Recovery, but Further Improvements are Possible, audit #2015-23 (dated September 2015)

- We recommend Oregon State Hospital management develop a plan for improving consistency of case formulations and integrating patient treatment goals with the treatment mall groups offered.

  We have implemented a consistent model of case formulation at OSH. The current training curriculum uses standard work and a standard approach. The curriculum includes Collaborative Problem Solving (CPS) concepts.

  The hospital is establishing a more consistent approach to, and training for, case formulation. Most licensed clinicians (such as psychiatrists, nurse practitioners, psychologists, social workers, and rehabilitation therapists) learn case formulation, most commonly the biopsychosocial model, during their individual clinical training. However, this training varies widely across the numerous universities where clinicians receive their education.

  Effective case formulation is only one step in treatment planning. Case formulations are highly individualized and do not lend themselves to standardized measurements of treatment effectiveness, nor do they provide ready data for identification of treatment mall therapy group need.

Treatment begins with assessment, followed by interdisciplinary case formulation. The formulation guides the team in identifying patient treatment needs. Treatment care planning is a collaborative process in which the clinical team, together with the patient:

- *Determines which treatment needs will be prioritized for focus at that particular time;*
- *Establishes long-term and short-term goals related to those prioritized needs; and*
- *Identifies treatment interventions (which may include group therapies) that will be used to address those needs.*

A formal plan, should encompass more than case formulation. OSH is using the approach of measuring patient treatment needs in three areas:

- *Skill Deficits (using the Collaborative Problem Solving Skills Inventory as we implement this treatment model across the hospital);*
- *Recovery Strengths (using Reaching Recovery scales); and*
- *Risks (using the Short Term Assessment of Risk and Treatability, or START, which is already in use).*

The hospital has followed the auditors' recommendation by drafting a formal plan for improvement that includes:

1. *Expansion of case formulation tools and standard work to include Collaborative Problem Solving concepts*
2. *Clinician training and implementation rollout, including pilots on specific living units*
3. *Ongoing implementation of the Collaborative Problem Solving treatment model (the hospital is currently in the midst of a five-year timeline for training and implementation)*
4. *Employment of Reaching Recovery scales to measure patient strengths*

The overall plan includes a timeline, metrics for evaluating success, and strategies for expanded rollout and communication.

Treatment malls develop class offerings based on the results of needs assessments and the effectiveness of the previous session's groups. Classes are evaluated every 10 weeks. When preparing the schedule for the upcoming treatment mall session, staff review the assessments, treatment teams determinations of effectiveness, and requests from both patients and treatment teams. After identifying which groups are most needed, the treatment malls work with the discipline chiefs to assign programming to group leaders. Depending on where groups are offered, patients may attend groups on multiple malls to best meet their treatment goals.

Patients and their treatment teams judge the effectiveness of groups by measuring the progression or regression for that individual. For example, if a patient is attending a 10-week Anger Management group to work on frustration tolerance, the team will review the progress notes from the group leader to determine whether the patient is attending and how well skills are being developed. The team will also evaluate the patients' behavior on the unit to determine progression.

One example of how the treatment malls are directly responsive to patient need and patient treatment goals is reflected in the increase in the number of Legal Skills groups offered to patients who are committed to the Oregon State Hospital in order to be restored to competency to stand trial. These individuals have been accused of a crime, but the court has determined that they are unable to "aid and assist" their own defense counsel because of their mental illness. The hospital has experienced a significant surge in the number of patients who need these services. Thus, the treatment malls focused resources on expanding Legal Skills materials, sessions, and treatment opportunities. This was recognized by The Joint Commission as a leading practice in our 2015 survey.

To further link/align treatment malls services with treatment plans, an initial pilot project in one mall area (Archways-9 units with 197 patients) is now under review. Briefly, the Archways Tx pilot focuses on alignment of group interventions with treatment planning and standardized documentation. A second iteration, factoring in 'lessons learned' from Archways is on schedule to start up for the Bridgeways treatment mall. It, again, is specific to each patient and their respective treatment care plans and will drive the number and frequency of groups provided.

It is noteworthy that, during a revisit, in May, 2016, a Joint Commission (TJC) surveyor, in observing the Archways pilot, had praise for the linkages of the treatment plans (TCP) to the program services and found all TJC Standards related to TCPs to be in compliance.

- Develop policies and procedures for developing and documenting case formulations; and designing, selecting, and scheduling treatment mall groups.

  We generally agree with this recommendation. Because case formulation is a task that requires structured professional judgment in the case of each individual patient, policy requirements should be limited to:

  - *Use the standardized tool (currently under development) for case formulations; and*
  - *Ensure clinicians are trained in its use.*

  Anything else would venture into the realm of professional judgment.

  The hospital will create a policy by the end of the 4th quarter, 2016, that demonstrates the flow between case formulation, designing curriculum, and scheduling treatment mall classes. The draft policy will be based on lessons learned with pilot projects and identified best practices. The OSH Treatment Services work team initiatives that focused on Treatment Delivery and Program Planning have been completed. The first group, Archways, has standardized group note formats and also have begun to address patient scheduling, program planning, and group evaluations.

  Pilot case formulations & clinical rounding also go through the Plan Do Check Act (PDCA) cycle process. Clinical rounding is occurring in multiple programs at this time and will be reviewed in Quality Council next month. This process has significant depth and breadth of scope. As such, a hospital-wide policy, rather than a departmental protocol will be needed to drive practice. The case consultation process is also reviewed on a programmatic level by the Program Executive Teams of the respective areas.

- Continue to address organizational cultural issues and meet staff training needs to reduce seclusion and restraint (S/R) incidents.

  The hospital has established the OSH Performance System. With clearly defined goals and measures for success, this system provides the structure and guidance necessary to achieve a culture of recovery, person-centeredness, continuous improvement, and Lean empowerment throughout at all levels of the organization.

  The hospital Lean culture fosters the identification of training and cultural needs and creates opportunities for raising quality consciousness and attitudes. Through Lean, the people doing the work each and every day are routinely problem-solving for increased effectiveness and working with leadership to discover improvement needs and opportunities together.

  Hospital leadership continues to prioritize and expand the performance improvement body of work until these continuous improvement efforts become part of the fabric of the organization.

  Integral to sustaining a culture change is ensuring that each person has the core knowledge of requirements, standards, and regulations. As such, the focus for the Seclusion/Restraint Committee and the organization has been updating the S/R policy to current standards, including revised OARs. The policy was reviewed, revised, updated and published in March, 2016. Coupled with the policy rollout was an online training to the specific changes that staff needed to know. The online training was vetted by multiple stakeholders, including patients at OSH. As of June 30, 2016, approximately 1,200 staff had successfully completed the training, which included a competency test embedded within it.

  A downward trend in restraint events has occurred in the last eight months. While it may be difficult to identify Collaborative Problem Solving (CPS) as a cause/effect relationship, it does appear to be correlational as noted with the units having consistent CPS coaches with reduced restraint events. Over 800 staff, from all levels of the organization, have completed the Tier 1 CPS training.

- Continue to use data to inform decision-making and practice in S/R reduction efforts.

  The efforts of the Seclusion and Restraint Committee have continued in earnest, in partnership with the clinical leadership and Data and Analysis teams. The Seclusion and Restraint Committee is accountable for reporting results to OSH Cabinet via the OSH Performance System quarterly performance review process as part of the overall Performance System framework. This will ensure appropriate visibility and intensity of efforts toward reducing seclusion and restraint.

  In addition, the hospital engaged in comparative work with the Western Psychiatric State Hospital Association (WPSHA) and the National Association of State Mental Health Program Directors' research arm, the National Research Institute. These collaborations allow the hospital to engage in regional and national discussions of best-practices in seclusion and restraint, standardize terminology and criteria, and identify the appropriate benchmarks for its organizational efforts.

  A comprehensive personnel database (CPD) to collect a range of information has been established and findings can be provided in future Secretary of State updates. Seclusion and Restraint Committee, Protection From Harm Committee and Program Executive Teams all use specific S/R data captures to determine resource allocation and pilot projects. OSH has had a trend established for the last eight months of reduced incidence of restraint events and a three month period of reduced seclusion event frequency and reduced duration in seclusion or restraint per episode.

- Continue Collaborative Problem Solving and Safe Containment implementation with real time coaching to ensure staff are competent in their new skills and consistently applying the methods.

  Safe Containment training continues on a daily basis to be available to staff on all shifts, and implementation of the Collaborative Problem Solving (CPS) model continues to be a top hospital priority. Since implementation over 800 staff have been trained in CPS tenets.

As noted above, there has been a significant push to get staff trained in CPS. OSH also hired a CPS trainer with extensive knowledge and experience in CPS. This level of expertise will provide mentoring for the advanced training sessions. This information has been presented in multiple Quarterly Performance Review sessions, most recently in May, 2016. We have gone from nine trained coaches assigned to units to sixteen trained coaches in order to systematically expand to other units. The CPS Breakthrough document is attached for reference.

- Update policies and procedures that guide the on-the-job training of nursing staff to ensure consistency among the programs.

  Nursing Services is currently establishing a comprehensive orientation program that includes mentoring and on-the-job training for all nursing staff. As this program continues to develop, Nursing Services will create the accompanying protocols and evaluation tools to ensure that all new nursing staff receive the appropriate level of both classroom and on-the-job training.

  We have established a focused Nursing Training Department with seven staff and starting in early 2016, they rolled out a six week, 'boot camp' for new Mental Health Technicians. Coupled with the boot camp, which includes mentoring elements, many nursing staff have also gone through the introductory, Tier 1, and Tier 2 Collaborative Problem Solving trainings. As these curricula are validated, policies will be created that drive future trainings based on "lessons learned".

- Consider reestablishing the mentoring program for nursing staff and provide adequate incentives for mentor participation.

  From January 2015 through January, 2016, the hospital launched the Leadership, Encouragement and Development (LEAD) program for all unit nurse managers and unit supervising registered nurses. This program focused on leadership and management skills that will create more consistent unit leadership across the hospital.

The first round of a RN training program that had mentoring elements was completed in January, 2016. While the program had some positive feedback, new nursing leadership is reviewing future options. One option being considered is an interval mentorship model.

Regarding the mentoring process, all of the program level associate directors of nursing now have mentors as well as other management level staff. This mentoring model goes up to the current interim Chief Nursing Officer as well who has a mentor.

Since its' inception in April, 2015, every new mental health therapist (MHT) and habilitative therapy technician (HTT) goes through a highly structured six week orientation or 'boot camp'. The course started out as four weeks and it was necessary to expand it to six weeks. During this orientation, they work closely with instructors who guide them through the Trauma-Informed Care model that prepares them to build positive therapeutic relationships with patients based on empathy. First, new employees gain an understanding of concepts in a classroom setting. Then they are partnered with an MHT mentor on the unit who helps the new employee put newly learned skills into practice. They then return to the classroom and debrief the on-unit experiences. We believe this method of training will lay a firm foundation for reducing incidents of aggression and decreasing the need for seclusion and restraint.

The change in orientation with the MHTs and HTT was intentional, as they constitute the highest percentage of the hospital's nursing staff and generally come less prepared to work at a psychiatric hospital than registered nurses (RNs). The boot camp includes mentoring components along with periodic evaluation/competency testing. To date, over 148 individuals have successfully completed the boot camp. As the boot camp becomes standardized and an integral component for MHTs and HTTs, resources will be able to be shifted to develop a similar, though more intensive program, for RNs and LPNs. As the scope of the RN work is significantly different with respect to seclusion/restraint events, medications, etc., a tailored training process is needed.

- Continue efforts to integrate S/R reduction tools and assessments into individual patient treatment.

We have continued our current efforts to integrate tools into individual treatment to reduce the use of seclusion and restraint.

CPS, clinical rounding, and case consultations have been key elements for S/R reduction. With the success of the CPS coaching program, we have found that CPS is more frequently identified in the Treatment Care Plans as a specific intervention to use before going to S/R. Regular clinical rounding, initiated in 2016, also serves as a focal point to review what has worked and what has not worked in reducing individual S/R events. In addition, Program Executive Teams also review high frequency or serious events to determine options to avoid future S/R incidents.

- Ensure success of the Peer Recovery Services department by providing the new director with the tools and support needed to form a department mission and development plan.

  Since the new director started in January 2015, Peer Recovery Services (PRS) has hired several more positions, including an outreach coordinator and a coordinator for the Patient Advisory Councils on both the Junction City and Salem campuses. As noted with the summary below, the department continues to expand its capacity to be involved in treatment team meetings, treatment mall service delivery, and community reintegration.

  PRS continues to grow in delivery of peer supported services. PRS increased the provision of engagement services on two of the mall areas, and have recently partnered with the psychology department. PRS participated with OSH patients in two community peer-centered conferences. PRS continues to support patients in bridging services, accompanying and assisting patients who are working with Disability Rights Oregon, Protection & Advocacy for Individuals with Mental Illness, Oregon Consumer Advisory Council, and variety of other peer-empowerment activities. At the present time, PRS facilitates the use of the Sjolander Empowerment Center for four to eight mall groups a week. PRS also facilitates three groups in the Crossroads Mall, two of which are assisting patients in community integration activities. PRS is involved in facilitation of four groups in the Bridges Mall, one of which is the all-day Peer Bridgers outing. In the Archways and Springs programs, interventions have focused on individual referrals at this time, except for the two weekly Springs Mall group to the Sjolander Empowerment Center. PRS has begun to shift part of our focus to activities also outside of the mall hours.

PRS has also been a part of the Civil Population Community Re-integration Team to improve transition services of those under a civil commitment. The PRS department has already sponsored training on this as well as purchasing materials to improve this service.

One of the PRS staff received training in facilitating a support group for people who experience Alternative Realities (i.e., auditory and visual hallucinations) and partnered with the OSH Psychology Department to offer this group hospital wide. The PRS Peer Advisory Council (PAC) Coordinator continues to facilitate six to seven meetings a week and work with the OSH LEAN Management team to improve and engage the communication and problem-solving process with OSH teams. This has been augmented by the development of a PEER Leadership team, PAC sub-committees, and quarterly retreat/ planning sessions, the latter which invites various departments to this session to engage in education and problem-solving discussions.

PRS staff have been active participants of the continued development of the Marion-Polk Peer Coalition and the peer led and sponsored activities in the local community that have included OSH patients.

PRS is developing, internally, a mission, vision, and value statement that is more consistent than that developed by the external consultants. In 2016, PRS will craft more accurate measures of what PRS reflects. In researching similar advocacy groups, PRS is inspired by the powerful, and simple mission statement of NARA in Portland: "Mission Driven, Spirit Led."

- Continue to ensure stakeholders and consumers have a role in S/R reduction efforts.

Consumers and other stakeholders have been active members of the hospital's Seclusion and Restraint Committee for several years, and they will continue to be.

The hospital has made multiple efforts to involve external stakeholders and current/former patients. The Hospital Advisory Board has also sought out membership support with the S/R Committee work. Currently, there are two patients attending S&R committee meetings; one has done so since April 2016. The final public position on the committee was filled in November 2016.

- Continue to work with the Governor and legislature to fill vacant seats on the Oregon State Hospital Advisory Board.

  Since the Secretary of State audit, OSH administration and the Advisory Board have worked with the Governor's Office to identify all vacancies and have identified applicants for all positions. We expect the Legislature to approve the new members in September 2016.

- Continue efforts to finalize the hospital's debriefing policy.

  The hospital is focusing the debriefing policy and ensuring that it is well aligned with the Collaborative Problem Solving (CPS) treatment model.

  The Seclusion and Restraint Committee reviewed the draft debriefing policy in the 2nd quarter of 2016 and found it to be too broad in scope. In the 3rd quarter, 2016, the committee reviewed another revision of the policy that incorporated elements from processes related to debriefing. The hospital formed a workgroup to review the documentation from all disciplines related to debriefing. The workgroup will make additional improvements to streamline the documentation and make additional changes to the revised policy.

  It should be noted that CMS does not have requirements regarding debriefing and The Joint Commission is removing all recommendations and standards for debriefing effective January 1, 2017. We believe debriefing to be person-centered, best practice.

- Develop strategies that could limit unscheduled absences where possible.

  We agree that unscheduled absences, or "call outs" as they are called at the hospital, continue to be the leading driver of overtime. However, this issue is closely tied to the labor management agreement, and any limits as recommended must be negotiated accordingly. In the meantime, the hospital will continue to address this issue through available personnel policies and procedures.

In February 2016, an independent, outside consultant, AKT Advisors, conducted a study of OSH direct care staffing practices. The study supported the staffing policy of the hospital and the hospital's efforts to expand a direct care staffing float pool. It's clear due to the amount of overtime, call-outs, vacancies and increasing patient acuity, that more direct care staff are needed. Since this time, due to the continued increase in Aid & Assist (.370) patient census, the acuity level at OSH has increased, which has increased the number of physician ordered "precautions" (a requirement to assign one, and in some cases, two staff to a specific patient). This has exacerbated the staffing need.

Float pool staff are used to help ensure required staffing levels are achieved within planned/reasonable overtime levels. In addition, OSH has and will continue active review of sick, FMLA/OFLA, and unauthorized leave to identify patterns and abuse for follow up with coaching and discipline action.

- Develop policies for managing staff overtime.

We agree that a limit should be placed on the number of overtime hours an employee is permitted to work. Recent efforts to revise the union contracts on this issue were unsuccessful.

OSH does have a policy and process to manage overtime by 1) its policy and practice of ratio based determination of required direct care staffing and twice weekly review of actual staffing to the required ratio based levels to assure compliance, 2) constant review and follow up action of staff call out patterns and excessive sick time use, and 3) efforts to expand OSH float pool staff to ensure required staffing levels are achieved within reasonable overtime levels.

No progress was made in the last union bargaining session in this regard to overtime limitations for employees. In February 2016, an independent, outside consultant, AKT Advisors, conducted a study of OSH direct care staffing practices. They concluded that: "the methodology of the calculation appears to be sound. In speaking with our outside council, OSH's delivery model is well known and viewed favorably by others in the industry." The report supported establishment of additional float staff to address excessive overtime and recommended OSH, "Hire additional staff to cover the vacancies created by absenteeism and covered leave as well as meeting the staffing

needs of precaution requirements." (Note: Since the time of this study, due to the continued increase in the Aid & Assist (.370) patient census, the acuity level at OSH has increased, which has increased the number of physician ordered "precautions" (a requirement to assign one, and in some cases, two staff to a specific patient). This has exacerbated the staffing need.)

The hospital revised and updated Nursing Services Staffing Protocol 2.150 on August 15, 2015. This included revised ratios for all areas of the hospital. This protocol is again under review for staffing assignments within both hospital-licensed units and secure-residential-treatment-facility-licensed units.

Additional actions regarding improving management of staff overtime are noted below:

- *Expanded the number of staff who qualify to provide some of the services that Mental Health Technicians had been providing.*
- *Increased the size of on-call float pools. This is beginning to reduce the overtime levels at both campuses.*
- *Established or expanded service contracts with multiple nurse staffing agencies to increase availability of contracted nursing staff.*
- *Improved the hiring process for nursing staff to reduce the vacancy level for these positions and reduce the amount of overtime needed to back-fill vacant positions.*
- *Offered RNs an option to 'test out' a night shift for 30 days. The short term goal is to temporarily cover existing needs in a safe and thoughtful way, and the long term goal is to permanently fill vacant positions on the night shift with staff who are currently working other shifts.*
- *Improve communication between the Central Staffing Office and nurse managers to facilitate a discussion of upcoming staffing needs, approval/documentation of safe staffing levels based on real-time unit acuity and patient care needs, and problem-solving for low-staffing situations.*
- *Created a nurse staffing needs modeling program that projects nursing needs in excess of available resources well in advance of the need. This allows sufficient time for Central Staffing Office schedulers to procure non-overtime staffing resources to fill these needs.*

- *Explored the option of offering overtime to non-nursing staff who can assist with non-nursing-specific tasks. For example, a recreational specialist could supervise a patient activity or an office coordinator could answer phones, freeing nursing staff from these functions. In turn, this would lower the number of nursing staff needed to meet patient care and safety needs.*
- *Convened the Nurse Staffing Committee, which meets regularly to review progress, review ratios, adjust ratios, identify recurrent staffing needs, consider staffing alternatives, and make recommendations to address staffing issues.*

- Provide training to staff on the causes and effects of fatigue and on how fatigue may impair their ability to provide safe patient care.

  The hospital agrees that training on the effects of fatigue could provide some benefit.

  In an analysis completed in early 2015, the hospital found no correlation between staff who work a high number of overtime hours and staff who were alleged to have abused or neglected (e.g., slept on the job) patients; however, the hospital agrees that training on the effects of fatigue could provide some benefit.

  It should be noted that addressing fatigue is more of a reactive process. While there is value addressing fatigue head on, a Failure Mode Effects Analysis process can identify steps to take, proactively, to mitigate fatigue issues earlier. The organization has taken a preliminary step towards a more proactive approach by meeting with PEBB, MODA, and Pacific University to begin a potential collaboration and pilot project to better manage stress. PEBB and MODA have identified that OSH is a high stress environment and are interested in providing some funding and training resources to evaluate if an evidence-based eight week pilot course for 20-25 direct care staff will yield positive results in better management of stress. The business case for this pilot is under development.

  Additional actions taken include Superintendent emails about worker fatigue and on-campus resources that OSH provides when staff end up working overtime.

  Additional actions are listed below:

- *The impact of staff fatigue is incorporated into the New Employee Orientation (NEO). The NEO program includes a presentation regarding fatigue in multiple slides.*
- *A brochure was created to inform new and current employees of the safety risks related to fatigue in the workplace.*
- *An educational campaign was completed in November 2015 to inform all staff workers of the safety risks related to fatigue.*
- *Fatigue informational signage is posted at key staff entry and staff gathering points, which can be reviewed while awaiting entry to and exit from the OSH secure perimeter.*
- *The Superintendent has sent out email notifications about options for sleeping, resting, and meals at OSH, particularly when adverse weather conditions increase staff overtime coverage.*

OSH has made these educational and training sessions an ongoing part of its staff and manager development plans.

- Consider using the analytical framework used in our 2012 audit of the Department of Correction's management of personnel costs to see if it is possible to identify cost savings while meeting patient treatment needs and maintaining a high level of patient and staff safety.

  In order to determine how many staff are needed to run the Oregon State Hospital, a 24/7, 365 days/year operation, organization leaders use a "posting factor" to calculate staff absences, such as weekends, sick leave, vacations, holidays, etc.

  Hospital leadership has reviewed the Department of Corrections (DOC) audit analytical framework to determine whether it can be applied in a psychiatric hospital setting. The Oregon State Hospital uses a "posting factor" of 2.0 to calculate staff absences, such as weekends, sick leave, vacations, holidays, etc. This means that OSH needs to hire two nursing staff to ensure coverage for all assignments dedicated to patient units. We are currently reviewing actual hours of staff absences to determine whether 2.0 is the correct posting factor to use for OSH according to the analytical framework of the DOC audit.

In February 2016, an independent outside consultant, AKT Advisors, conducted a study of OSH direct care staffing practices. They concluded that: "the methodology of the calculation appears to be sound. In speaking with our outside council, OSH's delivery model is well known and viewed favorably by others in the industry."

The OSH CFO/COO met with DOC representatives to discuss staffing models and found that DOC was also experiencing high levels of overtime even with their posting factor process in place. OSH shared its staffing ratio model and the tools used to monitor and manage it with DOC. While a posting factor approach would help plan for allowable staff vacancies such as vacations, holidays, and sick leave, it would not account for additional staffing needs for Doctor ordered patient precaution staffing (i.e., one or two staff assigned to watch one patient) and the excessive degree of staff absenteeism, both of which are major drivers of OSH direct care staff overtime.

An additional new factor that has affected the staffing model at OSH includes Senate Bill 469, which places constraints on the use of mandated overtime. As a result, the Nursing Services Staffing Committee is reviewing the staffing allocations across the entire organization. In a few areas, the staffing ratios regarded as being higher than required. This was done primarily for standardization of coverage and to more easily float staff from one area to another. The Nursing Staffing Committee is taking a much more active role and working with other WPSHA hospitals to determine best practice options.

- Complete electronic health records system's implementation while prioritizing resources on automating of processes that significantly impact patient care and converting critical patient information to electronic format.

  The hospital agrees with this recommendation. The hospital has continued to face several challenges during the sequenced rollouts of the electronic health record (EHR) system, and, as noted in the report, parts of the system are still in process of being completed. The Oregon State Hospital Replacement Project team and the hospital, together with the Office of Information Services (the information technology arm of OHA and DHS), have been working diligently with the vendor to overcome the challenges and to complete the implementation. The incomplete system adversely affects organizational efficiency and, potentially, the quality and cost of patient care.

To expedite the conversion of patient medical records from paper to electronic form, the hospital has retained project management and consulting services to recommend improvements to the conversion process, to assist in implementing those recommendations, and to help accelerate and improve overall clinical adoption of the electronic health record system.

OSH has continued working on the EHR's implementation, while prioritizing resources on automating of processes that significantly impact patient care and converting critical patient information to electronic format.

OSH has worked closely with its optimization consultant to operationalize the EHR functionality and to implement the medication management module of the system which will complete the project. OSH currently estimates that the close-out of the Avatar implementation project will occur during the fourth quarter of 2016.

During the past 12 months, the process-automation focus has been on:

(a) Medication Management (which is intended to reduce medication errors and diversion; due to the need to address issues detected in integration testing, the date for Phase I implementation in Junction City is being postponed from 8/2016 to 10/2016); and

(b) Disaster Recovery (which provides for us to "fail over" from the State Data Center to the Beaverton data center of partner Atmosera within 4 hours, for the Avatar EHR and four applications interfaced to Avatar).

The Junction City campus very successfully implemented Medication Management in November 2016, and it is functioning to specifications. This final key module of the HR system project, Medication Management, is scheduled to be fully implemented on the Salem Campus in April 2017. With this in place, the Avatar EHR system will be complete to project requirements, and this project, as the final component of the OSH Replacement Project, may be closed at that time.

The hospital expects the High Availability System Program (disaster recovery) to be operational by January 15, 2017, and upgraded by April 2017, with the implementation of the Medication Management system at the Salem campus.

During this same period, we have continued to move documents from the paper record into the EHR, including:

(1) Enhanced Supervision orders;
(2) Informed Consent documentation;
(3) Suicide Risk Baseline Factors;
(4) Rehabilitation Services Assessment;
(5) Spiritual Care Assessment; and
(6) Vocational Assessment.

6. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2015, audit #2016-09 (dated April 2016)

- Recommend department management ensure that adequate documentation is retained to demonstrate controls are operating as intended to ensure that expenditures are paid at proper rates.

  The Office of Financial Services has developed a "System Update Tracking Sheet" as documentation when federal funding split codes rate changes are updated or modified in systems. The tracking sheet was implemented with the federal rate changes effective October 1, 2015.

- Recommend department management consider the financial statement impact resulting from adjustments or entries made in underlying coding to ensure amounts are properly reported.

  To ensure the agency receives the accrual transaction information timely, the Statewide Financial Reporting unit has updated its accrual procedure to include instructions to request the accrual information before July 1 with the year-end task list, and then to check back for this information no later than August 1. To ensure the accrual review

will include an analysis of the financial impact, a section has been added to accrual procedures to include review at the comptroller and rollup GAAP object level.

- Recommend department and authority management strengthen controls to ensure sufficient documentation is maintained to demonstrate compliance with federal requirements and the client liability is calculated accurately.

  The department's Aging and People with Disabilities office will remind their managers and staff of the policies, appropriate documentation and retention of applications needed to determine eligibility for our program. These reminders will be agenda items for the APD Program Managers meeting, the APD Supervisors meeting and will be included in an "In the Loop" newsletter article.

  The department researched and has taken action on the nine cases with missing applications. For these cases, either an application has been obtained by the office, a current application was found on file, or the client is now deceased. We will also explore best practices to help better document evidence of redeterminations being completed in a timely manner.

  In relation to the eligibility coding error identified in the finding, the authority was actively working to renew the individual's benefits. The renewal was completed and benefits closed August 31, 2015. The authority will return the identified questioned costs to the federal government.

  The department has returned the federal funds for the one client identified in the finding where the client liability was calculated using an incorrect income.

- We recommend management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

  We agree the Department of Human Services and Oregon Health Authority have not completed all the elements of a formal ADP risk analysis and security review of the Medicaid systems. However, as we have previously

communicated, the agencies have traditionally relied on third-party assessments such as SOC 1, Type 2 reports, audits from Office of Inspector General, Secretary of State, and the Enterprise Security Office's Annual Information Systems Business Risk Assessment report to provide this information. Security control assessment is included in these assessments. Vulnerability assessment scans of the MMIS system software are periodically performed at least every three years or whenever major changes are made to the system. The last vulnerability assessment took place in September 2016.

We use these audits and reports, as well as leveraging reports from the Privacy and Incident Response section, to assist in that determination. While not strictly a formal risk assessment per se, it does provide an analysis of controls from both a system as well as program perspective. In addition, Information Security and Privacy Office (ISPO) staff have conducted physical security walk-throughs of the State Data Center where the MMIS production servers are located.

An information security risk assessment was conducted by the Information Security and Privacy Office (ISPO) on the Provider Services and Provider Enrollment units of Division of Medical Assistance programs (DMAP), which administers the Medicaid program for the State of Oregon. The risk assessment was completed in March 2015. In January 2015, the Oregon Health Authority began an agency-wide restructure. As a result of this major restructure and transitional projects, further ISPO-conducted risk assessments were postponed. We also agree that we need to develop a formal risk assessment and security review program based in industry standards and best practices that assesses risks for programs as a whole and not on a system-by-system basis.

Recommend management strengthen controls to ensure only allowable costs are paid for at appropriate federal funding participation rates.

The Office of Financial Services has a process to cross check the documentation provided by program staff to ensure the appropriate transfer has been completed. The agency is also working on a process to automate this transfer within the MMIS system.

A coding matrix is being developed to allow users to select the correct coding for the allowable expenditures.

For noted transaction errors corrective action was developed and is in operation at this time. A new agreement is being negotiated. Adjustments were made to ensure correct federal funding.

- We recommend management ensure staff are documenting that all databases were verified for new and revalidated providers.

  The authority agrees it is important to properly document verification checks. Upon further review, the provider identified in the finding was in the process of being renewed. While revalidations and reactivations of providers require the four database checks, renewed providers only require the completion of the two database checks noted. Currently our system does not display the renewal or reactivation designation in the panel. We regret we did not adequately communicate this differentiation in requirements.

  To address future documentation requirements, a change request has been submitted to create two additional labels for the Provider Validation panel. The result of this change will be better documentation for which databases where checked and why, based on whether the provider was revalidated, reactivated or renewed.

- Organization management should ensure compliance site visits are performed timely for all enrolled and active providers.

  The Centers for Disease Control and Prevention (CDC) has added new requirements to the Vaccines for Children (VFC) program over the past three years that create additional work related to provider site visits. These additional requirements, in addition to Oregon vaccine stewardship laws, have increased the length of time spent preparing for, completing, and following up on VFC site visits. Health Educators are now spending approximately 2.5 hours on site per visit, per clinic site, rather than 1.5 hours seen previously, and follow-up time has increased proportionately. At times, the new follow-up requirements require staff to complete additional overnight trips to ensure that clinics retain appropriate eligibility screening documentation. In addition, significant resources dedicated to completing site visits in the audit time period were unavailable due to vacancies in key positions and a hiring freeze which limited the program's ability to fill these vacancies.

To address this audit finding in 2015, the Oregon Immunization Program took a variety of steps aimed at impacting the program's ability to meet their federally determined site visit goal. These actions included:

- *Reviewing, and when needed, reprioritizing work in order to allow for timely site visits, while still complying with other grant-required activities.*
- *The use of technology to make the site visits more efficient for staff, namely tablets have been implemented to streamline site visits and cut down on double data entry.*
- *Removal of appropriate tasks from staff who complete site visits and assignment of these tasks to lower level staff.*
- *Development and use of new templates to increase the efficiency of provider follow-up.*
- *The use of process improvement activities to create additional efficiencies.*

In addition to continuing the steps described above, the Oregon Immunization Program has set in motion the following steps in order to impact the program's ability to meet their federally determined site visit goal in 2016.

- *Two positions on the Provider Services Team (which conducts the site visits) have been re-classified from a Health Educator 2 to a Compliance Specialist 2. This change in position classification will have significant impact on our program's ability to complete our site visit requirements, by creating two positions whose sole purpose is to complete site visits and site visit follow-up, will complete the bulk of our required site visits, and will be freed from the other duties previously assigned to Health Educators thus allowing more focused attention on meeting this audit requirement.*
- *We have developed a VFC provider waitlist which will provide additional control over the number of providers requiring site visits. This will help slow the continued growth in the program, especially*

considering our staffing and resource limitations which have not kept pace with our addition of provider sites.

Continued data analysis is planned to evaluate the number of staff needed to complete the new and upcoming CDC requirements for site visits. This will help us plan for the number of sites we are able to maintain in the program, develop justification for potential addition of resources, and support planful growth targeting areas where access to vaccination is of concern, such as rural or frontier areas of our state.

In addition to the two Compliance Specialists positions referenced above, the program has transitioned a third position into a Compliance Specialist. These three positions are wholly focused on completing site visits and addressing this target area. At the mid-year point, the program is well positioned to meet this federal and state target.

- Recommend management ensure staff receive training regarding the proper coding for expenditures and allowability of expenditures. Additionally, management should ensure documentation is maintained to support expenditures paid. Further, for the specific items identified, management should correct the coding errors and ensure the expenditures are billed to the appropriate program and/or source of funds.

  Agency management understands the importance of ensuring staff are trained on proper account coding, documentation, and allowable cost principles. Management will work with the Office of Financial Services to develop tools to assist staff in choosing the proper codes and develop additional quality assurance processes to review for unallowable costs. The identified transactions have been corrected.

- Recommend management update the cost allocation plans for the department and authority to reflect current practices and ensure future changes are communicated timely.

  The agency will continue to submit annual cost allocation plan updates and interim updates when there are major changes to allocation methodologies. The agency will continue to work with the federal Division of Cost Allocation on the Oregon Health Authority major plan updates. Due to changes in the organizational structure of OHA, our

update of the OHA PACAP was delayed until July 2016. The current biennium cost allocation plan was submitted for review in July 2016 and is awaiting a response from DCA.

7. OHA: Safe Drinking Water Revolving Loan Fund –Applying Agreed-Upon Procedures for Fiscal Year Ended June 30, 2015, audit #2016-13 (dated June 2016)

- We recommend the agency continue to refine their financial reporting process by having a person with experience and knowledge of financial reporting conduct a review of the adjustments prepared for financial reporting purposes.

  The Oregon Health Authority agrees with the recommendation. Our review process includes having a person with experience and knowledge of financial reporting review adjustments. We will continue refining our process to ensure that these adjustments are not overlooked in the future.

  SFR has also made several changes to our review process that should further reduce errors in the report. Last year, our experienced reviewer took a new job immediately prior to completion of the report. We have since hired a person who has experience in financial reporting, and she conducted a formal, detailed review of this years' report prepared by our lead accountant. This included a check of the formulas in the spreadsheet and of the queries used to produce the data. This formal review is now incorporated into our standard operating manual. In addition, we are working with the grant accountants more closely to determine if there are adjustments that did not have cash draws associated with them, or any other activity that may affect the financial statements. The process will conclude with a final review by the unit manager.

OHA Audits in 2015-2017

2015 – 2017 Internal and External Audits and Reviews for OHA

Internal Audits and Consults

Name of Audit:	Internal Fraud Detection
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	SPOTS Audit (2014)
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	OHP Medical Program Enrollment
OHA Programs:	Health Policy and Analytics, Health Systems
Status:	Completed
Name of Audit:	CareAssist 340B Drug Rebates
OHA Programs:	Public Health
Status:	In Progress
Name of Audit:	Staff Safety II
OHA Programs:	Agency Wide
Status:	In Progress
Name of Audit:	Ethics Structural Review (Consult)
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	Opinion on Imaging Documents (Consult)
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	Payroll Time Code Reviews – Military Leave (Consult)
OHA Programs:	Fiscal and Operations
Status:	Completed
Name of Audit:	Blue Mountain Recovery Center Medicaid Cost Settlement for FYE 6-30-12 (Consult)
OHA Programs:	Oregon State Hospital
Status:	In Progress
Name of Audit:	Oregon State Hospital Timekeeping Process Review (Consult)
OHA Programs:	Fiscal and Operations, Oregon State Hospital
Status:	In Progress

Name of Audit:	OHA Provider Audit Unit Review of Medicaid Medically Fragile Children's Waiver, Medically Involved Children's Waiver, Behavioral Model Waiver, Support Services Waiver, and the Comprehensive Waiver
OHA Programs:	Fiscal and Operations, Health Policy and Analytics
Status:	In Progress

Secretary of State Audits

Name of Audit:	Safe Drinking Water Revolving Loan Fund Agreed Upon Procedures for Fiscal Year Ended June 30, 2014
OHA Programs:	Public Health, Shared Services
Status:	Completed
Name of Audit:	Statewide Single Audit For Year Ending 6-30-15
OHA Programs:	Agency Wide
Status:	Completed
Name of Audit:	Oregon Needs Stronger Leadership, Sustained Focus to Improve Delinquent Debt Collection
OHA Programs:	Shared Services
Status:	Completed
Name of Audit:	Oregon State Hospital: Significant Actions Taken to Improve Safety and Promote Patient Recovery, but Further Improvements are Possible
OHA Programs:	Oregon State Hospital
Status:	Completed
Name of Audit:	Review of Contract Between Portland State University and Patient-Centered Primary Care Home Programs (Management Letter)
OHA Programs:	Health Policy and Analytics
Status:	Completed
Name of Audit:	Safe Drinking Water Revolving Loan Fund Agreed Upon Procedures for Fiscal Year Ended June 30, 2015
OHA Programs:	Public Health, Shared Services
Status:	Completed
Name of Audit:	Improving State Computer System Security Will Take Time, Resources and Cooperation
OHA Programs:	Information Services
Status:	Completed

Name of Audit: Wage Data Use Review
OHA Programs: Agency Wide
Status: Completed

Name of Audit: Oregon Eligibility (ONE) and Medicaid Management Information System (MMIS) System Review
OHA Programs: Health Systems, Information Services
Status: In Progress

Name of Audit: Statewide Single Audit For Year Ending 6-30-2016
OHA Programs: Agency Wide
Status: In Progress

Name of Audit: Medicaid Performance Review
OHA Programs: Health Policy and Analytics, Health Systems, Fiscal and Operations
Status: In Progress

Federal Audits and Reviews

Name of Audit: Corporation for National & Community Services AmeriCorps Review
OHA Programs: Public Health
Status: Completed

Name of Audit: Health Resources and Service Administration (HRSA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Early Childhood Comprehensive Systems (ECCS) Grants Review
OHA Programs: Public Health
Status: Completed

Name of Audit: Centers for Medicare and Medicaid Services (CMS) Oregon Rounds 1-3 Test Case Results Analysis
OHA Programs: Health Policy and Analytics, Health Systems
Status: Completed

Name of Audit: Health and Human Service (HHS) Office of Inspector General (OIG) Indian Health Services (IHS) Facilities Expenditure Review
OHA Programs: Health Systems, Shared Services
Status: Completed

Name of Audit: Payment Error Rate Measurement (PERM) FFY 2014
OHA Programs: Health Policy and Analytics, Health Systems, Shared Services
Status: Completed

Name of Audit:	OIG Audit of Office of Licensing and Regulatory Oversight (OLRO) Nursing Facility Survey Unit
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	Health and Human Services (HHS) OIG Survey of Medicaid Claims Adjustments
OHA Programs:	Shared Services
Status:	Completed
Name of Audit:	Centers for Medicare and Medicaid (CMS) Home and Community Based Services (HCBS) Aged and Physically Disabled Waiver Review
OHA Programs:	Health Policy and Analytics
Status:	Completed
Name of Audit:	Government Accountability Office (GAO) Study of Medicaid Personal Care Services
OHA Programs:	Health Policy and Analytics
Status:	Completed
Name of Audit:	Federal Bureau of Investigation (FBI) Non-Criminal Justice Information Technology Security Review
OHA Programs:	Information Services, Shared Services
Status:	Completed
Name of Audit:	FBI Review of Firearms Records Data
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	Substance Abuse Prevention and Treatment (SAPT) Core Technical Review
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	Centers for Decease Control and Prevention (CDC) Breast and Cervical Cancer Program (BCCP) and WISEWOMAN Site Visit
OHA Programs:	Public Health
Status:	Completed
Name of Audit:	CDC Immunization Program Site Visit 2015
OHA Programs:	Public Health
Status:	Completed

Name of Audit:	Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) Monitoring Report
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	U.S. Environmental Protection Agency (EPA) Safe Drinking Water Revolving Loan Fund Program Evaluation Report SFY 2015
OHA Programs:	Public Health
Status:	Completed
Name of Audit:	CMS Oregon Medicaid Electronic Health Records Incentive Program and Health Information Technology for Economic and Clinical Health (HITECH) Site Visit
OHA Programs:	Health Policy and Analytics, Information Services
Status:	Completed
Name of Audit:	HHS OIG Oregon Managed Care Organizations (MCO) Medical Loss Ratio (MLR) Standards
OHA Programs:	Health Systems, Fiscal and Operations
Status:	Completed
Name of Audit:	EPA OIG OHA Prior Labor Charging Practices Under EPA Grants
OHA Programs:	Public Health, Shared Services
Status:	Completed
Name of Audit:	Food and Nutrition Services (FNS) Civil Rights Division (CRD) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) 2016 Civil Rights Review
OHA Programs:	Public Health
Status:	Completed
Name of Audit:	
OHA Programs:	CDC Immunization Program Site Visit 2016
Status:	Public Health Completed
Name of Audit:	
	CMS 1915(i) Home and Community Based Services State Plan Option Review
OHA Programs:	Health Policy and Analytics, Health Systems
Status:	Completed

Name of Audit:	CMS Home and Community Based Services Office of Developmental Disabilities Services Comprehensive Waiver Review
OHA Programs:	Health Policy and Analytics
Status:	In Progress

Name of Audit:	PERM FFY 2017
OHA Programs:	Health Policy and Analytics, Health Systems, Fiscal and Operations
Status:	In Progress

Name of Audit:	EPA Safe Drinking Water Revolving Loan Fund Program Evaluation 2016
OHA Programs:	Public Health
Status:	In Progress

Name of Audit:	HHS OIG Review of Medicaid Community First Choice Option (K-Plan)
OHA Programs:	Health Policy and Analytics, Health Systems
Status:	In Progress

Other Agency Audits and Reviews

Name of Audit:	Information Security Business Risk Assessment Report – 2015 (Department of Administrative Services Contract)
OHA Programs:	Information Services
Status:	Completed

Name of Audit:	Oregon Department of State Police Criminal Justice Information Services (CJIS) Information Technology Security Audit – Oregon State Hospital
OHA Programs:	Information Services, Oregon State Hospital
Status:	Completed

Name of Audit:	Oregon Department of State Police Criminal Justice Information Services (CJIS) Information Technology Security Audit – Oregon Medical Marijuana Program
OHA Programs:	Information Services, Public Health
Status:	In Progress

Contracted Audits and Reviews

Name of Audit:	MMIS Controls Audit 2015
OHA Programs:	Health Systems
Status:	Completed

Name of Audit:	MMIS Controls Audit 2016
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	Oregon Disproportionate Share Hospital Report for State Plan Rate Year (SPRY) 2011
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	Oregon Disproportionate Share Hospital Report for State Plan Rate Year (SPRY) 2012
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	OHA Managed Care 2015 External Quality Review (EQR) Annual Report
OHA Programs:	Health Systems
Status:	Completed
Name of Audit:	Oregon Disproportionate Share Hospital Report for State Plan Rate Year (SPRY) 2013
OHA Programs:	Health Systems
Status:	In Progress
Name of Audit:	HealthInsight Information System Capabilities Assessment (ISCA) for 2016
OHA Programs:	Health Systems
Status:	In Progress

PROGRAM PRIORITIZATION FOR 2017-19

Agency Name: Oregon Health Authority

2017-19 Biennium

					Agency-Wide Priorities for 2017 -2019 Biennium								
1	4			5	6	7	8	9	10	11	12	13	14
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**
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	1,057,516,872	-	2,394,575,720	-	10,745,235,758	-	14,197,328,350
2	Health Programs	Health Programs Non Medicaid	No	HSD 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	276,393,311	10,106,595	121,099,886	-	49,697,267	-	457,297,059
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	13,503,187	-	14,738,771	40,000,000	93,075,646	101,929,051	263,246,655
4	Public Health Programs	State Public Health Director	No	Responsible for state emergency preparedness, planning, and response.		8, 10	4,026,198	-	6,776,517	-	6,285,264	-	17,087,979
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	3,909,030	-	2,719,418	-	22,288,185	-	28,916,633
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 faciilities licensure, quality improvemnet and regulation, medical marijuana, and Patient Safety Commission.		9,10	2,022,150	-	990,453	-	2,939,890	-	5,952,493

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
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	429,282,177	-	65,156,796	-	32,465,818	-	526,904,791
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	6,565,657	-	415,657	-	2,011,932	-	8,993,246
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 OOptional 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			1,885,849,931				1,885,849,931
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	-	-	1,651,747,668	-	-	-	1,651,747,668
11	Health Policy Programs	OHIT Incentive Payments	No	The Medicaid Electronic Health Records Incentive Payment provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.			-	-	-	-	63,889,736	-	63,889,736
							1,793,218,582	10,106,595	6,144,070,817	40,000,000	11,017,889,496	101,929,051	$ 19,107,214,541

10% General Fund / 10% Other & Federal Fund Reduction Options for the 2017-2019 Biennium

(Includes Other and Federal Funds non-limited, excludes Debt Service budget, per statute)

Current Service Level Budget	**3,077,122,151**	**5,754,677,668**	**11,901,405,117**	**20,733,204,936**
10% Target	**307,712,215**	**575,467,767**	**1,190,140,512**	**2,073,320,494**

Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF & TTX	Federal Funds	Total Funds	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
~~-0.27%~~	~~1~~	~~Medicaid~~	~~Make the mental health preferred drug list (PDL) enforceable. Prescribers of mental health medications would be required to adhere to the PDL. Exceptions to the PDL would be administered by prior authorization. An enforceable PDL for mental health medications would increase usage of preferred drugs. There would be no limitation on access to prescriptions under this reduction. Before being placed on the PDL, drugs are subjected to rigorous evidence review. LEGISLATIVE ACTION REQUIRED. CMS APPROVAL REQUIRED. Effective 1/1/18.~~	~~Y~~	~~$ (8,244,363)~~	~~$ 4,075,126~~	~~$ (14,507,867)~~	~~$ (18,677,103)~~			~~Many mental health organizations, including the National Alliance of Mental Illness (NAMI), strongly oppose putting mental health drugs on an enforceable PDL.~~
-0.32%	**2**	Non-Medicaid	Remove budgeted inflation for A&D treatment.	N	$ (1,466,737)	$ (725,651)	$ (1,652,297)	$ (3,844,685)	-	-	This action would eliminate the budgeted inflation for A&D treatment services. This is the first increase that service providers have had in years. Reducing the rate of funding paid to treatment providers as costs of doing business increase makes it more difficult to attract and retain qualified staff and to offer quality services to Oregonians in need.
-0.66%	**3**	Non-Medicaid	Remove budgeted inflation for Community Mental Health Programs.	N	$ (10,696,536)	$ (2,244,112)	$ (510,150)	$ (13,450,798)	-	-	This reduction would eliminate the budgeted inflation for Community Mental Health Programs. As actual costs do increase, this means there would be less ability to provide the same level of service to clients in the community programs. There is the possibility of reductions in workforce in community providers and the potential loss of some smaller providers due to the inability to secure funding through other sources.
-0.86%	**4**	Medicaid	Eliminate the Indirect Medical Education (IME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset indirect costs associated with their GME programs. IME includes indirect costs that arise from the inexperience of residents, such as extra medical tests and reduced productivity. CMS APPROVAL REQUIRED.	Y	$ (6,118,607)		$ (10,667,695)	$ (16,786,302)			This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians.
-1.37%	**5**	Medicaid	Eliminate the Direct Medical Education (DME) component of the Graduate Medical Education (GME) program. The agency would eliminate Medicaid payments to teaching hospitals that help offset costs associated with their graduate medical education programs. GME includes costs associated with stipends or salaries for residents, payments to supervising physicians, and direct program administration costs. CMS APPROVAL REQUIRED.	Y	$ (15,733,562)		$ (27,431,216)	$ (43,164,778)			This reduction would mean that hospitals would have less incentive to train new physicians. The impact on the provider workforce may limit access to quality health care for all Oregonians.
~~-1.47%~~	~~6~~	~~OSH~~	~~Amend Junction City Phase-In Plan: Remove the first of three cottages licensed as a Residential Treatment Facility (RTF) scheduled to be opened in the 2017-2019 CSL budget. Assumes a 24-month reduction of funding for this cottage from the 2017-2019 CSL budget and a reduction of CSL-funded capacity of eight beds. Because most staffing for these cottages serve all three cottages, the staff and dollar reduction for each cottage phase-in removal is not equivalent, rather it increases with each cottage phase-in removal.~~	~~N~~	~~$ (3,040,833)~~	~~$ -~~	~~$ -~~	~~$ (3,040,833)~~	~~(14)~~	~~(12.50)~~	~~Holding off the planned phase-in of this Junction City cottage will reduce the RTF transitional treatment capacity of the Junction City campus hospital by eight beds. Patients who are residing in Secured Residential Treatment Facility (SRTF) units of the Junction City facility who have recovered to the point that they are ready to move to a less restrictive setting may have to wait longer for an RTF transitional treatment setting due to limited capacity. This may result in an increased length of stay within the Junction City campus facility treatment units as patients ready to transition to community settings must wait until an opening becomes available.~~
~~-1.65%~~	~~7~~	~~OSH~~	~~Amend Junction City Phase-in Plan: Remove the second of three cottages licensed as a Residential Treatment Facility (RTF) scheduled to be opened in 2017-2019 CSL budget. Assumes a 24-month reduction of funding for this cottage from the 2017-19 CSL and an additional eight-bed reduction of CSL-funded capacity (a total of 16 beds). Because most staffing for these cottages serve all three cottages, the staff and dollar reduction for each cottage phase-in removal is not equivalent, rather it increases with each cottage phase-in removal.~~	~~N~~	~~$ (5,471,452)~~	~~$ -~~	~~$ -~~	~~$ (5,471,452)~~	~~(25)~~	~~(25.00)~~	~~Holding off the planned phase-in of this Junction City cottage will reduce the RTF transitional treatment capacity of the Junction City hospital campus by eight beds. Patients who are residing in Secured Residential Treatment Facility (SRTF) units of the Junction City facility who have recovered to the point that they are ready to move to a less restrictive setting may have to wait longer for an RTF transitional treatment setting due to limited capacity. This may result in an increased length of stay within the Junction City facility treatment units as patients ready to transition to community settings must wait until an opening becomes available.~~

Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF & TTX	Federal Funds	Total Funds	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
~~-1.77%~~	~~8~~	~~OSH~~	~~Amend Junction City Phase-In Plan: Remove the third of three cottages licensed as a Residential Treatment Facility (RTF) scheduled to be opened in 2017-2019 CSL budget. Assumes a 24-month reduction of funding for this cottage from the 2017-2019 CSL and an additional eight bed reduction of CSL funded capacity (a total of 24 beds). Because most staffing for these cottages serve all three cottages, the staff and dollar reduction for each cottage phase-in removal is not equivalent, rather it increases with each cottage phase-in removal.~~	~~N~~	~~$ (3,578,567)~~	~~$ -~~	~~$ -~~	~~$ (3,578,567)~~	~~(14)~~	~~(14.00)~~	~~Holding off the planned phase-in of this Junction City cottage will reduce the RTF transitional treatment capacity of the Junction City hospital campus by eight beds. Patients who are residing in Secured Residential Treatment Facility (SRTF) units of the Junction City facility who have recovered to the point that they are ready to move to a less restrictive setting may have to wait longer for an RTF transitional treatment setting due to limited capacity. This may result in an increased length of stay within the Junction City facility treatment units as patients ready to transition to community settings must wait until an opening becomes available.~~
~~-2.15%~~	~~9~~	~~OSH~~	~~Amend Junction City Phase-In Plan: Remove one of two Secured Residential Treatment Facility (SRTF) units scheduled to be opened in 2017-2019 CSL budget. This would result in five units opening within the Junction City facility rather than the planned capacity of six units.~~	~~N~~	~~$ (11,688,395)~~	~~$ -~~	~~$ -~~	~~$ (11,688,395)~~	~~(47)~~	~~(45.50)~~	~~Holding off the planned phase-in of this SRTF unit would reduce capacity of the Junction City campus by 25 beds and would further limit the availability of treatment that is closer to community and family for patients from southern Oregon. There would be less capacity for those patients who have recovered sufficiently to no longer need hospital-level care and are preparing to transition out of the hospital. Less capacity at Oregon State Hospital may result in more patients on the Civil Commitment wait list and for longer periods, which in turn, may result in longer stays in emergency departments for people waiting for an acute care bed. In addition, this phase-in adjustment would be contingent upon mandated state hospital caseload growth. While Guilty Except for Insanity (GEI) caseload growth is not currently growing at a pace to require the opening of another hospital unit, growth in Aid and Assist, or ".370," caseload does pose a significant risk to the need for additional capacity. Civil caseload growth has remained steady, and Junction City's most recently opened unit is serving the Civil population that has been displaced from the Salem campus by the increase in the Aid and Assist population.~~
~~-2.49%~~	~~10~~	~~OSH~~	~~Amend Junction City Phase-In Plan: Remove second of two Secured Residential Treatment Facility (SRTF) units scheduled to be opened in 2017-2019 CSL budget. This would result in four units opening within the Junction City facility rather than the planned capacity of six units.~~	~~N~~	~~$ (10,679,077)~~	~~$ -~~	~~$ -~~	~~$ (10,679,077)~~	~~(40)~~	~~(40.00)~~	~~Holding off the planned phase-in of this SRTF unit would reduce capacity of the Junction City campus by 25 beds and would further limit the availability of treatment that is closer to community and family for patients from southern Oregon. There would be less capacity for those patients who have recovered sufficiently to no longer need hospital-level care and are preparing to transition out of the hospital. Less capacity at Oregon State Hospital may result in more patients on the Civil Commitment wait list and for longer periods, which in turn, may result in longer stays in emergency departments for people waiting for an acute care bed. In addition, this phase-in adjustment would be contingent upon mandated state hospital caseload growth. While Guilty Except for Insanity (GEI) caseload growth is not currently growing at a pace to require the opening of another hospital unit, growth in Aid and Assist, or ".370," caseload does pose a significant risk to the need for additional capacity. Civil caseload growth has remained steady, and Junction City's most recently opened unit is serving the Civil population that has been displaced from the Salem campus by the increase in the Aid and Assist population.~~
~~-2.90%~~	~~11~~	~~OSH~~	~~Close ward at Junction City.~~	~~N~~	~~$ (12,632,910)~~	~~$ -~~	~~$ -~~	~~$ (12,632,910)~~	~~(53)~~	~~(53.00)~~	~~Closing this Civil unit will reduce the capacity of the Junction City campus by 25 beds and would further limit the availability of beds for Civil patients. Less capacity at Oregon State Hospital through this reduction option may result in more patients on the Civil Commitment wait list and for longer periods, which in turn, may result in longer stays in emergency departments for people waiting for an acute care bed.~~
-2.92%	**12**	PHD/AGRH	Reduce of Oregon Contraceptive Care Program Funding.	N	$ (525,115)	$ (1,034,246)	$ (14,034,020)	$ (15,593,381)	-	-	The Oregon Contraceptive Care (CCARE) Program provides contraceptive and counseling services to eligible clients. A 50 percent reduction in services would result in 24,300 clients to be unable to be served by CCARE during the 17-19 biennium. Fourteen percent of Oregon Contraceptive Care clients have an unintended pregnancy averted through the provision of effective contraceptive methods and counseling services. With the proposed budget reduction, an additional 3,402 unintended pregnancies would occur among clients unable to receive services. The proposed budget cut would result in approximately 1,225 of these unintended pregnancies ending in abortion and 1,837 ending in a live birth. Given a conservative cost of $16,000 per delivery and one year of infant health care costs under Medicaid, an additional $29.4 million in Medicaid expenditures (state and federal) is expected as a result of these additional unintended pregnancies. A reduction in CCare special payments would significantly impact the financial sustainability of Oregon's local public health authorities (LPHAs) that rely on revenue from the program to support their organization's infrastructure. Many LPHAs utilize a staffing model whereby revenue received from the provision of CCare services support clinical and business staff who fulfill a variety of functions related to essential public health services. These estimates are based on the proposed budgeted amount for FY 17-19. However, due to a drop in client enrollment, we are projected to be underspent in FY15-17, which, if this trend continued, would lessen the impact of these potential cuts. It should be noted that while there was a significant decline in client caseload in 2014, monthly enrollment numbers began to stabilize in early 2015.

Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF & TTX	Federal Funds	Total Funds	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-2.97%	**13**	PH	Eliminate Babies First! Program Funding.	N	$ (1,520,283)	$ -	$ -	$ (1,520,283)	(1)	(1.00)	Babies First! is one of several public health nurse home visiting programs that offer a continuum of care to pregnant women, infants and children ages 0-5, as well as children and youth with special health care needs, who are at risk for poor health and developmental outcomes. The goal of the program is to identify high-risk infants (based on social, emotional and medical risk factors) and improve the health outcomes and early learning opportunities for these children and their families. Babies First! nurses encourage parental self-sufficiency, appropriate utilization of medical and social supports, healthy lifestyle choices, secure attachment and improved parent sensitivity to the child's needs. Data analysis reveals that, compared to other Medicaid clients, children enrolled in the Babies First! Program had significantly higher rates of immunizations, annual well-child visits and annual dental visits for the same year. Nurses provided Babies First! services to 4,258 children in 2014 and 4,102 children in 2015. The loss of Babies First! Program activities would impact the support Oregon families receive in every county and would eliminate the opportunity for local health departments to draw down Medicaid Targeted Case Management funding from the federal government. We are currently working with Medicaid to expand this program into the prenatal period to better serve at-risk pregnant women.
-3.03%	**14**	OSH	Close one of two Salem Residential Treatment Facility (RTF) cottages.		$ (1,984,973)	$ -	$ -	$ (1,984,973)	(10)	(10.00)	Closing this Salem cottage would reduce the RTF transitional treatment capacity on the Salem campus by eight beds. Patients who are residing in Secure Residential Treatment Facility (SRTF) units and who are ready to move to a less restrictive setting may have to wait longer for an RTF placement due to limited capacity. This may result in an increased length of stay within the Salem campus as patients ready to transition to community settings must wait until an opening becomes available.
-3.12%	**15**	OSH	Close second of two Salem Residential Treatment Facility (RTF) cottages.		$ (2,748,525)	$ -	$ -	$ (2,748,525)	(10)	(10.00)	Closing this Salem cottage would reduce the RTF transitional treatment capacity on the Salem campus by eight beds. Patients who are residing in Secure Residential Treatment Facility (SRTF) units and who are ready to move to a less restrictive setting may have to wait longer for an RTF placement due to limited capacity. This may result in an increased length of stay within the Salem campus as patients ready to transition to community settings must wait until an opening becomes available.
-3.16%	**16**	Non-Medicaid	Eliminate the Mental Health Services Fund (MHSF) dollars to Community Mental Health Programs for residential development.	N	$ (1,000,000)			$ (1,000,000)			This fund is used to update and remodel existing residential programs to maintain safe and healthy environments for residents. Elimination of this funding would result in some program facilities deteriorating and potentially resulting in unsafe environments. This would erode the livability of residential programs for adults with a serious mental illness.
-4.73%	**17**	Medicaid	Cover 25 fewer lines on Prioritized List of Health Services. Oregon Health Plan (OHP) coverage is based on the Prioritized List of Health Services, which ranks treatment and condition pairs in order of effectiveness. Starting July 1, 2017, OHP would cover lines 1 through 473. The agency would seek federal approval to no longer cover lines 474 through 498 for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	$ (48,293,013)		$ (155,958,123)	$ (204,251,136)			This action would have a dramatic impact on health care services that are covered for all OHP clients, including pregnant women, children, and other groups. Coverage would end for treatments of conditions such as collapsed structure of a lung, hearing loss and neonatal eye infections. Conditions that may cause significant functional disability would no longer be covered, including urinary incontinence and osteoarthritis and uterine prolapse. Several mental health conditions would no longer be covered, including social phobias and obsessive compulsive disorders, which would likely result in broader family and community impacts. In addition, coverage of many basic dental treatments, such as missing teeth, dental caries and dentures, would be eliminated for all eligibility groups. Elimination of coverage of this magnitude would make it very difficult for physical, dental, and mental health providers to deliver high quality, comprehensive care. This proposal would significantly increase administrative burden for providers and for the department.
-5.98%	**18**	Non-Medicaid	Reduce Flex Funding Contracts with Community Mental Health Programs by 20 percent.	N	$ (38,503,486)	$ (4,718,417)		$ (43,221,903)			This reduction would significantly affect Oregonians with mental illness without Medicaid coverage. Access to crisis services, acute psychiatric treatment (in a hospital setting), medications and case management services would be reduced by this reduction. This would likely result in people becoming more ill, doing poorly in school, experiencing strained family relationships and in some instances people would become homeless or may be jailed. There would increase demands on the Oregon State Hospital. These reductions could jeopardize the Maintenance of Effort requirements for the Mental Health Block Grant.
-6.26%	**20**	Non-Medicaid	Reduce rental assistance planned with Tobacco Tax investments by 65 percent.	N	$ (8,708,097)	$ (6,942,715)		$ (15,650,812)			If this reduction was taken people, would lose their rental assistance and accompanying supports. Most if not all of these persons would need to leave their residence for inability to pay. Individuals would be homeless, move in with friends or relatives or end up in higher levels of care. A secondary concern is that any reduction in the new mental health investments may result in federal findings with an Olmstead lawsuit against the state. The US Department of Justice (USDOJ) has been pleased with the steps that Oregon has taken to improve community mental health services. The investment by the Legislature in the community mental health system is a large factor in our current positive relationship with USDOJ.

Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF & TTX	Federal Funds	Total Funds	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-6.26%	**21**	PH	Eliminate the HRSA Maternal, Infant and Early Childhood Home Visiting (MCHIEV) Program	N	$ -	$ -	$ (8,454,283)	$ (8,454,283)	(10)	(5.00)	The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program provides federal funding to local programs to expand evidence-based home visiting services that support families with diverse needs in the 13 counties identified as most at-risk in the needs assessment. MIECHV supports three evidence-based models: Early Head Start; Healthy Families Oregon; and, Nurse-Family Partnership. The MIECHV program has been described as a bridge between Oregon's health system and early learning transformation initiatives. The outcomes of the MIECHV program align with both health system and early learning outcomes: Stable and attached families; health care access: prevention; and, readiness to learn. The program was successful in improving in all six of six benchmark areas: Maternal and child health; school readiness and achievement; domestic violence; child injuries, child abuse, neglect or maltreatment, and reduction in emergency department visits; family economic self-sufficiency; coordination and referrals for other community resources and supports. MIECHV has capacity to serve 846 families at any given time, and has served 1669 families since inception in 2010; many families have remained engaged over several years.
-6.32%	**22**	PH	Reduce in School-Based Health Center Program funding.	N	$ (1,954,602)	$ (544,440)	$ -	$ (2,499,042)	-	-	School-Based Health Centers (SBHCs) are medical clinics located at or within school grounds and provide a full range of physical, mental and preventive health services to all students. Access to health care at SBHCs reduces barriers such as cost, transportation and concerns about confidentiality that have kept children and youth from seeking service. SBHCs succeed through public-private partnerships between Oregon Public Health Division (PHD) and school districts, county public health departments, public and private practitioners and the community. This 25 percent reduction to SBHC funding would result in the potential closure of 20 SBHC sites and 13,700 students would not receive preventive or mental health services and would have to seek these services elsewhere.
-6.58%	**23**	OSH	Close Aid & Assist Unit – Flowers 3		$ (7,792,276)	$ -	$ -	$ (7,792,276)	(35)	(35.00)	Closing this Aid and Assist, or ".370," unit would reduce the capacity of the Salem campus by 26 beds and would further limit the availability of beds for .370 patients. This reduction option is only viable if current legislation and other efforts to reduce the OSH Aid and Assist population are successful. OSH is required by ORS 161.370 to admit .370 defendants within seven days of the court finding them unable to aid and assist in their defense. Closing this unit would limit OSH's ability to be in compliance with this law. Because OSH is required to admit patients under .370 orders within seven days, OSH must give them precedent over patients who have been Civilly Committed. Less capacity at OSH through this reduction option may result in more patients on the Civil Commitment wait list and for longer periods, which in turn, may result in longer stays in emergency departments for people waiting for an acute care bed.
-6.76%	**24**	Medicaid	Eliminate coverage for specific dental services for Oregon Health Plan (OHP) Plus adult clients. The agency would no longer cover the following dental services for adults (including pregnant adults) receiving the OHP benefit package: Crowns, full and partial dentures; scaling & root planning. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	$ (5,587,184)		$ (42,754,466)	$ (48,341,650)			Adults receiving the OHP benefit package could end up requiring more teeth extracted if they cannot be restored. Loss of denture coverage would prevent these clients from getting dentures to replace missing teeth, which can result in difficulty eating and finding employment. With reduced dental benefits, clients may access the emergency department more often because of unmet dental needs.
-8.18%	**25**	Medicaid	Eliminate dental coverage for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate the remaining non-pregnant adult dental coverage for the OHP benefit package. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	$ (43,656,404)		$ (184,618,180)	$ (228,274,584)			The lack of a dental benefit for non-pregnant adults on the Oregon Health Plan (OHP) would cause adverse effects on their physical health, such as diabetes and cardiovascular disease. Emergency room visits would increase. The OHP dental care organization infrastructure would be threatened with the loss of the adult population. This reduction would negatively impact the health system transformation work as fewer services and dollars would be available.
-9.07%	**26**	Medicaid	Eliminate addiction services for Oregon Health Plan (OHP) non-pregnant adults. The agency would eliminate addiction services from the OHP benefit package for non-pregnant adults. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	$ (27,360,616)		$ (197,221,082)	$ (224,581,698)			This reduction would eliminate clinic and community-based assessment and treatment for substance use disorders for non-pregnant adults who receive the OHP benefit package. These services are covered in the Medicaid State Plan under rehabilitative services and are optional. Hospital-based detoxification, screening and brief intervention by a physician would remain covered. Clients would have difficulty obtaining and maintaining employment. Some parents who have OHP coverage and children in the custody of Child Welfare would have increased difficulty being reunited with their children due to the inability to complete treatment requirements and maintaining safe living conditions for their children. This reduction would negatively impact the health system transformation work as fewer services and dollars would be available.

Accumulative % Reduction of CSL GF	Agency Priority	Program Area	Reduction Description	Federal Approval required? (Y/N)	GF & LF	OF & TTX	Federal Funds	Total Funds	# of Employees Affected	BUDGET FTE	Impact of Reduction on Services and Outcomes (include other program areas, number of clients affected, etc)
-10.00%	**27**	Medicaid	Cover 25 fewer lines on Prioritized List of Health Services. Oregon Health Plan (OHP) coverage is based on the Prioritized List of Health Services, which ranks treatment and condition pairs in order of effectiveness. Starting May 1, 2018, OHP would cover lines 1 through 448. The agency would seek federal approval to no longer cover lines 449 through 498 for the OHP benefit packages. LEGISLATIVE ACTION REQUIRED. CMS NEGOTIATION AND APPROVAL IS REQUIRED - The Health System Transformation waiver Special Terms and Conditions (STCs) prohibit the state from reducing eligibility or benefits.	Y	$ (28,726,603)		$ (150,246,727)	$ (178,973,330)			This action would have a dramatic impact on health care services that are covered for all OHP clients, including pregnant women, children, and other groups. Coverage for treatments of serious conditions such as cancer of the gall bladder and non-union of fractures would end. Conditions causing significant functional disability would no longer be covered, including urinary incontinence and several types of conditions that may cause hearing loss. Several of the most common mental health conditions would no longer be covered, which would likely result in broader family and community impacts. In addition, coverage of many common dental treatments, such as root canal therapy, crowns, and dentures, would be eliminated for all eligibility groups. Elimination of coverage of this magnitude would make it very difficult for physical, dental, and mental health providers to deliver high quality, comprehensive care. This proposal would significantly increase administrative burden for providers and for the department.
	28	Medicaid	Eliminate all Leverage	Y		$ (124,161,639)	$ (382,084,407)	$ (506,246,046)			Eliminates all leveraged programs including the matching Federal Funds, effective 7/1/17.
	29	PEBB	Reduce PEBB Self Insured Plan. PEBB contracts with Providence as the Administrative Services Provider for its self-insured medical plans. The operating budget for PEBB is 0.60 percent. The remaining 99.4 percent is program budget, which is dedicated funding for payment of self-insured and fully insured benefit plans that PEBB is contractually obligated to pay to carriers for claims reimbursement or pass-through of premiums.			$ (242,250,000)		$ (242,250,000)			Taking reductions at any level may potentially default PEBB in its contractual obligations with carriers. Major plan design changes could possibly hit the reduction targets, but it would take a major reduction in medical plan coverage and would jeopardize the stabilization of the statewide risk pool. A major shift in cost sharing between employee and employer could also potentially hit the reduction target, but the reductions would have to be taken at the state agency budget level as it passes employee benefit dedicated dollars through to PEBB.
	30	OEBB	Reduce OEBB contract budget. OEBB contracts with insurance carriers for Entity and Self-Pay member benefit plans. The operating budget for OEBB is 0.70 percent. The remaining 99.3 percent is program budget, which is dedicated funding for payment of insured benefit plans that OEBB is contractually obligated to pass-through to carriers.	N		$ (83,200,000)		$ (83,200,000)	-	-	Taking reductions at any level may potentially default OEBB in its contractual obligations with carriers. Premium shifts to members will not change the pass-through budget dollars needed to meet contractual obligations with carriers.
	31	OEBB	Reduce OEBB contract budget. OEBB contracts with insurance carriers for Entity and Self-Pay member benefit plans. The operating budget for OEBB is 0.70 percent. The remaining 99.3 percent is program budget, which is dedicated funding for payment of insured benefit plans that OEBB is contractually obligated to pass-through to carriers.	N		$ (113,721,673)		$ (113,721,673)	-	-	Taking reductions at any level may potentially default OEBB in its contractual obligations with carriers. Premium shifts to members will not change the pass-through budget dollars needed to meet contractual obligations with carriers.
-10.00%					**$ (307,712,215)**	**$ (575,467,767)**	**$ (1,190,140,512)**	**$ (2,073,320,495)**	**(259)**	**(251.00)**	

10% Reduction Options
2017–2019 Governor's Budget
Oregon Health Authority

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

A large proportion of the Oregon Health Authority's (OHA) budget is expended for services directly provided to clients.

General criteria and principles applied to the reduction list included:

- 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 will shift people to a more costly service model within OHA or DHS
- Minimizing affect to Health Systems Transformation efforts in 2017-19
- Avoiding reductions that will weaken the OHA's ability to meet its responsibilities to improve the health of all Oregonians through protection, assessment, epidemiology and emergency preparedness and response
- Identifying where the Affordable Care Act (ACA) provides an opportunity to minimize impact on OHA clients/customers
- Mitigating any impact for OHA's ability to meet its obligation to CMS for the 2% test

At the beginning of the 2015-2017 biennium, OHA streamlined the agency by completing an organizational restructure to further integrate programs and services to better deliver services to Oregonians. OHA restructured divisions based on functional assessments and prioritized ongoing work within existing resources. Since its restructure, OHA continues to diligently manage to its position authority and ensure it effectively controls overhead costs. Reduction options that reduce or eliminate programs include corresponding staffing reductions associated with positions to administer those programs and deliver services.

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

Central Office and Shared Services
Most of the Central Office and Shared Services General Fund is necessary for on-going commitments for which OHA does not materially have the option to reduce. Central, Shared, State Government Service Charges, and Debt Service on Capital Construction authorized in prior biennium, account for only about 3 percent of this budget. Administrative cuts through staff reductions or vacancies, or cuts to professional service contracts have been implemented in prior biennia. As OHA continues with its Health Systems Transformation efforts, any further reductions in these areas would have a direct impact for the Director's Office, as well as many of the OHA dedicated service offices (e.g., Human Resources, External Relations, and Equity and Inclusion).

Health Systems Division
Prescribers of mental health medications for Oregon Health Plan clients would be required to adhere to the preferred drug list. Exception requests would be evaluated under a prior authorization process. ***The 2017-19 Governor's Budget included this reduction.***

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.

Budgeted inflation for alcohol and drug treatment and community mental health programs would be eliminated.

Elimination of the CMH Mental Health Services Fund for residential development may result in some facilities deteriorating and potentially becoming unsafe. This could affect the environment and livability of residential programs.

Community mental health flex funding would be reduced 20 percent directly affecting access to services for Oregonians who have mental illness, but do not have Medicaid or other insurance coverage.

Community mental health funding for the Adult Mental Health Initiative would be reduced 41 percent. This funding is used to facilitate the transition of civilly committed adults from the state hospital to the community when they no longer need inpatient mental health treatment.

Rental assistance funding would be reduced having a direct impact on individuals and their stability in maintaining housing.

Oregon Health Plan coverage would be reduced by limiting or eliminating specific services or reducing line items covered on the Prioritized List of Health Care Services. Specific options reduce dental services, eliminate non-emergent dental coverage for non-pregnant clients, and eliminate treatment of substance abuse disorders for non-pregnant adults. Obviously, some individuals could have immediate adverse impact to their health without these services; others could see their health deteriorate.

All reductions to the Oregon Health Plan would require approval by the Center for Medicaid and Medicare Services (CMS) and most would be prohibited under the special terms and conditions previously agreed upon by OHA and CMS.

Public Health

Funding for the Oregon Contraceptive Care program would be reduced 50 percent. The program would not be able to serve approximately 24,000 Oregonians during the 2017-19 biennium.

The Babies First! nurse home visiting program and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program would be eliminated.

Funding for school-based health centers would be reduced 25 percent, causing the potential closure of 20 sites and affecting over 13,000 students.

Oregon State Hospital

The planned phase-in of residential treatment facility cottages at the Junction City facility would be amended by removing units. This would inhibit the ability of moving patients that are ready to move from the Secured Residential Treatment Facilities. By removing cottages as a phased-in reduction, this would ultimately affect the ability to move patients to a community setting. ***The 2017-19 Governor's Budget included this reduction.***

The planned phase in for Secured Residential Treatment Facilities at the Junction City facility would be amended by removing units. Overall capacity would be reduced from 6 units to 4, and limits the available number of beds for patients. ***The 2017-19 Governor's Budget included this reduction.***

The Mountain 3 Civil Unit would be closed, reducing the capacity at the Junction City campus by 25 beds, and would further limit the availability of beds for individuals who are civilly committed. ***The 2017-19 Governor's Budget included the closure of the Junction City campus.***

Residential Treatment Facility cottages in Salem would be closed, reducing the transitional treatment capacity of the Salem campus.

The Aid and Assist unit at the Oregon State Hospital would be closed. This reduction is only viable if proposed legislative efforts are successful in reducing this population.

UPDATED **OTHER FUNDS ENDING BALANCES FOR THE 2015-17 & 2017-19 BIENNIA**

Agency: Oregon Health Authority
Contact Person (Name & Phone #): Janell Evans (503) 945-5775

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Other Fund Type	**Program Area (SCR)**	**Treasury Fund #/Name**	**Category/Description**	**Constitutional and/or Statutory reference**	**2015-17 Ending Balance In LAB**	**2015-17 Ending Balance Revised**	**2017-19 Ending Balance In CSL**	**2017-19 Ending Balance Revised**	**Comments**
Limited	44300-030-01-00 Health Systems Division	Fund 3448 - Treasury Acct 1385, Grant #426600 Hospital Assessment	Grant Fund: Medicaid	Section 2, chapter 736, Oregon Laws 2003, as amended, establishes an Assessment on hospitals in the State that are non-waivered hospitals. HB 2216 in 2013	145,000,000	35,000,000	**0**	83,000,000	$35 million is budgeted for final Hospital Transformation Performance Program (HTPP) payment.
Limited	44300-030-01-00 Health Systems Division	Fund 3449 - Treasury Fund Acct 1390, Grant 426000 Tobacco Tax	Grant Fund: Medicaid and Non-Medicaid	Chapter 595 Oregon Laws 2009 section SECTION 18 establishes the Oregon Health Authority Fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for carrying out the duties, functions and powers of the authority under section 10 of this 2009 Act. Note: (Since SFY 11 DHS has used this fund to booked tobacco tax revenue received from DOR and book Medicaid, CHIP and Mental Health expenditures against the revenue.	25,000,000	0			No Tobacco Tax carryover is budgeted in 17-19 CSL. Tobacco Tax is applied continuously as it is received with no balance. Any carryover will not be known until Closeout
Limited	030-05	0401	Operations	Restricted by legislative spending authority	6,750,000	7,386,112	6,750,000	7,386,112	Continued use for Oregon Medical Marijuana Program operations and funding other PHD programs in lieu of General Funds.
Limited	030-05	0401	Operations			241,000		241,000	Unitary assessment from Department of Revenue dedicated to Emergency Medical Services.
Limited	030-05	0401	Operations			67,610		67,610	Fees supporting Radiation Protection Services program which provides radioanalytical laboratory services for exported grain products
Limited	030-05	0401	Operations			142,600		142,600	Fee to certify training in Lead Abatement and protection of children who occupy facilities regulated by the program.
Limited	030-05	0401	Operations			405,000		405,000	Fees supporting Radiation Protection Services program that ensures radiation safety of registrant employees and their patients/consumers/public
Limited	030-05	0401	Operations			241,000		241,000	Fee supporting Health Care Regulation and Quality Improvement related to birthing centers and ambulatory surgery.
Limited	030-05	0401	Operations			76,800		76,800	Fee supporting Health Care Reculation and Quality Improvement related to Home Health Agencies.
Limited	030-05	0401	Operations			847,000		847,000	Fees supporting Health Care Regulation and Quality Improvement relating to Hospital/In Patient fees to support program costs
Limited	030-05	0401	Operations			114,000		114,000	Fees supporting Drinking Water Services to conduct on-site inspections of public water systems, identify deficiencies and assure correction
Limited	030-05	0401	Operations			226,000		226,000	Fees supporting Health Care Regulation and Quality Implrovement related to Emergency Medical Technicians certification.
Limited	030-05	0401	Operations			44,500		44,500	Fees supporting Drinking Water Services related to plan review and approval of water system construction plans.

Limited	030-05	0401	Operations			59,700		59,700	Fees supporting Radiation Protection Services relating to radiation safety of devices containing radioactive material and their patients/consumers/public.
Limited	030-05	0401	Operations			548,000		548,000	Fees supporting Food, Pools and Lodging licensing through County governments protecting all customers who eat in restaurants
Limited	030-05	0401	Operations			276,900		276,900	Fees supporting Health Care Regulation and Quality Implrovement relating to the licensing of hemodialysis facilities and technicians.
Limited	030-05	0401	Operations			45,000		45,000	Billable contract with OR-OSHA
Limited	030-05	0401	Operations		1,895,000	2,543,684	1,895,000	2,543,684	Fees related to Health Licensing Office. Budgeted amounts reflects inadvertent reduction in revenues and associated balances to match expenditures in ORBITS; intent is to adjust in future iterations. Months in excess of standard required 3 months working capital need (approx. 7-8 months in 15-17, 5-6 in 17-19, forecasted based on trends in actual revenues, expenditures and associated drivers) in projected balances are necessary due to potential for litigation expenditures substantially impacting operations, as demonstrated repeatedly over the past decade.
Limited	030-05	0401	Operations			3,072,953		3,072,953	TWIST Development Funding for 17-19. USDA Infrastructure grant amounts have not been awarded. This revenue is restricted for the Development of the WIC TWIST replacement system.
Limited	030-05	0401	Operations	Tobacco Master Settlement Agreement (TMSA) and allocated through the Tobacco Use Reduction Act (TURA) for tobacco prevention andf education programs. PHD Budget bill authority.		0		0	Tobacco Master Settlement Agreement (TMSA) and allocated through the Tobacco Use Reduction Act (TURA) for tobacco prevention andf education programs.
Limited	030-05	0401	Operations	OAR 410-121-400-4020 Restricted for use in setting up the infrastructure and drug monitoring program	650,000	750,000	650,000	750,000	Remaining Provider Fees that Support operations for the Prescription Drug Monitoring Program(PDMP) for 17-19.
Limited	030-05	0401	Operations	ORS 432.50		50,000		50,000	Support Otregon Cancer Registry fo 17-19.Cancer registry fees are collected and used to cover the cost of abstracting data from cancer reporting facilities, and for special cancer data analysis and reports using data from the Cancer Registry.
Limited	030-05	0401	Operations	ORS 431.832-836 Tobacco Prevention and Education Program (TPEP) funding comprised of State tobacco tax dollars allocated through the Tobacco Use Reduction Account(TURA) for tobacco prevention and education programs. ORS 431.832-836		0		0	Tobacco Prevention and Education Program (TPEP) funding comprised of State tobacco tax dollars allocated through the Tobacco Use Reduction Account(TURA) for tobacco prevention and education programs.
Limited	030-05	0401	Operations	Restricted by CDC for vaccine purchases	1,020,884	3,274,897	1,020,884	3,274,897	Funds used to purchase vaccine supplies that are distributed to Local Health Departmetns.
Limited	030-05	0401	Operations	ORS 443.100 section 3c	828,959	870,884	828,959	870,884	Contributions from hospitals for the Alert System
Limited	030-05	0401	Operations	Restricted use for VISTA program, linked to FF Grant 280633 https://egrants.cns.gov/termsandconditions/VISTA_Support_Rev2016.pdf 2 CFR 200.307		60,000		250,000	Funding to support the training and on-boarding of VISTAs. There are two groups of VISTAs each Fiscal Year: 1st group is Fall - Approximately mid-August and the 2nd group is Spring - Approximately mid-April. Funding is used to support trainings/on-boarding and travel costs for VISTAs around the State of Oregon. Revenue is generated from Host Sites that have applied for and received a VISTA.

Limited	030-05	0401	Operations	Restricted and accountalbe to CDC as program income under Title 45 CFR 24, and Title 45 CFR Part 92.25.		78,992		78,992	Possible sHIVer improvements to link testing with Surveillance data, backfill federal funds for the purchase of medical S&S
Limited	030-05	0401	Operations	45 CFR 92.25(g)(2) restricts funds to "be used for the purposes and under the conditions of the grant agreement". http://www.hrsa.gov/grants/hhsgrantspolicy.pdf, section II-62, further states: program income may be used only for allowable costs in accordance with the applicable cost principles and terms and conditions of the award. Federal award under grant 280544	45,000,000	61,188,000	45,000,000	61,188,000	Support new and expanded initiatives outlined in the End HIV Oregon plan (www.endhivoregon.org) announced on World AIDS Day 2016. Plan includes: 1) Expanding housing services statewide ($7.5 million allocated to transitional housing projects over the next 5 years in coordination with Multnomah County Health Department Ryan White Part A grantee). 2) Implementation of Early Intervention Services statewide to link newly diagnosed to medical care, get partners tested quickly, and ensure treatment of STDs and viral hepatitis. 3) Implementation of Pre-Exposure Prophylaxis access services. 4) Implementation of innovation grants to promote culturally competent testing in communities facing HIV related disparitites. 5) Increase patient navigation and case management for persons not virally supressed. 6) Develop peer support programs to support long term medication adherence. 7) Implement trauma informed training and technical assistance.
Limited	030-05	0401	Operations			1,300,496		1,300,496	This amount of carry forward will cover 3 months of operating expenses (July-Sept). The amount was calculated by taking the average monthly expenditure within the 15-17 biennium and multiplying by 3.
Limited	030-05	0401	Operations			2,193,000		0	While not legislatively restricted, NASTAD assumes these funds will remain within the HIV program; and on that assumption invites State AIDS Drug Assistance Programs to sign onto their agreements with pharmaceutical manufacturers. Funds are earmarked for services that are not allowable under other available funding per federal grant guidance: increase syringe exchange services and implement PrEP medication access program.

Objective: Provide updated Other Funds ending balance information for potential use in the development of the 2017-19 legislatively adopted budget.

Instructions:

Column (a): Select one of the following: Limited, Nonlimited, Capital Improvement, Capital Construction, Debt Service, or Debt Service Nonlimited.

Column (b): Select the appropriate Summary Cross Reference number and name from those included in the 2015-17 Legislatively Approved Budget. If this changed from previous structures, please note the change in Comments (Column (j)).

Column (c): Select the appropriate, statutorily established Treasury Fund name and account number where fund balance resides. If the official fund or account name is different than the commonly used reference, please include the working title of the fund or account in Column (j).

Column (d): Select one of the following: Operations, Trust Fund, Grant Fund, Investment Pool, Loan Program, or Other. If "Other", please specify. If "Operations", in Comments (Column (j)), specify the number of months the reserve covers, the methodology used to determine the reserve amount, and the minimum need for cash flow purposes.

Column (e): List the Constitutional, Federal, or Statutory references that establishes or limits the use of the funds.

Columns (f) and (h): Use the appropriate, audited amount from the 2015-17 Legislatively Approved Budget and the 2017-19 Current Service Level as of the Agency Request Budget.

Columns (g) and (i):

Provide updated ending balances based on revised expenditure patterns or revenue trends. Do not include adjustments for reduction options that have been submitted unless the options have already been implemented as part of the 2015-17 General Fund approved budget or otherwise incorporated in the 2015-17 LAB. The revised column (i) can be used for the balances included in the Governor's budget if available at the time of submittal. Provide a description of revisions in Comments (Column (j)).

Column (j): **Please note any reasons for significant changes in balances previously reported during the 2015 session.**

Additional Materials: If the revised ending balances (Columns (g) or (i)) reflect a variance greater than 5% or $50,000 from the amounts included in the LAB (Columns (f) or (h)), attach supporting memo or spreadsheet to detail the revised forecast.